POSITION PAPER DISCUSSING COVID-19 ELLICITED SOCIAL ISOLATION AND LONLINESS IN THE ELDERLY

My name is Kristen O'Brien, I am a qualified Social Worker, practicing from the 'Twin Rivers Centre' in Eagleby. My usual role requires me to be responsible for the supervision and coordination of adult aged students, assisting with grant writing, and the development and maintenance of various programs that are designed to support our community. This affords me access to the vulnerable, and provides opportunity for engagement and research. I am submitting this paper as an affiliate of the 'Twin Rivers Centre', but do state that any recommendations or opinions that are contained within this paper are a reflection of myself, and are not necessarily the views shared by the centre itself. All research has been sourced from scholarly peer reviewed articles, and are fully referenced.

There is a strong correlation which exists between those that have been exposed to essential quarantine interventions and social distancing, and to the experiences of social isolation and loneliness, with prevalence laying with the elderly (Hwang, et al, 2020). Social distancing should not mean social disconnection, but for many of the elderly living within our communities, it does.

For the purpose of this paper, I have conducted two informal qualitive studies; the first utilised existing clients that participated in our 'COVID-19 response' support program, and the second was through social media targeting the general population of Logan.

Group One

During the major COVID-19 lockdown of 2020, we created a program to try and address some of the isolation occurring within our immediate community. Through Social media platforms and referrals, we generated a list of highly vulnerable individuals that were in need of some support. The majority were elderly and living alone. Once a week, we would simply give them a call. Ask about their week, about their pets, and just generally how they were coping. For a lot of participants this was the only contact they were receiving over this time due to a lack of familial support and a fear of leaving the home due to existing health ailments which they felt made them more susceptible to the virus. This was a time of fear and uncertainty for many. This level of engagement also enabled us to assist with physical needs such as delivering medications, groceries, and necessity items. We found this program to be highly effective, and since restrictions have eased, the program has evolved into a peer driven weekly coffee morning. We have even heard from some of our participant's mental health care professionals about what a positive impact this contact has had and continues to have on their wellbeing.

Group Two

The second study was conducted solely through social media, targeting the general adult cohort of Logan. I simply made a request for anyone that would be interested in sharing their COVID-19 experiences with me. The results from this were quite unexpected. What I received was an influx of detailed stories from many different socio-economic and psycho-social backgrounds. What I was able to draw from this is that there is still a lot of unresolved trauma in our community as a result of the lockdown. With a societal badge of 'we're all in this together', I feel that individuals are reluctant to share their individual stories and challenges over this time. Focus was placed on the wellbeing of the whole, with the needs of individuals falling through the tracks.

As derived from the above information, this paper shall base its discussions around COVID-19 related social isolation and loneliness, and the inherent mental health crisis which is being elicited by the pandemic.

A proven consequence coming from the necessity of shielding the vulnerable, and social distancing requirements for the greater cohort, is that the physical separation is a catalyst for social isolation and loneliness (Cowan, 2020). Social isolation can be defined as an objective lack of contact or interaction with others, whilst the notion of loneliness refers to the subjective emotions elicited from being alone (Cornwell, Wait, 2009; Vangelisti, Perlman, 2006).

Researchers have speculated that now over a year into the pandemic, with countless lives being thrown into upheaval, that the risks of individuals developing mental health conditions as never been higher (de Nobel,2021). Negative mental health outcomes also carry with them the potential to develop into serious mental and physical health consequences, with those who experienced mental health challenges prior to COVID-19, in many cases, forced isolation has caused amplification (Hwang, et al, 2020). The danger is that COVID-19 elicited mental health issues run quite deep, and are often unacknowledged. It is just assumed that the person is OK (de Nobel,2021).

