Reducing loneliness and social isolation for people with mental health problems
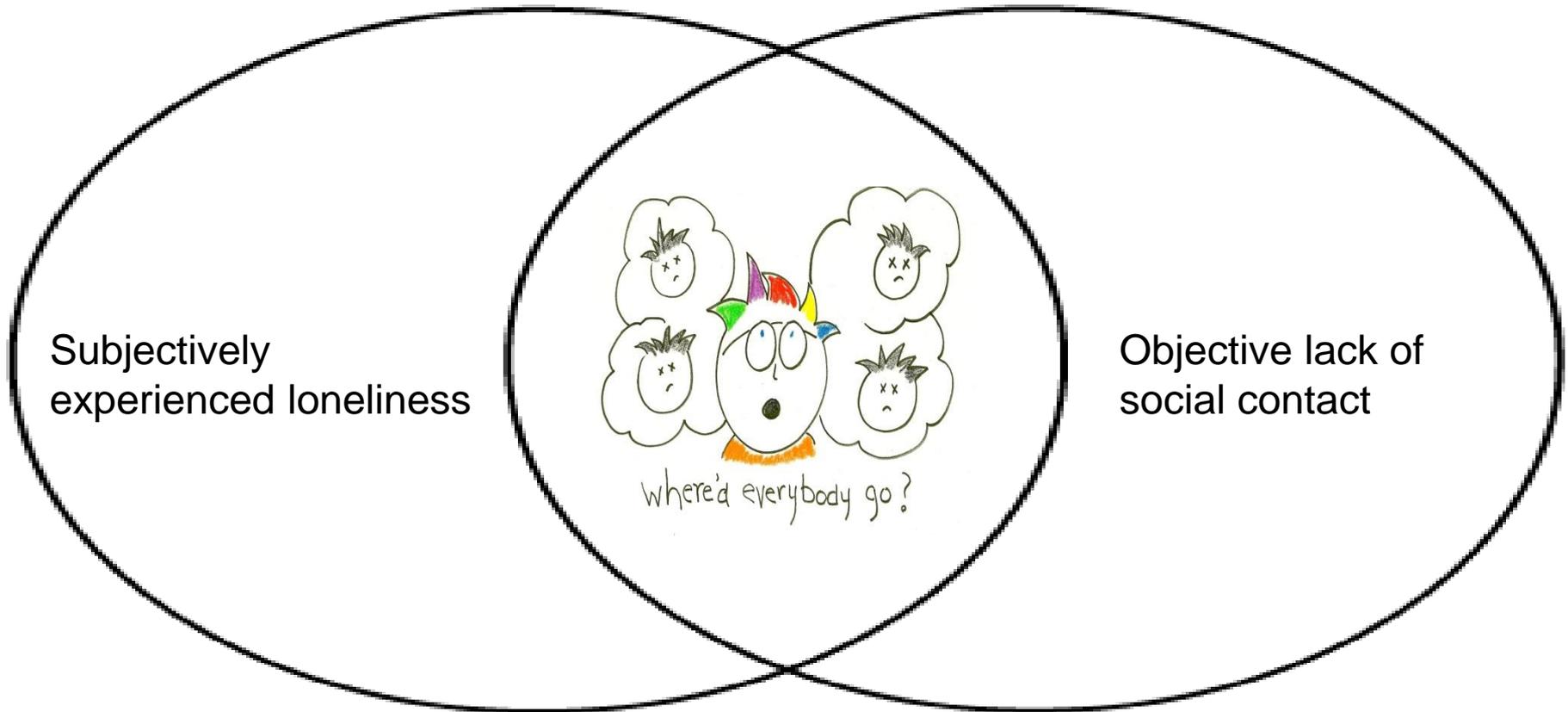
City University Social Inclusion Seminar
08/06/17

Dr Brynmor Lloyd-Evans
Division of Psychiatry, UCL

Social isolation

Subjectively experienced loneliness

Objective lack of social contact

where'd everybody go?

