Social Policy and Research-

EXPLORING THE IMPACTS AND MEANINGS OF SOCIAL ISOLATION: EASTERN SUBURBS COMMUNITY OPTIONS -

CLIENT AND STAFF PERSPECTIVES

Author: Leticia Funston

This research was conducted as part of the Field Education 1 component of the Bachelor of Social Work Degree, University of Sydney.

November, 2008

Acknowledgements

I am grateful to all the Community Options client participants who shared their stories with me. I would like to thank all of the staff at The Benevolent Society's Eastern Suburbs Community Care for their participation in the focus groups and for their encouragement and assistance throughout this project. I thank my supervisors Kathinka Linahan, Amy Dearn and Eliza Munro for all of their wonderful help and for providing such exciting learning opportunities. Special thanks to Dr. Genevieve Nelson from The Benevolent Society's Social Policy and Research Centre for her ongoing guidance, support and insight during this project.

Abstract

This research project aims to facilitate a greater understanding of the meaning(s) and impacts of social isolation on The Benevolent Society, Eastern Suburbs Community Options (ESOP) clients' lives. This project also aims to identify the challenges to social connectedness and social isolation risk factors for the ESOP client group. This knowledge may contribute to TBS policy and program development addressing social isolation and promoting caring and inclusive communities.

Eight semi-structured, in-depth interviews were conducted with ESOP clients. In addition, two focus groups, consisting of semi-structured questions and open-ended questions, were conducted with ESOP case-management staff. Content analysis of transcribed interviews was employed to identify key themes.

The results from this study supports a framework of social isolation that comprises both objective (e.g. minimal contact with others) and subjective factors (e.g. perceived lack of meaningful relationships). The results also highlight the importance of conceiving of social isolation as a form of social exclusion and that many of the identified challenges to connectedness must be addressed at a federal policy level. That is, social isolation must be reconceived as a serious social problem.

A social isolation assessment tool was devised from the emerging themes of this research. This tool has been designed to be used by TBS case-management staff and will be tested at a later date.

Key Words - Ageing, assessment tool, disability, mental illness, loneliness, loss and bereavement, qualitative research, social aspects, social isolation.

EXPLORING THE IMPACTS AND MEANINGS OF SOCIAL ISOLATION: EASTERN SUBURBS COMMUNITY OPTIONS -

CLIENT AND STAFF PERSPECTIVES

Introduction

The Benevolent Society (TBS), along with other major community organisations such as Mission Australia and the Brotherhood of St Laurence, has explicitly adopted a social inclusion framework (Hayes, Gray, & Edwards, 2008). The Benevolent Society endorses the theoretical premise of Social Inclusion, that social networks and social engagement promote and maintain 'social cohesion and foster a sense of community' (Hiller, 2007). This hypothesis has been supported in many studies (Hiller, 2007). Furthermore, other studies have suggested that social networks 'promote generalised feelings of psychological wellbeing that protect individuals from ill health' (Hiller, 2007). Social isolation is recognised as a key challenge to social inclusion and social participation (Cartwright & Findlay, 2002).

Social isolation is considered to be a significant social problem that particularly impacts people experiencing multiple disadvantage, aging populations, people with disabilities and health problems, and people living with mental illness (Gierveld & Havens, 2003). Current literature suggests that social isolation and loneliness impact negatively on the physical and mental health and wellbeing of individuals and the functioning of communities (Snijders, Smit, & Duijn, 2001).

Occasionally this issue is represented in the media in shocking instances where a person's care needs are severely neglected, or when it is clear that an individual, usually an elderly person, has died unnoticed and alone in their home (ABC Online, 2006). However, despite the growing evidence around the negative outcomes that are

associated with social isolation, there is a lack of federal policy explicitly responding to the issue. In an attempt to address social exclusion in Australia, the current federal Social Inclusion agenda asserts that social participation can be facilitated by engaging in the workforce and through volunteering activities (Hayes, Gray, & Edwards, 2008). However, this policy fails to address the social exclusion and isolation of people who cannot easily participate in the workforce, particularly, 'older people managing a chronic illness or disability (and or mental illness)' (Hillier, 2007). The lack of federal initiative and lack of funding commitment to programs specifically designed to respond to the social needs of older people, limits the ability of service providers to alleviate the impacts of social isolation for some of the most excluded client groups.

Literature Review

The bulk of gerontological studies on social isolation suggests a negative correlation between ageing and social engagement (Russell & Schofield, 1999). That is, as populations get older, their level of social engagement decreases. The literature suggests that this correlation between ageing and social isolation is due to the cumulative effects of multiple role loss through the death of relatives, partners, and friends, retirement, and the 'effects of chronic illness and disability' (Russell & Schofield, 1999). Furthermore, current research highlights serious risk factors for socially isolated individuals and particularly elderly populations, including: suicide, dying alone, reduced quality of life, and poor physical and mental health (COTA, 2006). Despite the findings of this body of research, social isolation remains a relatively underexplored phenomenon and the key dimensions of social isolation remain largely undefined (Gierveld & Havens 2004; Grenade & Boldy, 2008).

