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Loneliness, social isolation and social connection in Wales: A public health perspective

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Executive summary

Background

Loneliness and social isolation are increasingly recognised as significant public health challenges, with wide-ranging negative impacts on the health and well-being of individuals, communities and wider societies. In contrast, strong social connections are key to good physical and mental health, well-being and resilience.

In Wales, the value of building stronger social connections has been recognised for some time. A national strategy for addressing loneliness and social isolation was published in 2020, setting out key priority actions with corresponding funding. Since then, shifts in society due to the COVID-19 pandemic, advances in digital technology and the cost-of-living crisis have affected how people connect, opportunities to participate in society, and the level and nature of services. Furthermore, recent advances in research have deepened our understanding of loneliness and social isolation and effective solutions. These developments make it an ideal time to re-examine loneliness, social isolation and social connection in Wales, drawing on available evidence and identifying areas for future action.

At an international level, momentum on loneliness, social isolation and social connection has also been building through the creation of a World Health Organization (WHO) Commission on Social Connection (link opens in new window) and the publication of its flagship report in June 2025. These initiatives offer a valuable opportunity to reflect on how current global insights can inform and strengthen the progression of work in Wales.

Purpose

This report aims to present loneliness, social isolation and social connection in Wales from a public health perspective. Intended for professionals, policymakers and other individuals working directly or indirectly in the field of social connection, it includes data and evidence on: the prevalence of loneliness, social isolation and social connection in Wales and the population groups most affected; factors that increase the risk of loneliness and social isolation; impacts on health and well-being; evidence on solutions; examples of good practice in Wales; and key areas for future action.

Key findings

- In Wales, latest data suggests that 13% of people aged 16 and over feel lonely, 13% are socially isolated, and 71% feel fairly or very connected to others. Levels of loneliness vary by age, deprivation, ethnicity, sexual orientation and disability.

- There are a range of risk factors for loneliness and social isolation that span across socio-ecological levels. Examples include:

    - **Individual factors:** poor health, low education, financial stress,
    - **Relationship factors:** having no partner or being unmarried or widowed, low social support, bullying victimisation,
    - **Community and societal factors:** high deprivation, low neighbourhood safety, poor walkability, low access to green space. Loneliness can also be influenced by cultural values and levels of stigma in society.

- Loneliness and social isolation can have substantial negative impacts on the health and well-being of individuals, communities and wider societies, including increased risks of:

    - **Early death:** loneliness and social isolation are estimated to increase the risk of all-cause mortality by 14% and 32% respectively,
    - **Physical, mental and cognitive health conditions:** these include cardiovascular disease, type 2 diabetes, depression, anxiety and dementia,
    - **Poor education and employment outcomes:** loneliness has been linked to poorer academic achievement, unemployment and reduced income.

- Loneliness can have substantial economic costs through increased health and care service use, reduced work productivity and absenteeism. In the UK, severe loneliness is estimated to cost around £9,900 per lonely person per year.

- Internationally, a wide range of solutions have been used to address loneliness and social isolation, including those focusing on:

    - **Individuals and relationships:** implementing interventions that help support individuals experiencing loneliness or social isolation to make and sustain relationships. These include interventions to improve social skills, increase social support, and change social cognitions,
    - **Communities:** increasing people's access to social interaction. This includes establishing community groups, social prescribing systems that link people experiencing loneliness or isolation with non-clinical community services or groups, and modifications to the built environment. More widely, this includes improvements to social infrastructure,
    - **Societies:** implementing policies and strategies that address the structural determinants of social disconnection, including national policies on loneliness and social isolation, national campaigns and advocacy.

- Digital solutions are also available. These can include digitally delivered interventions (e.g. online social support or networking spaces) or the use of technology for connection (e.g. robotic companions). While they can reduce barriers to connection (e.g. overcoming mobility barriers), other issues may need to be addressed to facilitate engagement, such as poor digital literacy, poor access to internet services and digital ageism.