The concept of loneliness

- Subjective gap between actual and desired levels of social relations (Perlman & Peplau 1981)

- Loneliness is moderately correlated with both depression and objective social isolation (Cacioppo 2013) *but not synonymous*

- Social and emotional loneliness are sometimes distinguished (DeJong Gierveld & Tilburg 2006)

- Validated measures of loneliness exist (ULS-8; DeJong-Gierveld-6)

SOCIAL ISOLATION IN MENTAL HEALTH:

A CONCEPTUAL AND METHODOLOGICAL REVIEW

SCOPING REVIEW 14

JINGYI WANG, BRYNMOR LLOYD-EVANS, DOMENICO GIACCO,
REBECCA FORSYTH, CYNTHIA NEBO, FARHANA MANN, SONIA JOHNSON

Social isolation in people with mental health problems

Loneliness

- 7-11% of general population may experience severe, chronic loneliness (Victor 2005, CGF 2016)
- Up to 40% for people with depression (Victor and Yang 2011)
- 10x odds of loneliness for people with MH problems (Meltzer 2012)

Social network

- General population: 6.5% severely isolated in UK (Banks et al, 2009)
- Typical number of friends: general population 7-11; people with SMI 3 (Palumbo et al 2016)
- Higher proportion of family members in social network for people with mental health problems (Buchanan 1995)

Reducing social isolation: what do we know?

- A variety of psychological and social interventions can increase social networks in mental health (Anderson et al. 2015)

- But their long-term sustainability is less clear

- Limited evidence about how to reduce loneliness (Masi et al. 2011)

- Promising social interventions have not been evaluated robustly

➢ Social prescribing (navigation and providing social groups)
  https://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf

➢ Connecting People programme *https://connectingpeoplestudy.net/*

Reducing loneliness in people with depression in secondary care: why is this a priority?

- Strong social determinants to depression in general

- Links between loneliness and poor recovery from depression are established (van Beljouw 2010, Holvast 2015)

- Limits to the effectiveness of medical and psychological interventions for severe depression

- But secondary care for depression and anxiety is often very medically and psychologically-focused: a need for more socially focused support?