Defining the dimensions of social isolation is central to developing clear understandings of the factors that predispose someone to be socially isolated and to enable the

identification and management of individuals affected by or at risk of social isolation (Russell & Schofield, 1999). However, there is little consensus in the literature concerning this definition of social isolation and the identification of risk factors.

What does exist is a debate around the differences between 'objective' and 'subjective' dimensions of social isolation (Russell & Schofield, 1999). Some authors suggest that social isolation is an objectively measurable condition indicated by a minimal number of social contacts, low engagement with community activities and events, and infrequent contact with others (Gierveld & Havens, 2004). Objective indicators of social isolation may include: living alone; widowhood and loss of a significant other, including children and close friends; having a household focused social network; low socio-economic status; poor health and low mobility; and other factors which may negatively impact an individual's ability to participate in and access social resources (Russell & Schofield, 1999).

Many commentators, however, argue that whilst the objective definition of social isolation is useful, even essential to understanding the concept, it does not adequately address the complexities and multi-dimensionality of social isolation (Gierveld & Havens, 2004). Thus, some authors suggest that a subjective social isolation framework is equally important for understanding how minimal contact with others may be interpreted, experienced, and felt by the socially isolated individual (Hawthorne, 2008).

Subjective social isolation has been defined as perceiving or experiencing a lower level of social contact and participation than desired as well as a perceived lack of meaningful relationships with others (Pitkala, Reijo, Routasalo, Savikko, & Strandberg, 2006). Pitkala et al. (2006), argue that the subjective dimension of social isolation should be acknowledged because the severity of social isolation is influenced by a range of subjective factors including but not limited to, loneliness, low self-efficacy, depression,

low morale, perceived isolation, and alienation. However, Havens and Giervald (2004) emphasise that subjective factors are associated with but not causal factors of social isolation.

The relationship between social isolation and loneliness is another area that has been explored in the literature. Weiss (1973) defined two key dimensions of loneliness from a psychosocial perspective: emotional loneliness, which may be understood as the absence of intimate relationships (such as a partner); and social loneliness, which relates to the absence of a broad network of friends (Weis, cited in Havens & Gierveld, 2004). Other authors argue that social isolation and loneliness are related yet distinct concepts (Baarsen, Snijders, Smit, & Duijn, 2001). This distinction is important because loneliness is not considered to be an inevitable outcome of social isolation (Grenade & Boldy, 2008). In other words, an individual may be socially isolated, yet not feel lonely. Similarly, an individual may be highly socially connected, yet experience significant loneliness (Gierveld & Havens, 2004). However, whilst social isolation may not cause loneliness, socially isolated individuals are often at greater risk of experiencing loneliness and a cluster of other mood related difficulties including depression, low self-efficacy, and hopelessness (Gierveld & Havens, 2004).

Methodology

Background: Eastern Suburbs Options Program

The Benevolent Society's Eastern Suburbs Options Program (ESOP) is funded by Home And Community Care (HACC) and is a 'client focused model for managing client's support, care, and social health needs to enable them to maintain maximum independence in the community' (Service Standard 10.15/COPS model). ESOP case-management targets and supports individuals who have complex and high needs including a 'range of interacting physical/medical, social and emotional needs', frail aged

people, people with mental illness, and people with a disability (Service Standard 10.15/COPS model).

The COPS model of case-management also aims to prevent the 'premature or inappropriate admission of clients to long-term residential care' (Service Standard 10.15/COPS model). It was anticipated from research and discussions with case-management staff that many ESOP clients may experience social isolation.

Research Design

The majority of past research on social isolation have employed a quantitative research design. These quantitative approaches have largely attempted to measure social isolation as a unidimensional concept and thus have done little to explore the more complex, subjective meanings of experiencing a lack of social contact (Victor, Grenade, & Boldy (2005). Furthermore, as many of the key dimensions of social isolation have not been identified in the literature, this project employed a qualitative research design to broadly explore the impacts and meanings of social isolation from both client and staff perspectives. This qualitative design aimed to explore the subjective complexities of social isolation and how factors such as mental illness, low income, gender, ageing, migration, poor self efficacy, illness, disability, loneliness, loss, and bereavement may intersect with social isolation (Victor et al., 2005). This qualitative design was also employed to explore how client perspectives vary from the perspectives and understandings of case-management staff and health professionals.