The general stressors and conditions facilitated by the pandemic can be associated with a wide range of mental health issues, which is reflected in results of an online survey of 5070 Australian adults conducted in March and April 2020, which showed significantly elevated levels of anxiety, depression and stress (Newby, et al, 2000). The pandemic has been an escalating and continuous series of events that have impacted our medical, social, and emotional spheres (de Nobel, 2021).

Research pertaining to PTSD and other trauma based mental health issues has generally been based around the assumption that the cause is one singular event. The diagnosis of post-traumatic stress disorder (PTSD) as defined in the *Diagnostic and statistical manual for mental disorders*, 5th edition (DSM-5), requires exposure to a traumatic event, which is defined as 'actual or threatened death, serious injury, or sexual violence' (APA, 2013). What makes COVID-19 related mental health challenging is that we have been living with the experiences and repercussions of the pandemic for a prolonged amount of time, and it has greatly impacted many different parts of our lives (de Nobel, 2021). Other common mental conditions that may be caused by post-traumatic conditions may include depression, anxiety disorders and substance abuse (Cooper, et al, 2020).

Established programs and activities have been stopped, social groups and community centres have been forced to close their doors, and grandparents are currently unable to visit with their families. The initial proposed trajectory of the pandemic has been greatly extended, leading to prolonged social distancing and isolation, and we are now seeing the inherent physical, emotional and psychological repercussions (Cudjoe, Kotwal, 2020). As the pandemic continues to evolve, the necessity for the specialised management of this impact needs to be more urgently addressed. This is most evident within the elder cohort that are living in our communities and care facilities.

The impact that the pandemic is having on older adults is quite varied, based on numerous factors. Cognitive ability, education, and exposure in regards to technology has now become essential to maintain connection, with much of the aging population simply not possessing the skills required to navigate social media planforms. Socio-economic circumstances also play a large role, as many of the elderly simply do not have adequate finances to establish and maintain the required technology (Cudjoe, Kotwal, 2020). Whereas a normally well socialised grandparent may have access to people that can assist in these areas, during the pandemic this access is greatly diminished.

The facilitation of intervention and support via online platforms that has been suggested for development has the implications of being out of reach for many of those in need. Socioeconomic status, digital literacy, physical impairment and limited education are all potential barriers to utilising technologically based interventions and strategies, running the risk of even wider implications for the aging community (Torous, etal, 2020; Beaunoyer, et al, 2020). It would be fair to assume that there would be a considerate risk that those in our communities that are most in need of interventions and support would not be able to access or use the suggested online model (Williams, 2021). This is something that needs to be taken into consideration in the discussion and development of possible aids.

Many of our aging manage to live independently in our communities well into their later years. This is due to Government and familial supports which are designed to empower, and allow individuals to maintain their independence for as long as possible (Beland, 1995). COVID-19 has meant that many of these supports are simply no longer available. This can adversely affect individuals in various ways. Lack of practical supports may make life unmanageable, with individuals struggling to maintain their homes and to perform their day-to-day activities. This in turn can be detrimental to their emotional and mental wellbeing, by taking away their sense of autonomy. This paired with loneliness and social isolation can lead to severe mental health challenges. For some of the aging cohort, there may be reliance on interaction with services for their basic social connection. Without access to this, they may not have any interaction with others at all. For these particular individuals also, without contact, prevailing health issues may go unnoticed and become further exacerbated.

In particular, the residents of nursing and care homes are feeling the detrimental effects of COVID-19 policy, which prohibits visits and social gatherings with families (Wu, 2020; Deyer, 2020). Additionally, it would be fair to assume that this phenomenon is also occurring for the elderly that are still living independently, although may not be as documented. Strong evidence exists that both loneliness and social isolation can be linked with an increase in all-cause mortality, and the onset/progression of depression and anxiety (Leigh-Hunt et al, 2017).