- Care coordinators view social isolation as important, but rarely feel able to offer support with social connections (Pinfold 2014)
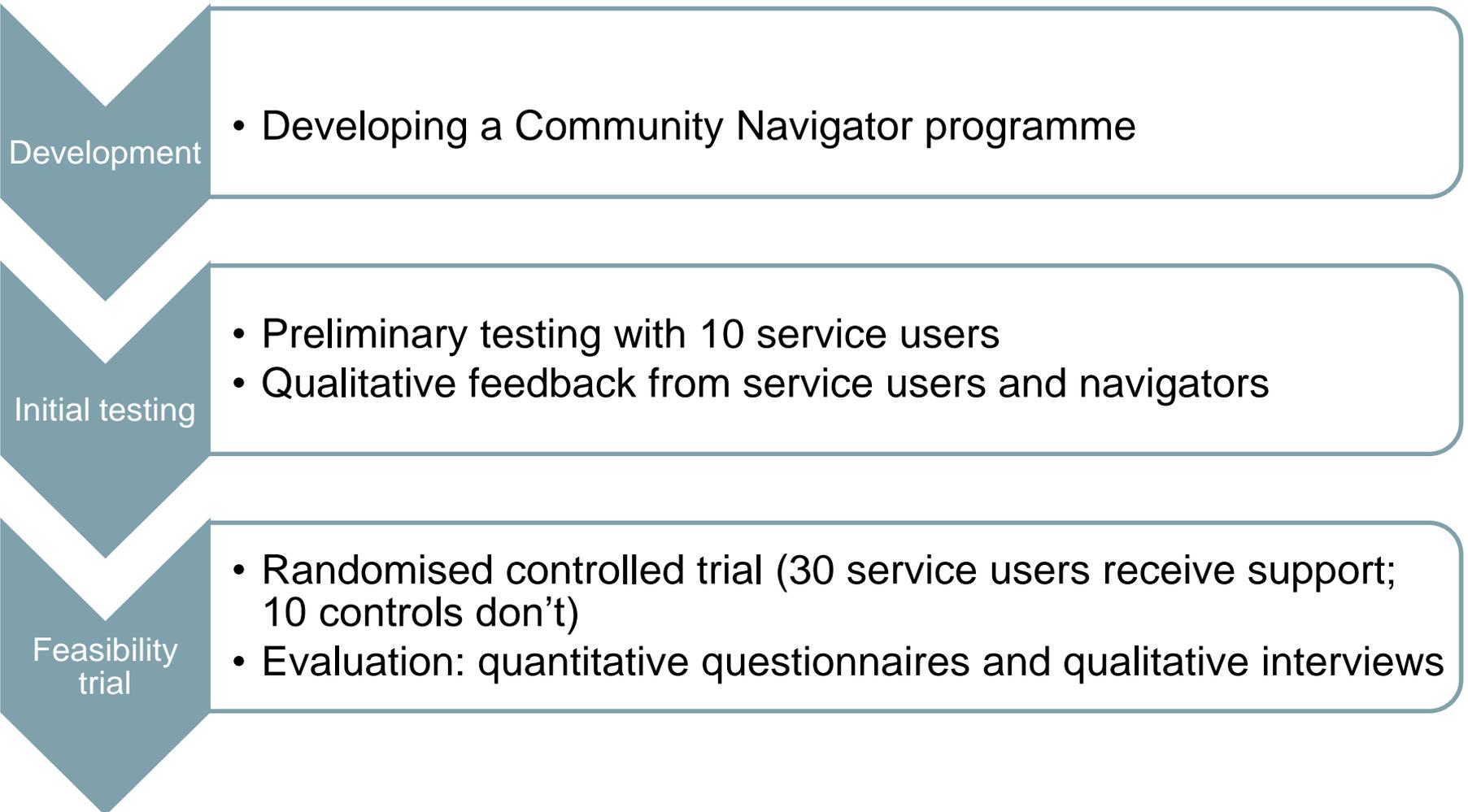
The Community Navigators Study

- 2-year study – started March 2016

- Funded by the NIHR School for Social Care Research

- Research Team from UCL and McPin

- 2 NHS Trusts (BEH and C&I) – secondary services for people with depression or anxiety

Aim: To develop and test the feasibility of a community navigator programme to reduce loneliness

Study team

Study Leads	Sonia Johnson, Bryn Lloyd -Evans (UCL)
Co-applicants	Vanessa Pinfold (McPin), Glyn Lewis, Jo Billings (UCL),
Study Researchers	Jessica Bone (UCL) Johanna Frerichs (McPin)
Working Group	6 experts with lived experience 4 x practitioners 5 x study researchers

Structure of the Community Navigator study

Development
- Developing a Community Navigator programme

Initial testing
- Preliminary testing with 10 service users
- Qualitative feedback from service users and navigators

Feasibility trial
- Randomised controlled trial (30 service users receive support; 10 controls don't)
- Evaluation: quantitative questionnaires and qualitative interviews

Following MRC guidance for developing a complex intervention

CN study
- Evidence review and consultation
- Modelling the intervention and theory of change

CN Study
- Testing feasibility and acceptability of the intervention
- Testing trial procedures and feasibility

Future studies
- Multi-site RCT
- Replication and implementation studies

Developing the Community Navigation Intervention

- 8 meetings of a study stakeholder working group (experts with lived experience, clinicians, researchers)

- Consultation with experts in the field (WE, G4H, NDTI)

