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1. Introduction

Loneliness and social isolation are two different things. Social isolation is defined by the actual lack or limited amount of social relationships, contacts or participation. Loneliness is a subjective state of feeling alone, and it is a feeling of a lack of relationships compared to what someone wants. This is important because an older person's age does not indicate that they are lonely, but someone who is lonely may not be elderly. Recent evidence, however, warns about considering contact frequency as a proxy for an emotional relationship (Puyan   et al., 2025; Kenny et al., 2025).

The issue of loneliness is still relevant in UK health and social care (NHS Digital, 2023; World Health Organization, 2025). The ONS carried out a survey between January and February 2026, which showed that 16% of adults aged 70 and over often, always or some of the time felt lonely. This was lower than for younger groups, but still represented a significant minority. Age UK has also reported separately that there are close to a million older people in the UK who are lonely. Although these figures defy the stereotype of being lonely in later life, they also indicate that there is a substantial high-risk group that is not going away (ONS, 2026; Age UK, 2024).

Loneliness is linked to depression, anxiety, decreased quality of life and other negative outcomes. Association does not equal causation, though. Social participation can be limited due to poor health, depression may lead to social isolation, and poor relationships can exacerbate psychological distress. Therefore, the usefulness of longitudinal data over a period of time is more helpful than a straightforward comparison of prevalence when considering the interaction of these factors (Di Gessa, Bordone and Arpino, 2025).

Another challenge is that loneliness is often considered as a monochronic construct, yet there are meaningful distinctions in terms of length and intensity. Loneliness can be temporary, for example after retirement, following the death of a partner or spouse, or due to an illness, and may be solved once the situation changes; on the other hand, if this loneliness is ongoing, it might be a sign of more serious issues related to health, finances, mobility or a loss of relationships. This is important for practice because, for some individuals, the social support they need is provided for a short period of time, while for others, the social support that is needed may be more chronic. Thus, a report of prevalence alone is not the only type of review that can be useful; a review which distinguishes between transient and persistent patterns can be more useful.

This review aims to answer this question: What do current peer-reviewed studies in the UK reveal about the effects of social isolation and loneliness on the wellbeing and mental health of older adults?

The review has four aims. It first reviews the link between loneliness and social isolation and mental health and wellbeing. Secondly, it helps to relate things that make a person more or less vulnerable.

Third, it critically compares five recent, peer-reviewed studies. Finally, it reflects on the implications of this for health and social care practice, policy and future research in the UK.

2. Background

Reducing the proportion of people who live alone is not the UK problem. According to the Community Life Survey, 6.6% of adults in England said they often or always felt lonely in 2024/25. But population surveys can't determine why someone feels lonely and whether greater contact would alleviate loneliness (Department for Culture, Media and Sport, 2025).

One of the key factors is health status. A lack of mobility, long-term health problems or bereavements can limit access to relationships. But their impact doesn't just affect the physical structure. Frequent contact can be maintained, but a previous intimacy or trust may be lost. Among community-dwelling older adults, poor health, widowhood, and loss of social networks were consistently identified as risk factors by Puyan   et al. (2025). They also differentiate between objective isolation and subjective loneliness, and they agree that there should be an objective measure as well as a subjective one.

The COVID-19 period is helpful as it illustrates how opportunities for social contact have changed at a rapid pace. Zaninotto et al. (2022) noted that levels of depression, loneliness and quality of life worsened in 2020, as compared to pre-pandemic times in the English Longitudinal Study of Ageing (ELSA). But the risk of infection, loss of loved ones, disruptions in healthcare and restrictions happened at the same time. The results thus indicate that social disruption caused a decline in mental health, but do not indicate that the decline in mental health was caused solely by the reduction in contact.

Retirement is also subject to some assumptions, with evidence to the contrary. Kenny et al. (2025) analysed ELSA data from 3,758 participants, including 766 who newly retired. There was a short-term decrease in social isolation for the retirement group and no short- or long-term change in loneliness. This does not mean that, when the structure of a social network changes, the same emotional reaction would take place.

Combating loneliness has become a cross-sector challenge and is increasingly being acknowledged as a policy concern in the UK. There are examples of government efforts to tackle community connection and local authorities that have developed anti-loneliness strategies (Department for Digital, Culture, Media and Sport, 2023). But strategic commitment does not mean effectiveness. In England, there was no overall decrease in the levels of loneliness, social isolation or depression after local anti-loneliness strategies (Li et al., 2024).