The research drew from eight in-depth interviews with ESOP clients and two focus groups with ESOP case-management staff. Eight client participants were recommended from ESOP case managers and were selected for their level of objective social isolation, such as limited family and social contacts and low levels of social participation, together

with some indication of subjective isolation, self-reported inadequate levels of social activity, feelings of boredom, loneliness, or unhappiness. Whilst the sample of clients is not representative, they were selected to reflect the diversity of the ESOP client group. As such, clients were selected from a range of adult ages (though all participants were over 50 years of age), socio-economic backgrounds, housing situations, CALD backgrounds, gender, and mental and physical health.

Selected clients were invited to participate in the research during a home visit and an ESOP case-manager was present during each interview. The topic of the research and its intended use was explained to each client participant. The researcher and case-manager ensured that informed consent was given by all participants and that the clients were willing and able to give this consent. Information regarding confidentiality and post-participation counselling details derived from TBS research protocols and the University of Sydney ethics guidelines were supplied to all participants.

The in-depth interviews with clients consisted of eight semi-structured questions, with three to four prompts per question. Questions related to general psychological and physical health and wellbeing, type and quality of social engagement, perceived quality of relationships, number and frequency of contact with family, friends, and neighbours, feelings about living environment, and one's relationship to the immediate community or suburb in which they were situated. Each interview ran for approximately thirty minutes and was recorded via audio recording equipment with the consent of clients. Two clients declined being recorded during the interview. During these interviews the researcher took notes with client consent.

Two focus groups of three randomly selected ESOP case management staff were conducted. The focus groups were organised around six semi-structured questions and prompts and some open-ended questions. These questions related to case-manager's

associations with and definitions of social isolation, identification of social isolation risk factors, the significance and prevalence of social isolation amongst the ESOP client group, the impact of social isolation on client's physical health, mental health, and wellbeing, and the perceived risks and concerns they had for socially isolated clients. The focus group sessions ran for approximately forty-five minutes and were recorded with the consent of staff participants. Issues pertaining to protecting the confidentiality of staff and client information were discussed prior to the focus group sessions. All participants were supplied with appropriate post-participation counselling support information.

The recorded in-depth interviews and focus groups were transcribed and the data was analysed using content analysis. Emerging themes and patterns from the data on social isolation have been reported and discusses as well as used to develop a social isolation assessment tool for TBS case management use. The tool will be tested at a later date.

Results

Staff Perspectives: Defining Social Isolation

Case-management staff definitions of social isolation generally reflect what has been described in the literature as objective isolation, where 'a person has no social group...no family around... no regular contact with friends or a carer' (624). Case-managers also highlighted the lack, or perceived lack, of quality in an individual's relationships and described 'emotional isolation' as being an important dimension to social isolation. The declining number and quality of relationships in later life associated with grief, bereavement, and loss were factors emphasised by staff. For example, one staff member said that 'often as people age, their friends start to die [and] that leaves

them isolated and depressed' (625). Another case-manager articulated the impact of this loss:

> I'm sure you only need one other person in your life to not be socially isolated. Some people are very lucky to have that person to still live with them. But unfortunately a lot of our clients are widowed and that's the problem… then they become lonely and socially isolated... In this way, if children have scattered over-seas or if they didn't have children, then their partner dies, then their whole life is gone. Really hard... and we find that a lot (626).

Some staff members highlighted structural barriers to social connectedness such as financial issues insufficient pension, lack of access to public transport, and broader socio-cultural problems such as over-reliance on the 'nuclear family model' and lack of 'community feel', as contributing factors to isolation. Case-managers across both focus groups identified several key social isolation risk factors and barriers to connectedness. The key barriers to clients' connectedness identified by case-managers included: the multiple impacts of ageing, bereavement and loss, mental illness, language barriers, limited mobility and disabilities, and drug and alcohol abuse.

Staff Perspectives: Evaluating the Impacts of Social Isolation on ESOP clients

Case-mangers had varying perspectives regarding the significance and impacts of social isolation on clients' lives. Some staff members felt that social isolation is a significant problem facing community options clients with many risk factors including: depression and paranoia (staff participant: 623); 'suicide' (staff participant: 623); and general exacerbation of 'pre-existing anxieties and phobias, [and] inability to socialise' (staff participant: 622). One case-manager described social isolation as a form of torture and

drew parallels to the negative psychological effects of solitary confinement: ‘You put someone in a room on their own and they just go right inside themselves because the only focus they've got is the tragedies that have happened in their lives’ (staff participant: 625).

Many staff members expressed concerns that social isolation can have a negative impact on a client's level of confidence when relating to other people and engaging in social situations. For instance;

> Some [clients] have lost so much confidence that when you try and get them to the things that are available in the community, like day centres and art groups, bus trips, they don't have the confidence to actually do it. (Staff participant: 623).

The above quote also highlights how low confidence can be a barrier to reconnecting with social activities and building new relationships. Staff members also identified a prevailing sense of ‘hopelessness' and ‘lack of control' over changing or improving circumstances in socially isolated clients. Further, staff members also stated that social isolation may compromise the physical health and safety of clients.