- In Wales, there are many interventions to improve social connection and address loneliness and social isolation at individual, community and societal levels. Further evaluation of these approaches would help to develop knowledge of what works, and for whom.

Recommendations and conclusions

Wales has demonstrated a strong commitment to addressing loneliness and social isolation and is actively engaging in many of the internationally recognised solutions. Building on this positive foundation, several areas for further action are suggested that could help to expand work on social connection. By doing so, Wales can help build more connected, healthier and more resilient environments for current and future generations.

Key considerations

Data collection

1. Collect data on social isolation in Wales routinely, finding agreement on the most appropriate methods and measures.
2. Allow for data on loneliness and social isolation to be disaggregated into narrower age-bands, particularly for older age groups.
3. Map existing sources of data collection on social connection in Wales to develop a more comprehensive understanding of the issue.
4. In the longer term, consider creating a central location (e.g. an online tool) for data on loneliness, social isolation and social connection in Wales to increase knowledge of, and access to, data sources.

Research

5. Conduct further research on social isolation in Wales, including on demographic variation, risk factors and impacts on health.
6. Explore how loneliness, social isolation and social connection impact across different sectors, and the role each sector may play in solutions.
7. Improve understanding of the role of digital technology in social connection and how technology can be best used to build connections whilst avoiding harms.

Interventions

8. Ensure targeted interventions for population groups at higher risk of loneliness and/or social isolation, for example those living in deprived areas, individuals with a disability, people in poorer health.
9. Identify and encourage opportunities to evaluate action in Wales, including how interventions impact across population groups and locations, and barriers and enablers to implementation and participation.
10. Raise awareness of the importance of indirect interventions (initiatives that contribute to social connection without this being a primary aim), and ways in which small changes to these initiatives could influence social connection further.
11. Identify opportunities to align action on social connection with solutions for other public health issues.
12. Ensure that interventions are co-produced with representatives from the target population.

Partnerships and networks

13. Raise awareness of the health, social and economic impacts of social disconnection and connection across sectors, for example through webinars/events in Wales.
14. Create the opportunity for regular cross-sector meetings to share research and experiences, network, and enable new opportunities for action on social connection.
15. Identify further opportunities, alongside current engagement with the WHO Global Network for Age-friendly Cities and Communities, to feed into international initiatives and agendas.

Chapter 1: Introduction

Forms of social disconnection, such as loneliness and social isolation, are increasingly recognised as significant public health challenges. A growing body of international evidence highlights their substantial and wide-ranging impacts on physical, mental and cognitive health and well-being, as well as wider societal costs due to reduced work productivity, absenteeism and increased use of health and care services. The impact of loneliness on mortality has been equated to that of smoking up to fifteen cigarettes per day (1). Conversely, healthy social connections are key to good physical and mental health and well-being, as well as individual and community resilience (2).

In Wales, a substantial proportion of the population are affected by social disconnection - 13% of people aged 16 and over in Wales are estimated to be lonely (3), and 13% socially isolated (4). Furthermore, although social disconnection can affect any individual, higher levels of loneliness are reported by marginalised groups of society, such as individuals with a disability, LGBTQ+ individuals, migrants and refugees, and those with a long-term illness. This makes social disconnection an important inequality issue.

The value of addressing loneliness and social isolation and building stronger social connections in Wales has been recognised for some time. Wales was one of the first countries internationally to launch a dedicated national strategy for addressing loneliness and social isolation (5), proposing key priority actions with corresponding funding for their implementation. Recognising the importance of social connection to individual and community well-being, levels of loneliness were also included as a national indicator for progress towards the goals set out within the Well-being of Future Generations (Wales) Act 2015 (6).

Since the launch of the Welsh strategy (5), there have been major shifts in society due to the COVID-19 pandemic, advances in digital technology and the cost-of-living crisis. These shifts have affected how people connect, opportunities to participate in society, and the services available to individuals and communities. Further, advances in research have been made that contribute to our understanding of social disconnection and effective solutions. This makes it an ideal time to re-examine loneliness, social isolation and social connection in Wales, bringing together available evidence and reflecting on areas for future action.