This is an important disconnect between policy action and outcomes that are measurable. Even the best intentions of local programmes can be undermined if they are not accessible due to transport, disability, confidence or cost, or if they aren't available digitally. Further, initiatives which record participation but

not emotional impact could look successful if they don't actually reduce loneliness. The evaluation should differentiate between service delivery and benefit. This is especially relevant in health and social care, where there are limited resources, with an emphasis on interventions that show significant change as opposed to high participation.

3. Methods

3.1 Review Design

The available evidence was in the form of longitudinal, quasi-experimental and qualitative studies, so a scoping review was selected. Scoping reviews are appropriate for mapping the evidence, making comparisons of research approaches and determining research gaps, but not for calculating one pooled treatment effect. There is also a strong focus on transparent study selection, data extraction and synthesis related to the research question (Pollock et al., 2023; Pollock et al., 2024).

3.2 Search Strategy

The literature search was structured and conducted via PubMed, Europe PMC and academic publisher databases. Searches used a combination of terms for population, exposure, outcome and location.

A sample search term used was:

("older adults" OR ageing OR elderly) AND ("social isolation" OR loneliness OR "social connection") AND ("mental health" OR depression OR anxiety OR wellbeing OR "quality of life") AND (England OR UK OR "United Kingdom")

Relevant recent reviews were also used as a source of reference lists. Only studies within the period from 2022 to August 2026 were considered.

3.3 Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
Peer-reviewed research articles	Editorials and commentaries
Published 2022–August 2026	Publications before 2022
Older or ageing populations	Studies focused only on younger groups
UK or England evidence for core studies	Non-UK studies as core evidence
Loneliness or social isolation central to study	Irrelevant social-contact studies
Mental-health or wellbeing outcomes	No relevant outcome
Primary or secondary research	Policy documents as core studies

The five core studies did not include government reports and national statistics, which were kept as contextual evidence.

3.4 Study Selection and Data Extraction

Titles and abstracts were initially screened, followed by a review of eligible full texts. Five studies were retained that were peer-reviewed and showed evidence of longitudinal, quasi-experimental or qualitative designs directly relevant to older adults in England or the UK.

Data were collected in each study for population, sample, design, exposure, outcomes, findings and methodological limitations.

Ranks of the selected studies were not a function of only sample size, but also of the methodological value that each study design could provide to the question under study. Large longitudinal databases were used to find changes over time, and qualitative research was used to obtain information on experiences and barriers which could not be measured in a survey. The mixed evidence base expanded breadth, but also necessitated caution as evidence from distinct designs could not be compared to the same extent or used as evidence of the same type.

3.5 Analysis

Thematic analysis was used for the comparison of findings. Coding was done on regularly occurring patterns and key conflicts. Thematic analysis is not a matter of counting, but an interpretative process, as emphasised by Braun and Clarke (2023). Three themes emerged: meaningful connection is more important than mere contact; loneliness and poor mental health are intertwined over time; and effects of vulnerability and intervention are socially patterned.

3.6 Ethical Considerations

No subjects were recruited and no personal information was collected. Ethical concerns thus focused on correct citation and representation of results, and the avoidance of unsupported causal statements. Study limitations were not excluded from the analysis because excluding them would only inflate the findings.

4. Results

4.1 Characteristics of the Five Core Studies

Study	Design and Sample	Main Result	Key Methodological Issue
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Zaninotto et al. (2022)	Longitudinal ELSA cohort; 5,146 older adults	Depression, loneliness and poor quality of life increased during 2020	Multiple pandemic exposures prevent isolation of one causal factor
Vlachantoni et al. (2022)	Longitudinal UK study; 1,235 adults aged 70+	33.7% experienced loneliness; living alone and changing support increased risk	Existing lonely participants were excluded
Willis and Vickery (2022)	Interviews with 72 men aged 65–95 living alone	Masculine norms and self-reliance complicated disclosure and coping	Selected sample limits generalisation
Li et al. (2024)	Difference-in-differences analysis using ELSA and UKHLS	Local strategies produced no significant overall improvement	Strategy presence may not reflect implementation quality
Di Gessa, Bordone and Arpino (2025)	Ten-year ELSA panel; 4,740 participants	Distinct loneliness trajectories occurred over time	Observational data cannot remove reverse causation

4.2 Theme One: Meaningful Connection Matters More Than Contact Alone

In all studies, contact frequency was not a sufficient explanation for loneliness. Vlachantoni et al. (2022) determined the influence of social support and relationship quality on loneliness onset in adults aged 70 and older. One-third of those who never endorsed loneliness prior to the pandemic experienced it later.

The survey does not capture the mechanism provided by Willis and Vickery (2022). Sometimes older men who lived alone did not talk about loneliness because of the importance of self-reliance to their masculine identity. Contact-based interventions might therefore fail to reach individuals who have some contact, but aren't comfortable sharing their emotional needs.