Whilst many staff members recognised several adverse risks and effects for clients experiencing social isolation, the majority of staff members stated that they did not prioritise clients' social needs due to limited resources and time. One case-manager employed Maslow's Hierarchy of Needs to explain that addressing ‘basic needs' such as food and shelter has precedence over addressing clients' social needs. Another case manager affirmed this idea stating that addressing social isolation ‘come[s] maybe a little down the list of the sort of things we're looking at in personal care…unfortunately. Even though it's really important' (staff participant: 626). Other case-mangers felt that social

isolation was ‘only a problem' when a client ‘is not having their primary needs met' (staff participant: 626).

Most case-managers conceived of social isolated clients as being isolated either involuntarily or by choice. This distinction appears to be significant as case-managers perceived involuntary isolation as having a greater impact clients' wellbeing than those who were perceived as choosing low social attachment.

Staff Perspectives: Involuntary and Voluntary Social Isolation Dichotomy

There was agreement between ESOP case-management staff in both focus groups that social isolation may be understood as either a voluntary or involuntary condition. Many case-managers stated that they felt that some clients were socially isolated by ‘choice'. Generally case-managers described clients who ‘chose' limited social contact, as a personality trait. For example, ‘sometimes it is voluntary…some people just like their solitude' (staff participant: 622) and ‘I found that some people, they're just not mixers, all their lives' (staff participant: 625) and ‘…some clients would have it by choice and actually don't want to be around other people' (staff participant: 624).

Conversely, involuntary isolation was described by many staff members as the result of externally imposed factors, or factors beyond individual control, such as mental health problems, disability, mobility problems, and health difficulties. One case-manager gave the following example to describe involuntary isolation:

> It might just be a factor in their lives at that moment and that their family aren't around them. Or they might have health problems that prevents them from going out into the community, so that they actually wish for that social contact but they aren't able to get that (staff participant: 621).

In distinguishing between voluntary and involuntary social isolation, some case-managers commented that involuntary social isolation was of a greater concern for clients. Furthermore, case-managers indicated that different consequences and risk factors are attributed to the involuntarily isolated when compared to those who are isolated by choice. They stated that clients experiencing social isolation involuntarily may be at greater risk of depression, hopelessness, loneliness, and suicide ideation. For instance, one case manager noted:

> I mean, if you're isolated and you're not happy with the isolation, that's a problem. But if you're quite happy and self-fulfilled and isolated by choice, then that's not going to have the same impact (staff participant: 624).

Another case manager stated that ‘social isolation isn't necessarily a problem’ (staff participant: 622) providing that the client is isolated by choice:

> We might say “oh you know it's not great they are staying at home, they are not going out”… But it's their choice. We can't make someone do something even if we feel that their life will be enhanced by it. Like who are we to decide that. It's just not necessarily an issue, it's just not the most important thing (Staff participant: 622).

Here the issue of choice appears to be couched in language related to respecting client's self-determination and decision to have minimal contact with others. This perspective may be summarised by the following statement: ‘I think [social isolation] is very important to highlight but again only if the [client] wants to change it' (Staff participant: 621).

Staff Perspectives: Efficacy of Services in Addressing Social Isolation

Some staff members stated that there were not enough services ‘geared up to do that much about [social isolation]' (staff participants: G6). Other staff members stated that there was a gap in services responding to clients' social needs and that the few services that do exist are ineffective in alleviating social isolation. For example, the following discussion highlights that quality of contact may be more desirable for clients than simply the objective amount of contact:

> `But then again, [clients] may not want a volunteer come and just chat'. (Staff participant: G6).
>
> `Yeah it can be a superficial experience'. (Staff participant: L4).
>
> `Yeah, they want real friends. Yeah and they don't want that, it's a big problem you know'. (Staff participant: G6).

Client Perspectives: Reflections on Limited Social Engagement

Some clients reflected on reasons for experiencing limited social contact. For instance, a common theme emerging from client interviews was a reluctance to engage in relationships with others. Four clients reported feeling a lack of trust in their relationships with other people due to negative experiences they had had in the past. One client commented that 'relationships aren't what they are cracked up to be. Sometimes if people have got someone around they are a lot happier. But it's not always the answer' (client participant: 504). Another client said ‘I'd rather be alone... I suppose my idea of friendship and other people's idea of friendship might be totally different... the more I see of humans, sometimes I prefer my animals' (client participant: 507). Other clients

expressed that they felt anxious and avoidant about social company, for example, 'I get nervous about the other people. That's why I don't go' (client participant: 504). This client also felt unable to continue to attend a sculpture course because: ‘I got a complete stress attack when I was there and all the people there new how to sculpt and I didn't… so eventually I got so stressed out I couldn't go back' (client participant: 504).