Internationally, concerns around the impact of social disconnection on health, and uncertainty in how advances in digital technology are influencing social connection, have prompted the World Health Organization (WHO) to create a three-year Commission on Social Connection (Box 1.1). The Commission's flagship report, published in June 2025 (7), brings together the latest international research on social connection across the world and identifies key strategic areas for action. Its publication offers a valuable opportunity to reflect on how this knowledge can contribute to the progression of work in Wales.

Box 1.1: The WHO Commission on Social Connection.

The WHO Commission on Social Connection was established in 2023, with the aim of positioning loneliness and social isolation as global public health issues. It intended to raise awareness of the negative impacts of social disconnection on physical, mental and cognitive health, and the health benefits of stronger social connections. Recognising that social disconnection can affect all ages and world regions, the Commission is working to identify and scale cost-effective solutions and promote global and national action to enhance social bonds, to improve the health of individuals and communities around the world.

This report aims to present loneliness, social isolation and social connection in Wales from a public health perspective, bringing together available evidence from Wales and incorporating learning from the WHO Commission on Social Connection. It is intended for professionals, policymakers and other individuals working directly or indirectly on social connection. The report includes data and information on:

- Definitions of loneliness, social isolation and social connection (Chapter 2),
- The prevalence of loneliness, social isolation and social connection and population groups most affected (Chapter 3),
- Factors that increase the risk of loneliness and social isolation (Chapter 4),
- The impacts of social disconnection on health and well-being (Chapter 5),
- Evidence on interventions and policy solutions (Chapter 6),
- Examples of good practice across Wales (Chapter 7), and
- Areas to consider for future action (Chapter 8).

Using this public health perspective, the report intends to highlight the value of building stronger social connections, not only for those experiencing loneliness and social isolation, but also to help build more connected, healthier and resilient environments for current and future generations.

Chapter 2: Understanding loneliness, social isolation and social connection.

Loneliness is an unpleasant, subjective feeling that arises when there is a difference in the relationships we want and those that we have. Most people will have experienced loneliness at some point in their lives, even for short periods of time. Social isolation on the other hand is an objective lack of social relationships in terms of their quantity or the frequency of contact. A person can therefore be socially isolated yet not feel lonely, or feel lonely and not be socially isolated. These ideas reflect the definitions of loneliness and social isolation used in Wales (Box 2.1). Loneliness can be defined as transient or chronic (Box 2.2), with chronic forms associated with greater health problems (see Chapter 5).

Box 2.1: Definitions of social connection and disconnection used in Wales.

Loneliness: a subjective, unwelcome feeling of lack or loss of social relationships, which happens when there is a difference between the social relationships we have and those we want (5). There are two types of loneliness. **Social loneliness** is an unpleasant feeling arising from an absence of broad social networks. **Emotional loneliness** is an unpleasant feeling arising from an absence of close relationships.

Social isolation: an objective lack of social relationships at individual, group, community and societal levels (5).

Social connection: a feeling of belonging or feeling close to someone (8).

Social capital: the relationships and participation in social networks that can impact on individual and community health and well-being (9).