This is confirmed by the study carried out by Di Gessa, Bordone and Arpino (2025). In total, over the 10-year period, about 37% continued to have low levels of loneliness consistently, and smaller numbers of people felt increasingly lonely or stayed lonely. More favourable trajectories were linked to better or improving relationships. The quality of the relationship and changes thus seem more informative than household status alone.

4.3 Theme Two: Loneliness and Mental Health Interact Over Time

Worsening depression, loneliness and quality of life during the pandemic were found by Zaninotto et al. (2022). Individuals not in a relationship had worse outcomes, and individuals with fewer economic

resources had worse outcomes. But the concurrent increase in loneliness and decrease in depression does not create a causal sequence from loneliness to depression.

Other factors that were associated with increased or chronic loneliness, such as poor health and depressive symptoms, were also found by Di Gessa, Bordone and Arpino (2025). This indicates one of the possible feedback mechanisms. Psychological distress can affect social functioning, and not being happy in relationships can aggravate distress. A contact deficit approach to loneliness may miss the point and may not be sufficient to address mental and/or physical health issues.

4.4 Theme Three: Risk and Intervention Effects Are Unequally Distributed

Some gender differences were found by Vlachantoni et al. (2022), and some socioeconomic and relationship groups had poorer outcomes in Zaninotto et al. (2022). Age alone is therefore not sufficient and cannot be used as a basis for support.

In conclusion, there was no overall evidence that local-authority strategies affected loneliness, isolation or depressive symptoms, as highlighted by Li et al. (2024). There were some better-educated or higher-income groups that showed small benefits. This indicates that programmes at the population level may not be equitable in reaching people with the greatest need.

The three themes also dovetail into each other rather than working separately. A lack of physical health can limit contact, a lack of contact can take its toll on support, and a lack of support can lead to a lack of motivation to get in touch. Likewise, financial difficulties can impact transport and social participation and can contribute to psychological stress. The evidence thus favours a 'cumulative risk' interpretation over a single-factor interpretation. It is important to note that those who are older and have multiple disadvantages may require more intensive and coordinated support than those who are just temporarily affected by social disruption.

5. Discussion

The five studies demonstrate that there is a consistent correlation linking loneliness, social disconnection and reduced wellbeing, and that simply increasing social contact is not sufficient to have a positive impact on mental health. Their common conclusion is that the quality of the relationship, health, and social situations are interwoven.

The strong longitudinal evidence is provided by Zaninotto et al. (2022), who re-assessed the same population before and during the pandemic. This design is more robust than a stand-alone lockdown survey. COVID-19 brought multiple concurrent shocks, however, such as bereavement, disruption of healthcare and concerns about infection. Rising loneliness can't be blamed for the rise in depression.

Vlachantoni et al. (2022) take a closer look at adults who were not lonely prior to the pandemic to improve the temporal interpretation. Their study was designed in seven waves, which can detect the factors involved in the onset of loneliness. But excluding those who might be at risk of loneliness beforehand restricts conclusions about chronic or persistent loneliness. The study is therefore robust on knowledge of transition into loneliness, rather than on in-depth knowledge of severe loneliness over time.

Willis and Vickery (2022) consider another constraint. Surveys do not provide a complete explanation of why people do not seek support; rather, they identify prevalence. The interviews indicate that there was a masculine expectation of independence that influenced disclosure among older men. The non-statistically representative sample does not account for the possibility that available support may not result in help-seeking, but the study does provide a plausible explanation.

All the research presented here poses the most compelling counterarguments to policy optimism, specifically Li et al. (2024). They use a difference-in-differences design instead of comparing authorities at one time. However, this lack of an average effect doesn't mean all anti-loneliness interventions fail. A strategy can be implemented in very different ways in terms of intensity, funding, uptake, and delivery. More importantly, there were greater benefits in the more relatively advantaged groups, indicating a potential inequity in access or engagement.

Di Gessa, Bordone and Arpino (2025) go beyond the pandemic. After ten years of research, they found that loneliness has different trajectories, not one ageing trajectory. This conclusion is further supported by the long follow-up. But there is no definitive evidence to establish if loneliness and poor health are causes or consequences of depression, or if there is a bidirectional relationship.

Further evidence that social isolation and loneliness should be measured separately is presented by Kenny et al. (2025). Social isolation decreased but not significantly in the short term due to retirement, and there were no significant changes in loneliness. Where both concepts represented the same process, their trajectories should have been similar. They were not.

This distinction may have implications for screening. Single items on living alone are too simple to measure emotional loneliness, and a loneliness score might not capture practical isolation, such as that caused by transport, disability, or neighbourhood conditions. A more robust assessment would consider both subjective and objective measures and would discuss the changes in the person's relationships. This would also minimize the chances of providing social services to socially independent but non-distressed individuals.