Other clients described various reasons why certain organised social activities such as day centres, respite, outings, and courses were not preferable or appropriate for them. For example, one client aged over eighty felt that the elderly day centre was inappropriate for her as the other clients who attended were frail and unwell, and ‘shaking and drooling' (client participant: 501).

Client Perspectives: Key Barriers to Connectedness

For most of the clients interviewed, lack of contact, or less contact than desired with immediate family members presented a very negative impact on their emotional wellbeing and level of social engagement. One client described his feelings about being estranged from his wife and children:

> It's a pretty sad and dismal situation for a seventy year old to be in… I miss her, oh…very much… Life's tough for me living here. I should be…with her and [my sons] (client participant: 503).

Another client stated that she felt particularly ‘upset' by both the lack of meaningful contact and the limited time she spends in contact with her only daughter: ‘She's not very close to me now. She's not close and I am very upset about this. Too long time we are not together twenty years she stay[s] in [Victoria]. She[`ll] ring me for two, three

minutes in the morning. “Mummy how are you? Okay. I am very busy. Bye”. That's all!' (Client participant: 501). For another client the absence of family ‘worried' her because she felt that there was ‘nobody to lean on…it's really hard' (client participant: 502).

Furthermore, many clients highlighted the often negative impact of bereavement and loss on their quality of life and level of social engagement. One client said: ‘after my husband died I haven't been out much. He's left a big void. Oh well that's life (cries)' (client participant: 501). Another client described her overwhelming feelings of grief and loneliness following the death of her husband: ‘I miss my husband I cry all day. Everyday I cry and talk to him.' (client participant: 501). This client continued to describe the impact of this loss and loneliness on her life:

> And I want to die... and I stay alone, twenty four hours a day I stay at home. Alone. That's the main problem… It make[s] me very unhappy. And some time I want to die. But I can't do it. Nothing. I can't… It's very bad when it come the older time. And you stay alone. That's the bad time (client participant: 501).

Another client acknowledged that the death of her son - her ‘closest friend' - was the main reason she had felt ‘miserable for the rest of my life' (client participant 505).

Loneliness was a feeling that almost all participants reported to have experienced. Three clients stated that loneliness ‘was a big problem' and one client described the feeling of being lonely as a 'nightmare' (client participant: 506). Another client said that she 'worried' about living alone, if her husband was to die: ‘Being on my own… wondering how I would pass the days…I don't know what I would do… that's a big worry' (client participant: 502). In addition, some clients reported that whilst they may experience loneliness, they also commonly experience other troubling emotional states such as

‘depression', ‘anxiety', ‘longing', ‘missing' significant people and relationships, and ‘boredom' (client participants: 501, 503, 504, 505, 506, and 507).

One client stated that feeling disconnected from her local community made her feel not so much lonely, but ‘bored shitless' (client participant: 507). This client identified the lack of ‘real community' as the main reason she feels isolated. For example, ‘there's no community here whatsoever... to be honest with you, you rarely see anyone... there's nothing for me here, no one here' (client participant: 507). For many clients, poor or challenging relationships with neighbours appeared to exacerbate negative feelings about living alone. One client described her limited interactions with her neighbours as: ‘difficult…“Oh hi, bye” that's all from the neighbours' (client participant: 501). This client also stated that her neighbours would not know 'if I am alive or dead. You understand me?' (client participant: 501). Another client described her lack of contact and connections with her neighbours in this way:

> I've seen next door twice in the two and a half years I've been here and he just said to me the first time I met him, that he just keeps to himself… I said “god if I had to identify you in a police line up I wouldn't have a clue”. And the funny thing is, in Bondi, I knew heaps and heaps of people in my street… And here, you don't hardly see anyone talking to anyone. So it's eerie and scary. And I suppose for a single person who doesn't have her own children or whatever, it can be quite isolating (client participant: 507).

Other clients described feeling fearful or wary of their neighbours particularly if the neighbours are perceived to have mental health problems. One client commented that she occasionally feels ‘disturbed' by the behaviour of her next door neighbour who has bi-polar disorder. Behaviour such as ‘banging on the walls', and ‘screaming' made her feel ‘very alone and scared' (client participant: 505).

Some clients described the impact of living with ill health, mobility difficulties, and disabilities as having a very restrictive effect on being able to connect with family, friends, and activities in the community. One client stated ‘over the last two years I've been house-bound more or less because of the broken leg' (client participant: 507). For this client, her limited mobility has been a significant barrier to accessing community resources and events. For example, she stated: ‘things like the art gallery, libraries and I wouldn't mind going to a pub and watching live music and that. But again when your mobility is limited and the things you take for granted, all of a sudden you can't do it any more'. Another client described the constraints of having a colostomy and low mobility as 'frustrating' and said 'I have to give up a lot (including organised excursions for the elderly) because of this problem' (client participant: 500).

