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# Older People, Rural Areas and Loneliness

## Evidence Review

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Dr Jennifer Betts

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## Abstract

The purpose of this report is to assess interventions aimed at addressing loneliness and social isolation among older people living in rural areas of Scotland.

Key words: Scotland; Rural; Elderly; Loneliness; interventions; systematic reviews; reviews.

## Introduction

This report is based on a review of systematic reviews addressing loneliness and social isolation in rural areas. Its purpose is to inform interventions to alleviate loneliness and social isolation in a rural area of Scotland. Research shows that the prevalence of loneliness in older people in rural areas requires urgent attention (Hussain et al, 2023)<sup>i</sup>. Loneliness and social isolation are major contributors to ill health, both mental and physical. They are associated with a list of adverse health and social outcomes including anxiety, depression, dementia, stress, sleep disturbance, coronary heart disease and stroke, poor health behaviours (e.g. a lack of exercise), increased mortality, a diminished immune system, and increased healthcare costs (Williams et al, 2022)<sup>ii</sup>. A systematic review conducted over a 25-year period reported that loneliness in old age is a predictor of increased suicide ideation, a conclusion supported by later studies (Hussain, 2023). In Scotland over 900,000 of the population live in rural areas and 46% of these are aged >65 (National Records of Scotland, 2017). Social isolation, ill health and socio-economic deprivation mean that older people living in rural areas are at higher risk of experiencing loneliness (Hussain et al, 2023).

## Methodology

Five electronic databases were searched for systematic reviews of interventions to alleviate loneliness and social isolation in older adults aged >65 living in rural areas. This was conducted between July and September 2023 and included: PubMed; Ovid; Medline; Cochrane Library; ResearchGate and Google Scholar. Initial

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searches included literature published between 2005 and 2023 and identified 48 publications. Searches identified 49 publications of which academic papers (n = 36), voluntary sector reports (n = 2), and Government reports and policy papers (n = 10). Of these only 3 related to rural areas (Williams, et al, 2022; Hussain et al, 2023; and Fien et al, 2022). A reading of the full text left (n = 16) publications for review. These were published between 2015 and 2023. Academic reviews (n = 11), primary research (n=1), Government report (n = 1) and voluntary sector reports (n = 2). Systematic reviews found a variation in age profiles that ranged from >50 to >65. The inclusion selection criteria for reviews were broadened to include reviews of interventions to address loneliness and social isolation in older people living in the community aged from >50 years.

### Defining concepts

There is currently no international definition of ‘older adults’ and as stated by the UN there is currently no international definition for rural areas (Fine et al, 2022)<sup>iii</sup>. A lack of definition as to what constitutes ‘older people’, ‘rural’, ‘loneliness’, and ‘social isolation’ has been identified in academic research. Unsurprisingly given the range of ages included in reviews of interventions to address loneliness in older people, where interventions reported in the reviews included participants from 50 years of age.

### Older people

Thompson et al, (2023) notes that there has been an increase in research publications relating to loneliness, social isolation, and older people since 2000 with varying definitions of what constitutes an ‘older person’<sup>iv</sup>. The United Nations defines older adults as persons over 60 years of age, while in the UK a person over 65 years is considered an older person. The World Health Organisation (WHO) provides global statistics for persons over 60 years, but also states that health and mental capacity changes relating to ‘old age’ “... are neither linear nor consistent, and they are only loosely associated with a person’s age in years.” (WHO, p1)<sup>v</sup>. WHO also

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points out that the diversity seen in old age is not random, and that beyond biological changes, ageing is often associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and partners.<sup>vi</sup> The reviews included in this report had different inclusion criteria in relation to age. For example, Noone and Yang (2021)<sup>vii</sup> included sample groups aged from 50 years, while Hussain et al (2023) defined older adults as those aged over 60 years. In others community-dwelling adults aged over 65 years were included (Thompson et al, 2022 and Jimenez et al, 2021<sup>viii</sup>). Thompson et al (2023) defined ‘community dwelling older people’ as being over 65 years but due to the varying definitions of ‘older people’ included reviews if the mean age of participants was 65 years or over.

## Rural Communities

Rural areas are normally defined by population density. In the UK the Office for National Statistics (ONS) defines an area as ‘urban’ if its population is over 10,000, a minimum area of 200,000 square metres, and settlements within 200 metres of each other being linked. All remaining areas are considered rural with a low population density where economic activity includes farming and forestry. The UN Statistical Commission and US Census Bureau also define rural based on population density. Hussain et al (2023) conclude that rural areas can be defined as having a population of fewer than 5,000, have low building density and are situated at a distance from an urban area.

In Scotland the definition of rural is a settlement with a population of less than 3,000 and although 17% of the population in Scotland is aged >60, they make up 21% of the rural population in several rural local authority areas<sup>ix</sup>. In 2017 National Records of Scotland reported that over 900,000 of Scotland’s population lived in rural areas and 46% of these were >65, with a third living in remote rural areas. It was also projected that there would be a 50% increase in those aged >60 in 2023<sup>x</sup>. Rural areas in Scotland are categorised by the length of time it takes to drive to them. An accessible rural area is considered to be less than a 30-minute drive to the nearest settlement of >10,000 population, and remote rural is more than a 30-minute drive from a settlement of >10,000.