The differences have implications for practice in the UK. If the older person has a well-established network, albeit small but fulfilling, they may not require assistance. One can also be involved in social groups on a frequent basis but feel disheartened after a loss. A third might want more contact but have

obstacles to mobility, transportation, finances or psychological issues. The unmet need should therefore be identified before referral through assessment.

Practice should also not be limited to a social or a psychiatric approach to loneliness. When depression, anxiety, functional decline or withdrawal is accompanied by persistent loneliness, there is a need for a more comprehensive evaluation. The mental, physical and social needs are frequently interrelated, as stated by Zaninotto et al. (2022) and Puyan   et al. (2025). Where there is clinical need, the wellbeing support of community activities should not be an alternative to appropriate mental-health care (Finn et al., 2025).

Equity must be a focus of service evaluation as well. High numbers are not a measure of the extent to which programmes are reaching people with high levels of isolation. Reluctance to report feelings of loneliness itself can hinder access to loneliness services and interventions, as described by Willis and Vickery (2022), and benefits may be socially inequitable, as suggested by Li et al. (2024). Commissioners must then look at those who aren't in attendance and those who are.

National statistics should be used as context, not as a basis for determining individual risk. The difference in loneliness between adults aged 70 and over and some younger age groups runs counter to the stereotype that old age causes loneliness, according to ONS statistics. Lower average prevalence does not mean that the service need has been reduced; however, Age UK's estimate of nearly 1 million 'often-lonely' older people shows that (ONS, 2026; Age UK, 2024).

5.1 Limitations of This Review

The core analysis consisted of only five studies, as this is the number required for the assignment, and is not necessarily representative of the whole of the UK population. The majority of evidence was from England, and some studies employed ELSA, which limited the independence of findings. ELSA is also heavily weighted towards community-dwelling adults and may underrepresent those in residential care or those with severe illness.

The currency of recently published research was improved, but older foundational research was omitted. There were also three key studies that were directly or indirectly affected by pandemic conditions. Lastly, there was researcher judgement in the process of thematic synthesis. Structured coding enhances transparency but doesn't take the place of total interpretation.

6. Conclusion and Recommendations

Findings from the review indicate that social isolation and loneliness are linked to poor mental health and wellbeing among older people in the UK, especially depression, psychological distress and a reduction in quality of life. The relationship, however, is not uniform, nor is it simply a causal one.

Loneliness is more subjective; social isolation is more objective. Changes in one do not always cause changes in the other.

Factors affecting vulnerability include relationship quality, physical health, living conditions, socioeconomic factors and willingness to seek help. The evidence thus does not justify the use of chronological age or living alone as a proxy for loneliness.

The first one is differentiated assessment. Loneliness and objective isolation should be considered separately by health and social care practitioners. The quality of relationships, bereavement, support changes, mobility, physical health, mental health and barriers to participation should be taken into account. Referral should then focus on the problem identified and not automatically refer people to group activities.

Second, there need to be linkages between social and mental-health-related responses where there is an overlap. If a person is feeling lonely and depressed or has high levels of anxiety that persist, then there is a need to assess the person's mental health condition and provide the opportunity to connect with others. Social programmes are a useful but non-substitute option among current evidence-based interventions where applicable, but not a substitute where clinical care is required (Hoang et al., 2022; Shekelle et al., 2024; Patil and Braun, 2024).

Third, outcomes, reach and equity are the issues that should be assessed by local authorities and commissioners, not whether a strategy and/or programme exists. Measures need to evaluate changes in loneliness, wellbeing and relationship quality, and need to gauge whether there are disadvantaged people, people reluctant to disclose loneliness, or homebound people who are not being reached. Li et al. (2024) illustrate why adoption of a strategy does not necessarily mean it is effective.

Further recommendations include improving pathways for referrals to be made between primary care services, social care and community organisations. For older people, loneliness is not usually their chief complaint but may be combined with other issues. A GP might see a person as being low in mood, or it might be a social worker who first observes bereavement, decreased mobility or reduced ability to participate in the community. Common referral pathways can minimise disjointed responses and support professionals to provide the psychological, practical or social assistance needed based on the need.

Future UK work needs to consistently differentiate between loneliness and social isolation and, where possible, employ a longitudinal or experimental design. More representation is required for residential-care populations, severely homebound adults and groups often missing from longitudinal studies. Additionally, intervention studies should include measures of participation, magnitude and differential outcomes by socioeconomic status.

In general, accuracy is key to effective action. The goal should be to address the social or emotional need of the older adult, not the older adult's age.

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