Client Perspectives: Coping Strategies

Many of the clients interviewed did not have many close friends or broader social networks. However, for the three clients that said they had meaningful and trusting relationships with friends and neighbours, these connections were very important. One client remarked that receiving visits from her neighbour and sharing a pot of tea ‘really helps because sometimes I get a bit lonely…it makes a difference when people are friendly even if you don't see a lot of them, it's a positive feeling' (client participant: 500). Another client said that his one close friend helps him to feel 'normal… He doesn't make me feel like I'm crazy. He talks to me like I'm a normal person' (client participant: 504).

Many clients used mediums such as television and radio to cope with loneliness. For one client who migrated from Russia, Russian pay television helped her to ‘forget about being alone' (client participant: 501). This particular client described feeling alienated from Australian culture and explained that the Russian television programs such as

‘Russian concert, nice song, dance, and the Russian language...helps me. It's my life. I see, I hear. They talk to me, I understand them' (client participant: 501). Another client also described using television and radio as the main way of coping with living alone and ‘passing the time' (client participant: 506).

Many clients said that contact with their case-managers and care workers was very important and supportive. One client commented that her case-manager's support had helped her to cope since the death of her husband:

> If not [for my case-manager], I would pass away long time ago. You must believe me. It's honest. I love her when she ring[s] me. It's made very good my heart. When I hear her voice. I can't explain what I feel to this woman (client participant: 501).

Another client described the regular contact with his care-worker as having a ‘positive' influence on his emotional wellbeing and emphasised the importance of this contact: ‘No matter how bad I feel, she always makes me feel positive. And she's been someone who's been a true motivation in my life. It's really important to get those visits on Friday' (client participant: 504).

Discussion

Overall, staff perceived social isolation as a ‘problem' that can have detrimental impacts on clients' wellbeing, including suicide, having injuries, reduced quality of life, and poor outcomes for physical and mental health. Staff and clients both emphasised the debilitating effects of low levels of social contact on emotional responses including grief, loss, loneliness, low morale, hopelessness, depression, anxiety, and boredom. From

the clients perspective, the experience of social isolation appears to be exacerbated by complex interactions of multiple disadvantage, loss, and exclusion.-

Whilst the causes of social isolation are not made clear in this study, it appears from both the client and staff data, that the following may be considered risk factors (usually more than one) for social isolation:

- Living alone (low amount and frequency of social contact);
- Perceived lack of meaningful contact with others and loss of significant relationships, e.g. death of partner, children and friends, estrangement from family and friends;
- Difficult moods and emotions, e.g., depression, grief, and bereavement;
- Living with mental health problems;
- Living with limited mobility, e.g., disability, frail age, and chronic health problems;
- Poor or underdeveloped relationships with neighbours;
- Feeling ‘alienated' from the general community in a suburb or not able to access a desired community group;
- People from Culturally and Linguistically Diverse backgrounds.

Although staff perceptions regarding how social isolation is conceived and prioritised as a need, was not a key research question, the data provides some interesting insights.

It is interesting that case-managers interviewed in this project distinguished between voluntary and involuntary social isolation and also perceived greater negative consequences for those who are involuntarily isolated as opposed to those isolated by choice. Similarly, Russell and Schofield's (1999) study on service providers' perceptions of social isolation in old age, found the majority of service providers viewed social isolation as a ‘choice'. Furthermore, Russell and Schofield (1999) found that service providers perceived the consequences of social isolation for those who ‘chose' to be isolated as less severe ‘since they were quite satisfied with their own company’. It is not so surprising that these views are represented across both studies and – as Russell and Schofield state, the notion of client ‘choice' is ‘embodied in the core values of Australian aged care policy' (Russell & Schofield, 1999, p. 86).

Interrogating the notion of ‘choice' in this context exposes the ‘paradoxical effect' of service delivery (Russell & Schofield, 1999, p. 86). Whilst respecting and upholding clients' ‘independence' and ‘choice' to not engage in social activities, clients' social and emotional needs may continue to be unmet. During interviews with clients, many expressed reluctance to engage in opportunities to socialise, yet several clients explained their reluctance as due to a range of factors including social anxiety, history of diminished and untrustworthy relationships, and inadequate or inappropriate socialising services. Importantly, clients' agency to engage in social relationships is constrained by a variety of intersecting subjective and structural factors. Therefore, clients' social reluctance or avoidance should not be always construed as an active ‘choice'. The construction of ‘choice' in this context, lends focus to the role of the individual as an agent of their circumstances and may overlook the complex interplay between the subjective factors and broader structural inequalities which constrains the ability of individuals to engage in social worlds.