- Reference to relevant literature

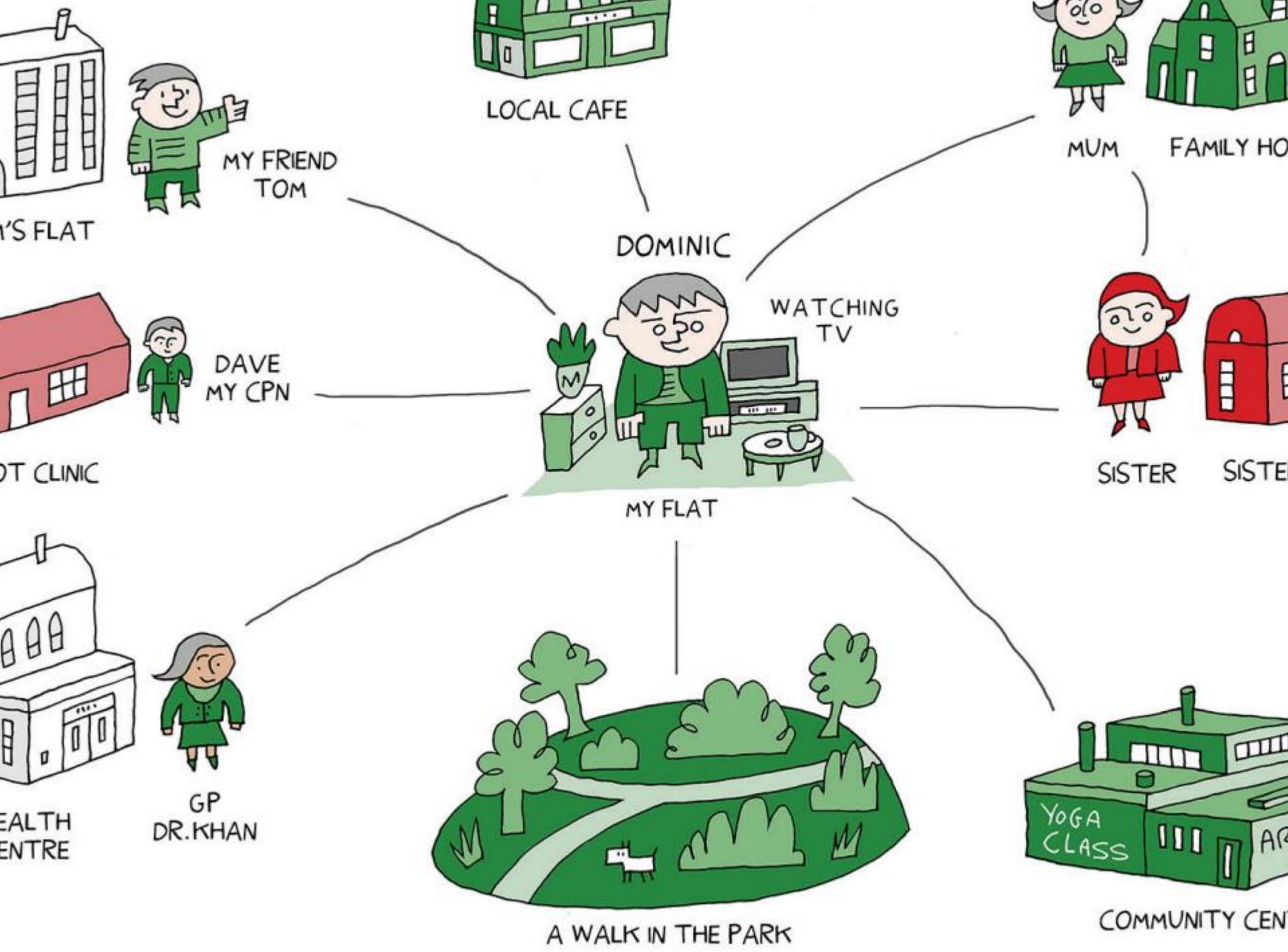- Intervention manual and theory of change model developed

