Social prescribing for the loneliness epidemic

Patients are living longer, but often with fewer social supports, family, and friends than they would like. As physicians, can we improve their quality of life through social changes?

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Nonmedical determinants of disease include poverty, lack of employment and housing, uncertainty, and limited access to care. Here we highlight a growing area of concern among such fundamental causes of poor health: the loneliness experienced when elders find themselves isolated and short on common social connections, the relationships we have with people around us that ground us in our functional well-being.

Vancouver Island has a population of 864 000, 26% of whom are 65 years of age and over.[1] Some would consider Vancouver Island a retirement destination. In our practices, we see people who are sometimes sick and sometimes not. They come to our offices for advice, education, medications, plans for surgical intervention, and, quite commonly, connection. Our patients may live alone, with family far away. Some are bereaved, and some may be frail in mind and body.

Patients confide in us their hopes, fears, anxieties, and vision of the future. They may be living in an empty nest, grieving the loss of a loved one, or subsisting on a limited pension in inflationary times. They may not be well enough to join a walking group (arthritis) or drive a car (dizziness). Their vista can change from abundant connections with others to a flight of stairs and two or three rooms. They usually make it to their doctor's appointments to refill a prescription, renew an acquaintance, or just confirm their interest in a periodic assessment. As physicians, we are their confidants, friends, and health advocates, and we are privileged to learn about our patients' circumstances in the office, in the hospital, in a meeting room, or in public. It is both the nature of our job and a unique obligation to empathize and respond to the plight of the disadvantaged, including those who are lonely—feeling empty, alone, and unwanted due to solitude.[2]

Compounding this epidemic of loneliness is a clear ripple effect from the COVID-19 lockdown period, which resulted in a wave of social isolation, thanks to reduced nurse visits, bridge parties, trips to the theatre, and chitchat at the grocery checkout. Life became less colorful; grandchildren didn't come to visit, or visits were reduced to waving through a window or standing at a distance in the driveway. The stoic refrain of the time, "I'm getting by," sums it up. But "getting by" does not imply quality, enjoyment, fulfillment, or fun. Looking further into the past, we see that the phenomenon of disconnection precedes the COVID-19 lockdown, precipitated by even larger and more pervasive forces than a global pandemic.

In 2018, the City of Vancouver Seniors Advisory Committee[3] produced a set of recommendations to mitigate the erosive aspects of social isolation and loneliness. And it is not only physicians who see the burden of loneliness from day to day. A survey by Statistics Canada in mid-2021[4] found that more than 40% of Canadians feel lonely some or all of the time, with the problem worst among single people and those who live alone. In "A kingdom of one: The great loneliness pandemic,"[5] Nava makes clear that social isolation confers a greater risk of premature death than obesity. The data clearly show that this condition shares equivalent potential for harm with other illness promoters (e.g., cigarette smoking). Loneliness has been linked to reduced cognitive function and a higher risk of dementia, as well as stroke, heart disease, and cancer mortality. It contributes to the prevalence of anxiety, depression, and even suicide.

Recognizing that loneliness is associated with reduced physical activity, insomnia, hypertension, cardiac disease, and early mortality, the UK appointed its first Minister for Loneliness in 2018.[6] Similar appointments followed in Japan, Australia,

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and New Zealand. Last year, US Surgeon General Dr Vivek Murthy called loneliness a growing health epidemic on par with every chronic public health issue of import over the past half century.[7] A 2022 report from the National Institute on Ageing estimates that 12% of Canadians aged 65 years and older feel socially isolated, and 24% report low social participation.[8] Other estimates are substantially higher. The report acknowledges that few long-term strategies have been adopted to address these health issues and advocates for metrics to track their prevalence. Recognizing that we need to develop and share effective programs, it offers six policy recommendations:

1. Adopt consistent definitions.
2. Raise awareness and destigmatize these conditions.
3. Raise public and health provider awareness of the adverse outcomes of loneliness at any age.
4. Continue research on impacts of social isolation and loneliness and evaluate the effectiveness of interventions.
5. Build capacity for organizations to address isolation and loneliness.
6. Prioritize equity, accessibility, and inclusion-based approaches.

Recently, a pharmacist colleague who emigrated from Armenia shared her experience of coming to Canada 15 years ago. She found the "warehousing of elders" to be disorienting compared with the intergenerational homes she was used to in Europe. She said that her first few years in Canada were some of the loneliest of her life. Our society may have evolved traits that are potentially injurious to mental and physical health—a fact that may be more apparent to those accustomed to intergenerationally integrated environments.[6]

Our fragmented and individualistic society is failing our elders' need for networking, communication, encouragement, and support. Remember Dr Bonnie Henry's clarion call during the pandemic to be kind, be calm, be safe? What if what the world needs most right now is the wisdom and care of the elderly?

Within BC and across Canada, a movement called social prescribing is evolving to better respond to these pervasive nonmedical and social needs of seniors. Social prescribing connects people at risk of loneliness and its complications with activities and people in the community. It acknowledges that health is more than the absence of disease and aims to support mental, physical, and social well-being through enhanced access to community, cultural, and recreational stimulation. Such a resource should be in the toolbox of all health care providers. For this population, we might reflect that quantity has been achieved, but where is quality? If we ask seniors what quality looks like to them, we might be surprised how often it comes down to connectivity with friends, family, neighbors, activity groups, the arts, health care professionals, and others.[9] Such informal connections have long been observed to be a vital component to effective care.

We should ask patients "What matters to you?" And our response should be a codesigned, coproduced attempt to connect them with others, with local resources, and with local networks. Activating these networks[10] is at the core of high-quality social prescribing. We can learn key aspects of successful coproduction from the UK's National Health Service. Those interested in implementing social prescribing into their practice can access information from the World Health Organization, the Red Cross, the United Way, the Canadian Institute for Social Prescribing, the Canadian Alliance for Social Connection and Health, and the Genwell Human Connection Movement.[10-12]

Repairing social malfunction requires something simple and human: social connectedness. The Minister of Health and the Office of the Seniors Advocate have recognized our escalating burden of human disconnection, with support for programs that target this anomaly. With a clear and present epidemic of loneliness, especially among our elders, we hope that all health professionals will participate in social prescribing and coproduction programs as they roll out across British Columbia. It starts by asking patients "What matters to you?" Connections are likely to be the cure. ■

Competing interests
None declared.

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