In several papers produced by The Brotherhood of St Laurence, it is argued that social isolation is a form of social exclusion (Hiller, 2007; Naughtin, 2008). Naughtin (2008) went as far as saying that the lack of direct social policy addressing the psycho-social needs of older people is a form of age-based-discrimination. The current research project also identified several ‘structural' challenges to connectedness. Clients and staff described the constraints of inadequate pension and the experience of poverty, the experience of racial and cultural prejudice and alienation from communities, and stigma and discrimination against people with disabilities and mental health problems. Furthermore, the cumulative effects of multiple disadvantage and exclusion further exacerbate isolation, making rebuilding relationships and reconnecting to communities ~~a~~ difficult tasks (Naughtin, 2008).

There appeared to be some incongruity in staff responses whereby staff acknowledged several serious risks for socially isolated clients and yet many staff members stated that addressing clients' social needs was not prioritised in their case-management practice. For many case-managers, lack of time, funding, and limited resources restricts their ability to prioritise clients' social needs. Furthermore, many case-managers stated that ensuring clients' basic needs (e.g. food, shelter, security) are met, dominates their practice. In addition, a central dilemma for case-managers encountering socially isolated clients is that there is a limited range of options and services available to alleviate the effects of social isolation. Also many clients indicated their dissatisfaction with various activities and services and emphasised that the quality and meaningfulness of the social engagement is the most important aspect of human contact. Some case-managers also acknowledged that ‘addressing social isolation is limited to identifying options available... social services... yet they know that these services are often neither appropriate nor acceptable' (Russell & Schofield, 1999). Further research is necessary to identify the range of socialising services and programs that are available and to measure the

efficacy of these avenues in ameliorating social isolation. Further research could also explore the relationships between clients, case-managers, and care-workers, in order to gain a better understanding of how these caring relationships may or may not intervene in social isolation.

Both the secondary prioritisation of social needs and the perceived lack of effective services providing quality socialisation opportunities indicates that social isolation is a neglected area of social policy. Many commentators have highlighted the state and federal funding imbalance ‘between core maintenance services and those to which could be seen to have a more socialising function, such as transport' (Russell & Schofield, 1999, p. 71). It is imperative that social isolation is conceived as a social problem and not merely the unfortunate circumstance of a few individuals. Without a shift in policy discourse which recognises the serious and detrimental impact of social isolation, the development and funding allocation to public socialisation services and programs targeting social isolation will not occur. The consequences of this gap in policy will result in the continuation of unmet social needs for particularly vulnerable members of the community, such as the ESOP client group. Finally, without serious policy efforts to build social inclusion, communities and the broader society is deprived of the richness and diversity of the many currently isolated people.

References

ABC Online. (2006). *Community groups call for system that prevents unnoticed Deaths.* Accessed: November 2008: http://www.abc.net.au/pm/content/2006/s1578074.htm

Baarsen, B., Snijders, T., Smit, J., & Duijn, M. (2001). Lonely but Not Alone: Emotional Isolation and Social Isolation as Two Distinct Dimensions of Loneliness in Older People. *Educational and Psychological Measurement*, *61,* 119-135 .

Boldy, D., Grenade, L., & Victor. (2005). Addressing Elder Abuse: Western Australian Case Study. *Australasian Journal on Ageing, 24,* 1.

Boldy, D., & Grenade, L. (2008). Social Isolation and Loneliness Among Older People: Issues and Future Challenges in Community and Residential Settings. *Australian Health Review, 32* (3), 468 - 478.

Cartwright, C. & Findlay, R. (2002). Social Isolation and Older People: A Literature Review, Report for Seniors Interest Branch & Ministerial Advisory Council on Older People, *Australasian Centre on Ageing*: The University of Queensland.

Council on the Ageing (2006). *Social Isolation Policy Position,* Accessed: November 2008: http://www.cota.org.au/

Havens, B. & de Jong Gierveld, J. (2004). Cross-national Comparisons of Social Isolation and Loneliness: Introduction and Overview, *Canadian Journal on Ageing, 23,* pp. 109 -113.

Hawthorne, G. (2008). Perceived social isolation in a community sample : its prevalence and correlates with aspects of peoples' lives. *Social psychiatry and psychiatric epidemiology,* 43(2): 11.

Hayes, A. & Gray, M. and Edwards, B. (2008). Social Inclusion: Origins, Concepts and key themes, Melbourne: Australian Institute of Family Studies.

Hiller, M. (2007). Rebuilding Connections: Creating Opportunities for Socially Isolated Older Australians, Melbourne: Brotherhood of St Laurence Research and Policy Centre.

Naughtin, G. (2008). Social Inclusion and Older People*,* Melbourne: Brotherhood of St Laurence Research and Policy Centre.