The Community Navigator Programme

Structure

- Up to 10 sessions
- Up to 6 months
- £100 budget
- Additional group element
- Adding to standard care
- Training from study team/CDAT practitioners
- Supervision from MH service social workers

Key components

- Mapping my social world
- My connections plan
- G4H social identity building
- Solution-focused approach
- Help only with social contact/connections

LOCAL CAFE

MUM

FAMILY HO[USE]

MY FRIEND TOM

[TO]M'S FLAT

DOMINIC

WATCHING TV

DAVE MY CPN

[FOO]T CLINIC

MY FLAT

SISTER

SISTE[R]

[H]EALTH [C]ENTRE

GP DR. KHAN

A WALK IN THE PARK

YOGA CLASS

COMMUNITY CEN[TRE]

MY CONNECTIONS PLAN

Connect

Reconnect

Explore

Join in

My Goals:

Next Steps:

Time frame:

Strengths and resources to help me...

Name _____

Date _____

Community Navigation: conceptual overlap with other interventions

Intervention	How is Navigation different?
Befriending	Focus on *linking in*, not doing with Mobilises existing social support
Behavioural activation	Focus on *social contact* (quality and quantity) not just activity
Social identity programmes (e.g. G4H)	Focus on *1:1 relationships* as well as groups. Non-didactic approach
Interpersonal Therapy (IPT)	Focus on making *new social contact* as well as mobilising current network Simpler, *non-psychological* approach

Monitoring process and outcomes

We will monitor how the intervention is delivered:

- *How many sessions?*
- *Are mapping and goal setting done?*
- *What new activities or groups are accessed?*

And use outcome measures and qualitative interviews to explore mechanisms of effect:

- *Social network*
- *Activity (time budgets)*
- *Social capital*
- *Depression*

Towards a theory of change..

Ways of reducing loneliness (De Jong Gierveld 2006)	How Navigators may help
Making new social contacts	Asset mapping – finding groups and activities Help and encouragement to try new things £100 budget
Enhancing existing relationships	Relationships inventory (IPT) Encouraging reconnection and identifying shared interests
Changing thinking about social connections	G4H social identity materials Instilling hope Small steps make goals feel manageable Normalising difficulties, reinforcing achievements

Community navigation case example

Participant 01: Now – Meditation classes, Health Condition Group, Film
        Previously – Sport and outdoors, volunteering, music

	Miss	Maybe	Hit
Volunteering	KCL	City Farm Neighbourhood Centre	
Film	Local film club		Neighbourhood Centre film group
Sport		Local football team Cricket club trips	
Outdoors		City Farm	TH Walking Group (new friend)
Social	Adult Ed	Recovery College Family plans	Neighbourhood Centre (lunch club, film group > weekend trip with new friends)

Reported impacts:
- More active, more confident
- More comfortable with others even if no point of connection (health condition)
- Finding interpersonal contact easier (e.g. brother-in-law)

Preliminary testing: qualitative feedback

Overall – really encouraging. Positives include:

- Navigators' positive, friendly style
- Focus on social connections was valued – even though it's scary
- Even small gains are appreciated

Challenges

- Endings are difficult
- G4H group programme was not welcomed by many
- Need for good lines of communication with care coordinators

She wasn't in a rush to go. I could stay as long as you need me, which is nice in this day and age to have help. She was lovely, very, very kind.

It has got me out and talking to someone and looking at what is around the local area that might be interesting, that I might like to do. There's more out there than you think.

It's giving me encouragement to try and do it myself, but at the same time, I know that they are helping me out too.

Reflections from navigator case examples

- Navigators need to know the local community

- Individualised plans help

- "Going with" helps overcome initial barriers

- False starts will occur: a sustained, intensive focus is needed?

- Non-NHS groups led to informal contact/friendship

- Changes in thinking follow changes in behaviour

A navigation approach: questions to answer..