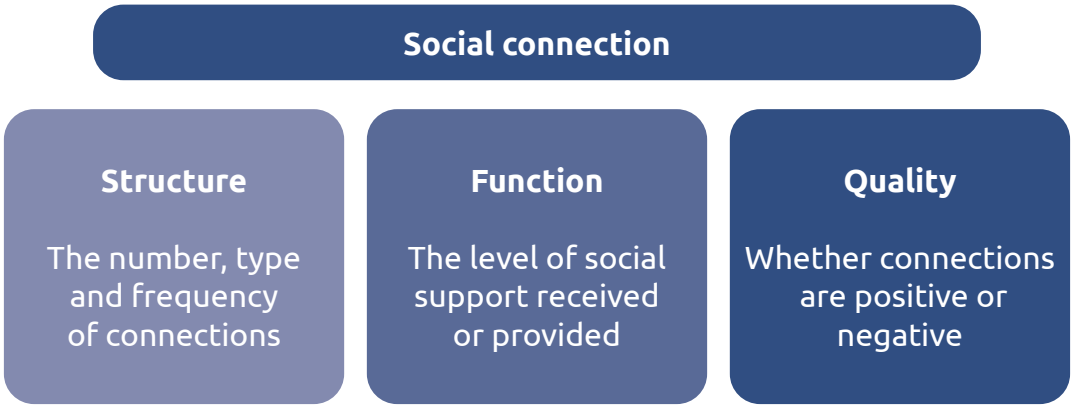


Figure 2.1: Three elements of social connection (7,10).

It can be helpful to view loneliness and social isolation in terms of the wider concept of social connection (7,10). At a basic level, social connection is a feeling of belonging or feeling close to someone (Box 2.1). However, three elements of connection have been identified that can vary from high to low: structure (the number and type of social connections and the frequency of interaction), function (the level and type of social support received or provided), and quality (whether relationships are generally positive or negative/harmful; Figure 2.1). A person is more socially connected if they have higher levels of these components. Low structure (e.g. having a low number of connections or frequency of contact) can be described as social isolation, and a low level of one or more of the three components can lead to feelings of loneliness. Categorising social connection in this way can help identify how connection can be improved – through increasing a person's network, level of social support and the quality of interactions. It can also help explain why focusing on only one of these components may not necessarily address loneliness. For example, improving a person's social network (structure) may not provide more social support or better-quality interactions.

Box 2.2: Chronic and transient loneliness (7).

Transient loneliness is temporary and often occurs due to external factors such as a relationship breakdown, retirement or leaving home. It usually resolves as the situation passes and may trigger periods of reflection and personal growth.

Chronic loneliness is persistent and sustained over a prolonged period of time, often two years or more. This can be maladaptive and can impact on an individual's physical and mental health (see Chapter 5).

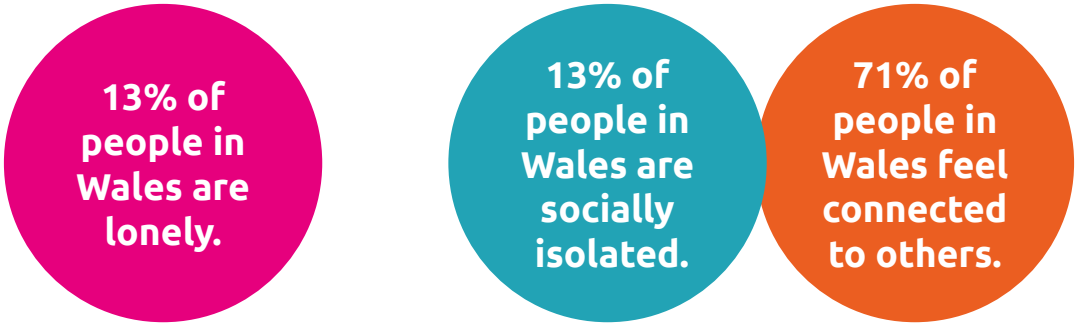
Chapter 3: The prevalence of loneliness, social isolation and social connection

This chapter presents data on the prevalence of loneliness, social isolation and social connection in Wales and demographic variation. It focuses on loneliness data from the National Survey for Wales (NSW [3]), supplemented by data on social isolation and social connection gathered via the Public Health Wales Time to Talk Public Health (TTPH) population panel (link opens in new window).

3.1 Prevalence of loneliness, social isolation and social connection

The NSW is a national cross-sectional survey that is performed each year, surveying around 12,000 people aged 16 years and over (3). A measure of loneliness (the *de Jong Gierveld Measure* [11]) has been included in the NSW since 2016. In the most recent findings (2022/2023), 13% of people were classified as lonely. Social loneliness (23% of people) was more prevalent than emotional loneliness (18%). Almost half - 48% - of people in Wales reported experiencing loneliness at least some of the time (3).