Pitkala, K. & Reijo, T. & Routasalo, P. & ,Savikko, N. & Strandberg, T. (2006). Social Contacts and Their Relationship to Loneliness among Aged People - A Population-Based Study, Helsinki :*Gerontology, 52*: pp.181-187.

Russell, C. & Schofield, T. (1999). Social isolation in old age: a qualitative exploration of service providers' perceptions*, Ageing and Society, 19.*

Schnittker, J. (2007). Psychology of Social Support. Look (Closely) at All the Lonely People*. Journal of Aging and Health, 10*.

Stone, W. (2001). Measuring social capital: Towards a theoretically informed measurement framework for researching social capital in family and community life (Research Paper No. 24). Melbourne: Australian Institute of Family Studies.

Appendices

the benevolent society | initiating change

Indicators for Case Management Need

- □ Limitations in cognitive or perceptual functioning
- □ Behavioural, emotional or mental health issues
- □ Lack of informal support network or need for carer support
- □ Social or geographical isolation
- □ Level of physical frailty, vulnerability impacting on the ability to organise their own care or advocate on their behalf
- □ Involvement of multiple services
- □ Coming from a diverse cultural or linguistic background
- □ High risk of moving into an inappropriate full time care environment

DRAFT SOCIAL ISOLATION TOOL

Demographics

1	**What is your gender?**	1☐ Male 2☐ Female
2	**How old are you?**	_____
3	**In which country were you born?**	1☐ Australia 2☐ Other (please specify) _____
4	**What is your cultural background?**	_____
5	**Do you speak a language other than English at home?**	1☐ No 2☐ Yes (please specify) _____
6	**Who do you live with?**	1☐ Myself 2☐ Myself and my partner 3☐ Myself, my partner, and my children 4☐ Myself and my children 5☐ Other
7	**Are you a widow?**	1☐ Yes 2☐ No
8	**When did you become a widow?**	1☐ In the last 2 months 2☐ In the last 6 months 3☐ In the last 12 months 4☐ More than 2 years ago 5☐ More than 5 years ago
9	**Have you experienced any other significant loss (or bereavement)?**	1☐ Yes 2☐ No
10	**If Yes, please give details (e.g., who, how long ago they passed away)**	_____ _____

11 **Do you have a disability?**

1 ☐ Yes
2 ☐ No

12 **Does your mobility limit you in any physical activities? (e.g., walking, shopping, accessing services)**

1 ☐ Yes
2 ☐ No

Social Connections

1 **How many members are there in your <u>immediate family</u>? (E.g. children, brothers & sisters)**

Please write here _____

2 **How many of your <u>immediate family</u> do you have regular contact with?**

1 ☐ All of them
2 ☐ Most of them
3 ☐ Not many of them
4 ☐ None of them

3 **How often would you have face-to-face contact with members of your <u>immediate family</u>?**

1 ☐ Daily
2 ☐ Weekly
3 ☐ Fortnightly
4 ☐ Every 3 weeks
5 ☐ Monthly
6 ☐ Less than monthly

4 **Approximately how many close <u>friends</u> do you have?**

1 ☐ None
2 ☐ 1 - 2
3 ☐ 3 - 5
4 ☐ 6 or more

5 **How many of your <u>friends</u> do you have regular contact with?**

1 ☐ All of them
2 ☐ Most of them
3 ☐ Not many of them
4 ☐ None of them

6 **How often would you have face-to-face contact with your friends?**

1 ☐ Daily
2 ☐ Weekly
3 ☐ Fortnightly
4 ☐ Every 3 weeks
5 ☐ Monthly
6 ☐ Less than monthly

7 **Approximately how many of your neighbours do you have regular contact with:**

1 ☐ All of them
2 ☐ Most of them
3 ☐ Not many of them
4 ☐ None of them

8 **How often would you have face-to-face contact with your neighbours?**

1 ☐ Daily
2 ☐ Weekly
3 ☐ Fortnightly
4 ☐ Every 3 weeks
5 ☐ Monthly
6 ☐ Less than monthly

Subjective Measures of Isolation

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**I feel a part of my community**	1	2	3	4	5
2	**I feel alienated from the rest of my community**	1	2	3	4	5
3	**I am unable to access services in my community (e.g., social groups, hobby clubs, GPs etc)**	1	2	3	4	5
4	**Transportation makes it difficult for me to access places and services in my community**	1	2	3	4	5

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5	**I feel that I have enough people in my life who support me**	1	2	3	4	5
6	**I trust the people around me to help me in times of need**	1	2	3	4	5
7	**I feel lonely a lot of the time**	1	2	3	4	5
8	**I am still grieving the loss of someone in my life (e.g., partner, sibling)**	1	2	3	4	5
9	**I am very bored with my life**	1	2	3	4	5
10	**I often feel that life is not worth living**	1	2	3	4	5
11	**I wish I had more people in my life that 'mean something to me'**	1	2	3	4	5