We are a faith based Community Centre that services Logan in its entirety, with focus laying with the suburb of Eagleby and its surrounding communities. We have found that the model that we utilised during the initial lockdown of simply phoning those that are vulnerable and isolated to be extremely effective, and we would like to suggest that this model be developed and utilised on a larger scale. Evidence of this approach being successful can be seen in the current pilot program 'Plus Social', which is being rolled out in Sydney. This pilot was first implemented in 2016/2017 and was targeted towards individuals with mental illness and mood disorders, and has so far exhibited positive results, evidencing that social prescribing may improve participant outcomes (Aggar, et al, 2021).

As we continue to advance into a new COVID-19 influenced social climate, the prevalence of non-medical health challenges such as loneliness, depression and anxiety are becoming more recognised. This in turn has created a need to be able to 'treat' such conditions through non-medical means (De Iongh, 2018). From this has developed the notion of 'social prescribing', which is defined by the University of Westminster (2016) as;

> "Enabling healthcare professionals to refer patients to a link-worker, to co-design a nonclinical social prescription to improve their health and wellbeing"
>
> (Mofizul Islam, 2020).

The term 'prescribing', for some, may facilitate the notion of treatment, with a general assumption that you receive treatment when there is something wrong with you. Although this term may prove to be useful in gaining acceptance and traction within the clinical community, it also runs the risk of creating unjustified and unwarranted labelling of what is common and normal for individuals to experience (De Iongh, 2018). Such labelling dehumanises the approach, suggesting that individuals need to be 'fixed', and takes away from the perceived value of communities and social supports.

We are in agreement with the notion of social prescribing, but feel that it would be more effective if it was delivered on a more personal level. It isn't always plausible to expect an individual that is in the throes of loneliness and depression to even consider engaging with a group. Primarily, what they need is a friend, a routine, and something that they can rely on. For our organisation, that looked like a phone call, at about the same time on the same day every week. No restrictions or obligations, no pressure, just an opportunity to connect.

Within our approach, we enlisted the services of a retired social worker. Someone from the elderly cohort, with the ability to sympathise and generate genuine and meaningful rapport. We stayed away from engaging in clinical content, or suggesting that they have something wrong with them we need to fix. Using a person-centred framework, we allowed our participants to be in charge, and to drive the relationship in their own way, at their own speed, in a way that meets their own needs. We recognized the participant as the expert of their own lives.

Regarding our program, as COVID-19 restrictions began to lift, we encouraged the participants to join us for a coffee once a week at our centre. From this, we were able to connect these individuals, forming a peer driven friendship group. This is something that has continued to grow. Helping build these connections means that the individuals now have a support network. They feel empowered, they feel supported, they feel safe.

Historically, programs and strategies that target the notions of loneliness and isolation have been largely neglected due to a lack of funding and research (National Academies of Sciences Engineering and Medicine, 2020). Unfortunately, these issues have now been thrust into the forefront of public and community need, restricting opportunity to develop thorough evidence based interventions. It is in this authors opinion that non-clinical

challenges should be handled by non-clinical health care professionals, or through a collaboration of both. Through our programs we have seen great evidence for the effectiveness of peer led support, under the gentle supervision of a professional.

In summarisation, it is the opinion of this author that a non-clinical, person-centred approach would be most effective in tacking our immediate COVID-19 influenced inherent challenges. This is something that can be done in partnership with clinicians where needed, offering a fully personalised and holistic approach to client care. In many circumstances this approach would be deliverable from a community level, with the aid of volunteers, under the supervision and guidance of professionals. This means that it could be delivered at very low cost, and as research has evidenced, will lead to fewer hospitalisations in the future. This takes some of the pressure off our already crowded hospital system, and saves the tax payers money. This issue requires immediate response and attention from all levels of Government and Community so as to ascertain a best practice model so that we are able to move forward in unison.

The pandemic has brought to the forefront a pre-existing threat that is faced by our older population that is rarely spoken of, loneliness and isolation (Hwang, et al, 2020). Perhaps it could be hoped that the Government will seize the day on this opportunity of having such a serious community level crisis showcased in the public arena.

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