- Will people identify as lonely?

- Will people want this support?

Will it be too stressful for people?

Will people be able to increase their social connections?

Will increasing social contact address loneliness?

Next stage: Feasibility Trial

- RCT (n=40)
- Treatment group (n=30) receive CN support
- Control group (n=10) will be given a written list of local resources
- Baseline and 6-month follow-up
- Qualitative interviews with participants (n=20) navigators (n=3) and other stakeholders (n=10)

Main outcomes

- Trial recruitment and retention
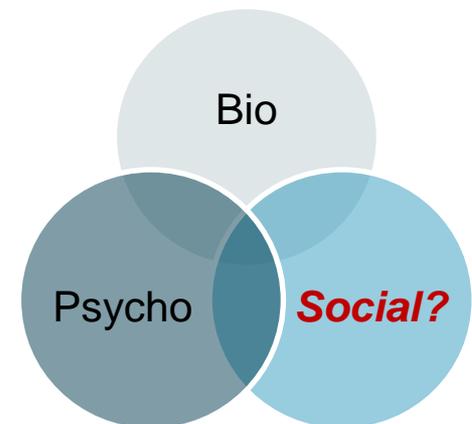- Intervention integrity
- Acceptability and perceived usefulness

Outputs from the study

- A manual for the Community Navigators programme

- Clear ideas about the expected outcomes of the programme and how they will be achieved: a refined theory of change

- Tested procedures and outcomes to use in a future trial

- Preliminary evidence about the acceptability and usefulness of the navigator programme

Next steps

If the programme shows promise in this trial..

- A multi-site RCT with internal pilot
- Evidence about how to reduce loneliness and improve health outcomes for people with severe depression

Bio

Psycho

Social?

Social determinants of depression

Brown and Harris(1978) risk factors for depression in women:

- **Unemployment**
- Lack of a **confiding partner**
- 3 **children** under 14
- **Maternal loss** before age 11

Low **income**, low **education**, **unemployment**, **social isolation** all subsequently associated with increased risk of depression in numerous studies (WHO 2014)

Loneliness predicts the onset and poorer recovery from depression (van Beljouw 2010, Holvast 2015)

Social interventions for severe depression: Evidence gap or treatment gap?

Family work

Employment support

Social isolation

Family interventions

High expressed emotion predicts poor recovery in depression

- Relapse rates: 35% (low EE) vs 65% (High EE)
- EE is a stronger predictor of relapse in depression than in schizophrenia (Butzlaff and Hooley 2010)

NICE recommends:

- Family Therapy for young people (CG28)
- Behavioural Couples Therapy (BCT) for TRD (CG90)

BCT has the highest rates of recovery of all modes of therapy in high intensity IAPT settings (HSCIC 2016: Annual report on use of IAPT Therapies)

Employment Support

- IPS supported employment is highly effective for severe mental illness (studies often include severe depression) (Bond 2012)

- Evidence re IPS in common mental disorders is equivocal (Hellstrom et al 2017)

- But promising evidence that IPS + work-focused CBT helps employment and symptom reduction in depression, *especially for the more severely depressed* (Reme et al. 2015)

Social Isolation

Effective treatments for symptom reduction in mild/moderate depression: systematic reviews support

- Befriending (Mead 2010)
- Peer Support (Pfeiffer 2011)