Figure 3.1: Latest available data for levels of loneliness (2022/2023), social isolation (2025) and social connection (2025) in Wales.



Data from the NSW (3). **Data from the TTPH panel survey (4).**

Note: NSW and TTPH use different sampling approaches and data collection methods. For example, NSW is a cross-sectional population survey that uses a random-sampling approach. TTPH is a population panel survey that uses a non-random sampling approach.

The NSW data does not differentiate between chronic and transient loneliness (see Chapter 2). The Office of National Statistics, however, measures chronic loneliness using a single question ('how often do you feel lonely?') and defines chronic loneliness as the responses 'always' or 'often' (12). Figures from 2023 suggest that 7.1% of people in Great Britain experience chronic loneliness, which is less common than transient loneliness (12).

NSW data shows that the prevalence of loneliness was similar in 2020/2021, 2021/2022, and 2022/2023 (3). These levels were slightly lower than they were in 2019/2020 (15%), which may have been influenced by the COVID-19 pandemic and the ensuing periods of lockdown (13) (Box 3.1). Across Great Britain, the prevalence of chronic loneliness has increased, with levels rising from 6.0% in 2020 to 7.1% in 2023 (12).

There is limited data investigating social isolation and social connection in Wales. To explore this, we included questions in the TTPH February 2025 population panel survey (4). TTPH is a national panel of people aged 16 years and over living in Wales who are invited to take part in surveys to collect population insights to inform public health policy and practice (see Appendix for the measures used). This data showed that:

- 13% of people were socially isolated; 2% scored the maximum social isolation score,
- 71% of people felt fairly or very connected to other people.

Box 3.1: The COVID-19 pandemic and its impact on loneliness in Wales.

The COVID-19 pandemic from 2019 to 2023 (14) significantly impacted opportunities for socialising for many people. In Wales, to limit the spread of infection, public health legislation restricted in-person socialising outside of households and limited the time people were permitted to be outside of their household for several extended time periods (15). The impact of these restrictions on levels of loneliness in Wales was clear. Alongside higher overall loneliness in 2019/2020 compared to subsequent years, the NSW showed that whilst 19% of people reported '*missing having other people around*' in 2016 and 2017, this figure increased to 57% in 2020, returning to pre-pandemic levels in late 2023 (23%). In addition, notably more people reported themselves to be 'sometimes lonely' in 2021 (71%) compared to 2017 (53%) and 2023 (48% [3]).

Social restrictions also influenced the provision of services for individuals experiencing loneliness and social isolation, such as befriending schemes (see Chapter 7), potentially exacerbating social disconnection. However, many such services moved to virtual or telephone connections to allow support to continue.

During the pandemic, Public Health Wales ran a regular survey (the 'How are we doing?' survey, [link opens in new window] [16]) to assess how the pandemic was affecting how people thought, felt and behaved. Results showed that levels of loneliness and social isolation were significantly higher during periods of lockdown and peaked during the winter of 2021, during which restrictions were high.

3.2 Prevalence across demographic groups

Multiple reports detail the prevalence of loneliness across demographic groups both within Wales and across the UK, as well as highlight inequalities (3,12,17–20). However, less is known about how levels of social isolation and social connection vary across demographic groups. A breakdown of data from the TTPH survey by age group, sex and deprivation is provided here, but further work examining variation across other population groups is needed. Data collected through charity organisations is presented in the following sections where available, but these surveys may use different measures and definitions of loneliness and isolation to those used in national surveys.

Age

Loneliness, social isolation and social connection may affect different age groups (aged 16+) in different ways. For loneliness, those aged 16–24 years in Wales report the highest levels (16%),

followed by those aged 25–44 years (15%), 45–64 years (12%) and 65 years and above (9% [3]). Children are not included in the NSW, but other sources of information on loneliness in children are available (Box 3.2). Conversely, the highest levels of social isolation in Wales are reported among those aged 50-69 years (19%), followed by 70+ years (13%), 30-49 years (12%) and 16-29 years (3%).