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## Loneliness and social isolation

The terms ‘loneliness and social isolation’ are often used as a single concept or viewed as interchangeable. However, researchers have made a distinction between the separate concepts of loneliness and social isolation as findings suggest that each concept may have independent impacts on health and therefore should be viewed as individual (Hussain et al, 2023; Fakoya et al, 2020<sup>xi</sup>). An individual can be socially isolated, but not identify as lonely and another person may be ‘lonely in a crowd’.

Hussain et al (2023) define loneliness as “... based on perceptions, evaluations and responses of one’s interpersonal reality, and is expressed through the multifaceted interplay of behaviors, feelings and cognitions” (Hussain et al, P.2). Cotterell et al (2018)<sup>xii</sup> define social isolation as “...an objective measure reflecting an individual’s lack of contacts or ties with others, such as family, friends, acquaintances and neighbours” (Cotterell et al, P80).

## Social networks

Social networks refer to relationships with friends and collaboration between individuals and organisations. Hussain et al (2023) describes social networks as being composed of socially relevant nodes and ties. Nodes are network members consisting of individuals and organisations a person is a part of, and ties are relationships with family, friends, acquaintances, and colleagues. Social networks are also referred to as social capital, social connections, and social support. The perceived and received support determines the quality of a social network (Hussain et al, 2023).

## Social connection

A person’s social connection is determined by the size of their social network and amount of social support they receive, aspects of social life, and the quality of social relationships. It satisfies an inherent need for interpersonal relationships, and is

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where people get a sense of belonging, connection, and being cared for and valued among family and friends (Hussain et al, 2023).

## Ageing and loneliness

The Opinion and Lifestyle survey in the UK (ONS, 2021) collected data during Covid 19 and the associated lockdowns in the UK (October 2020 to February 2021). Findings showed that it was in areas with a higher concentration of young people (16 – 24) and unemployment where there were higher rates of loneliness, compared to local authorities in countryside (rural) areas that had lower rates than industrial and urban areas<sup>xiii</sup>. In February 2020, the Guardian reported that more than 2 million adults suffer from chronic loneliness that in its severe form is more prevalent among Britain’s oldest and younger citizens than any other age groups<sup>xiv</sup>.

A UK Government review to identify gaps in research into loneliness (HM Gov, 2023)<sup>xv</sup> found that previous and current work on loneliness was based on individual factors that predict loneliness with an absence of research on community level risk factors, or place-based impacts. It also raises questions around what factors cause transient loneliness to become chronic loneliness. People are living longer with complex conditions and multi-morbidities. Loneliness can occur in any location, urban or rural, and can be caused by losing a partner, divorce, ill health, and/or lack of mobility. A review focusing on social isolation defines social isolation as “...an absence or limitation in the quantity of social interactions” (Cotterell et al, 2018, p80). However, rural areas that are geographically isolated have additional issues such as family moving away, diminishing community resources, and a lack of access to primary health and social care.

## Ageing in rural locations

Many people move to rural areas when they retire. At this stage in their lives they will associate words like ‘relaxation’ and ‘tranquillity’ with a rural lifestyle. However, with age come additional challenges for rural living. Poor transport services can limit social participation and access to health services, leading to costly home visits by

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social care staff. Community and voluntary sector services exist but are not available everywhere leading to gaps in provision. For rural areas there are increased costs for service delivery with lower economies of scale, higher per-capita costs, and increased travel costs. *“Failure to plan ahead or engage with preventative care and intervention can result in older residents engaging with services at ‘moments of crisis’* (Shared Lives Plus, 2020, P5)<sup>xvi</sup>.

A report by Age UK and Public Health England (2020)<sup>xvii</sup> found older men from the farming community had specific support needs due to the circumstances of their working lives and sometimes preferred to be supported from within that community in later life. Some older male carers were not supported by existing carers’ services and the closure and changing nature of pubs contributed to their loneliness and social isolation. However, many of the older people who took part in the study continued to work into later life and felt that this had benefits such as connecting them to their communities.

A Government report identifying gaps in research into loneliness (HM Gov, 2023) found that previous and current work on loneliness was based on individual factors that predict loneliness with an absence of research on community level risk factors. There was also a lack of work that addressed place-based factors. This is in line with the research we have conducted where there was a lack of research focusing on loneliness in rural areas.

### Factors that can lead to loneliness and social isolation

While it is true that social isolation, particularly in rural areas can lead to loneliness, not everyone who is socially isolated will experience loneliness and many of the factors and circumstances that can lead to loneliness are true for urban as well as rural areas. Cotterell et al (2018) list personal characteristics, life-course transitions, and community and societal level factors that can lead to social isolation. At a personal level these include: being aged 75 years and over; living and spending significant periods of time alone; being widowed or divorced; having limited financial resources; having psychological vulnerabilities; belonging to certain minority groups; language barriers; having no children.

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Life-course transitions that can lead to social isolation are also identified as: a decline in general health; loss of vision or hearing; physical disability or loss of mobility; diagnosis of dementia; retirement; loss of income; losing the ability to drive; losing a partner; being a care giver; children leaving family home; children locating a long way away.