➢ *Applicability to TRD populations are not established.*

Social prescribing approaches are increasingly popular in primary care, but lack robust evaluation (York CRD 2016)
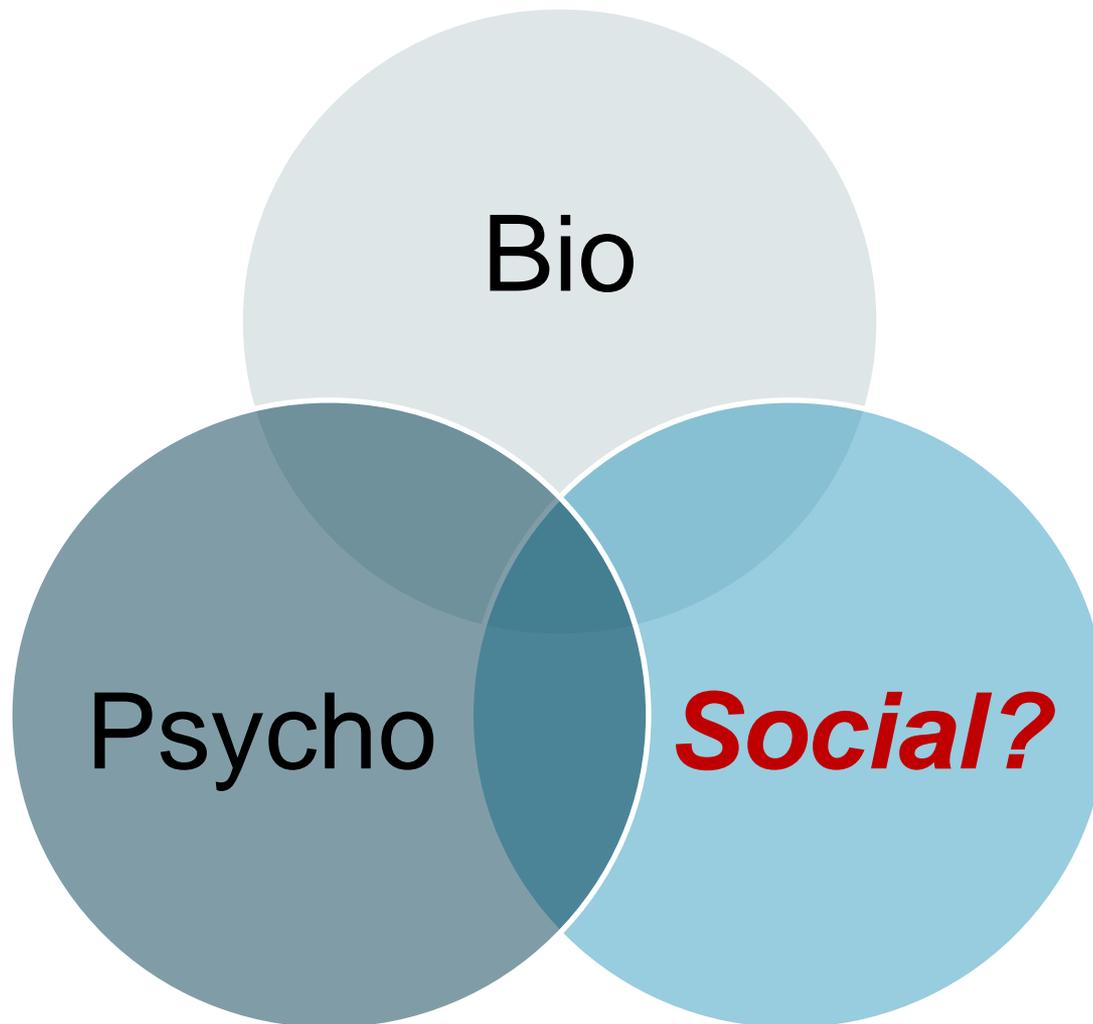
Current provision of social interventions for TRD

The secondary care depression and anxiety service local to me does not provide:

- Behavioural Couples Therapy
- Specialist employment support
- Any programme in routine care to reduce social isolation

Is this typical of secondary care services for people with severe depression?

Few specified service standards for depression and anxiety services in secondary care (e.g. compared to EIS services)

Improving outcomes in severe depression?

Thank you!

For more information

Study website:
http://www.ucl.ac.uk/psychiatry/research/epidemiology/community-navigator-study/

Or please contact:
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