At community level factors include: living in a socially deprived area; high levels of neighbourhood crime; high residential mobility; limited opportunity to participate in social activity; limited access to services, amenities and public transport. At societal level structural influencing factors are: discrimination and marginalisation; economic and social policies that maintain socioeconomic inequalities; and a lack of social cohesion and social norms that discourage social activity (Cotterell et al, 2018).

These circumstances can occur wherever a person lives, producing feelings of loneliness and/or social isolation. However, they can be exacerbated for older people in rural areas by the objective reality of socioeconomic deprivation, diminishing community resources, poor access to health and social care, and not having access to a private car where public transport is limited (Noone et al, 2021).

Fakoya et al (2020) highlight the need for clarity in relation to the concepts of loneliness and social isolation to allow service providers to use the accumulated evidence to inform the intervention most appropriate for certain individuals. It will also assist in deciding what outcomes should be measured for evaluation purposes. Social isolation can remain undetected as it is not routinely assessed in primary care. Reviewers emphasise the importance of raising awareness and the central role of primary care professionals in assessing and referring those at high risk to appropriate interventions (Thompson et al, 2023). The ‘Making Every Contact Count’ (MECC) assessment tool is recommended to be used by primary care staff and community workers. This involves having brief conversations with people about how they can make changes in their lives to improve their health and wellbeing and can provide an initial assessment of risk of isolation to decide if onward referral is appropriate. They argue that this can easily be fitted into existing clinical practice (Cotterell et al, 2018).



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## Interventions

There is agreement among review authors that there is no ‘one size fits all’ in relation to interventions to alleviate loneliness or social isolation. Categorisation of interventions to address loneliness and social isolation differed throughout the literature studied (Fakoya et al, 2020; Hussain et al, 2023; and O’Rourke et al, 2018<sup>xviii</sup>). Fakoya et al found review authors used a range of terms to categorise the characteristics of interventions, often with different meanings. These included mode of delivery, focus, nature, format, type and goal. Intervention studies were divided into categories based on the programme or method type: group activity, one-to-one interventions, service delivery, and community-based approaches. Other reviews categorised interventions based on cognitive-behavioural therapy, social skills training, and the development of social support networks.

Thompson et al (2023) found that there were substantial variations in how programmes were implemented and limited evidence of how effective they were, while Cotterell et al (2018) identified that some one-to-one interventions involved an element of group interaction making it difficult to infer causality. Fakoya et al point out that the characteristic of whether the intervention is delivered to a group or individual is important as group interventions are likely to be more appropriate for those with insufficient social links than one-to-one interventions. There are also different approaches, for example psychological interventions will try to change attitudes while sociology will build on social structures and social networks. Not having uniform categorisation of interventions can lead to confusion for service providers and policy makers. Fakoya et al conclude that there is a need for the development of a framework to define key constructs in relation to loneliness and social isolation interventions. Otherwise, they argue interventions will be undermined by a lack of clarity around the characteristics of interventions which are complex with interacting components. They argue there is a pressing need to tailor interventions to individual needs as not all older adults experience loneliness to the same extent.

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## Success of interventions

Hussain et al found that social networks were important in rural areas where for older people social networks consisted of family and neighbours. These play a vital role in feelings of social connectedness and being able to talk and share thoughts, feel cared for and supported and create a sense of belonging. Family networks also provide an older person with a meaningful role that contributes to their sense of wellbeing. Participation in neighbourhood and religious groups were also found to reduce loneliness. Volunteering and engaging in sports or exercise meant lower social isolation from family, neighbours and friends. Social networks were also established through technology. For example, telephone calls on a daily basis strengthened social support. Having a poor social network and feelings of loneliness was found in one study led to admission to nursing homes for older adults in rural areas.

In relation to psychological interventions social prescribing, and education programme for social participation and an Active Ageing programme all found that social participation scores increased in the sample groups. It is also noted that the studies were carried out in different countries but produced the same positive results. The Active Ageing programme found that the older adults, through participation in different activities developed social connections and a sense of belonging and being cared for.

Fien et al, found that exercise programmes play an important role in stopping a physical decline in older adults. However, rural settings experience unique challenges in relation to access to equipment and resources, transport and significant costs.

## Conclusion

This is a confusing area with a need to develop agreed terms to describe the elements involved. It is also difficult to identify the components within interventions that are responsible for a positive effect. Further research in designing an assessment tool to identify those at risk of social isolation is needed. It is also hard to identify what part of an intervention has made a difference as some one-to-one

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interventions involved some element of group interaction making it difficult to infer causality (Cotterell et al, 2018).

Noone and Yang (2021) recommend that “...*In order to advance understanding of community-based loneliness interventions, a comprehensive investigation into their level of success is needed. The success of loneliness interventions varies significantly, but only limited evidence exists.*” (p870, section 4.1). They criticise the focus on the number of people reached and their level of satisfaction with interventions meaning that contextual circumstances are overlooked. Future research should include contextual circumstances such as place of residence with a distinction between urban and rural areas.

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