For social connection, individuals aged 16-29 years report the highest levels of feeling fairly or very connected to other people (82%), followed by those aged 70+ years (80%), 30-49 years (67%) and 50-69 years (65%).

Broad age categories, however, may mask the prevalence of social connection and disconnection in the oldest age groups (e.g. 85 years and above), and further breakdown of age data would be helpful (Box 3.3).

Box 3.2: Loneliness in children.

Data from the European Health Information Gateway (21) suggests that 56% of boys and 63% of girls under the age of 11 in Wales feel a high level of peer support (a measure of the 'function' component of social connection, see Chapter 2). Further, in the Health Behaviours in School-aged Children report for Wales 2023 (22), 3% of children reported the highest loneliness score of 9, and 31% reported the lowest loneliness score of 3 (as measured by the University of California Los Angeles (UCLA) measure of loneliness [22]). Non-binary children had higher average scores for loneliness compared to female and male children. The highest average score was found for children in Year 11 and the lowest in those in Year 7. Children with lower family affluence were also more likely to report themselves as lonely.

In a Co-op survey of young people aged 10 to 25 years in the UK, only 5% never felt lonely, whereas 12% were chronically lonely (20). Those aged 16-25 years reported higher levels of chronic loneliness than those aged 10-15 years (16% and 5%, respectively). Young people living in cities or towns reported higher levels of feeling lonely at least occasionally (78%) than those living in rural areas (68%).

Box 3.3 Loneliness in older people.

Life events or transitional stages that are known to be associated with the onset of loneliness and social isolation, such as retirement, bereavement or ill-heath, are common across later life, particularly for the 'oldest-old'. As a result, older people may be particularly vulnerable to loneliness and social isolation at different stages of ageing. This is especially the case for those with limited social or family support (e.g. older people without children), who may be left behind by policies and systems that assume some level of family care (23). Currently, much of the data collected on loneliness and social isolation is presented in broad age groups. For older age groups, further breakdown of data into younger-old and oldest-old age groups (e.g. 85+ years) would improve understanding of older people's experiences and needs.

Sex

Data from the NSW (2022/2023) shows that individuals identifying as male and female have similar levels of overall loneliness (12% and 13% respectively [3]). However, females report more emotional loneliness (21%, compared to 16% for males). Across Great Britain, women are also slightly, but significantly, more likely to report chronic loneliness (7.7% compared to 6.3% for men [12]). However, men may under-report feelings of loneliness. Research by the Royal Voluntary Service, using a different methodology to the NSW, found that in the UK, 35% of men felt lonely at least once a week, with 11% feeling lonely at least once a day (24). Importantly, 10% of men said that they felt lonely but would not admit this to anyone.

TTPH data found that, in Wales, males and females have equivalent levels of social isolation (13% for both sexes) and reported similar levels of social connection (70% and 73% felt 'fairly or very connected', respectively).

Deprivation

Both loneliness and social isolation show a similar pattern with deprivation. NSW data for 2022/2023 shows that individuals living in households in material deprivation had substantially higher levels of loneliness (34%) than those living in households not in material deprivation (9%) (3). Similarly, TTPH data showed that levels of social isolation were highest for individuals living in the most deprived areas of Wales (17%) and lowest for those in the least deprived areas (9%; based on the Welsh Index of Multiple Deprivation [25]). For social connection, individuals living in the most deprived areas reported the lowest levels of feeling fairly or very connected (66%), whilst levels for those living in all other areas ranged from 71% (second most deprived areas) to 73% (third and fourth most deprived areas).

Ethnicity

In the NSW (2022/2023), those who identified as Black, Asian or as part of other minority ethnic groups were more likely to be lonely (24%) than those who identified as White (Welsh, English, Scottish or Northern Irish) (12% [3]). Similarly, in the UK, a non-representative survey from the British Red Cross found that 38% of those who are part of minority ethnic groups (including minority White groups) agreed that they felt alone and had no one to turn to, contrasted to 31% across the UK as a whole (26). The relationship between ethnicity and loneliness may be explained by differences in education and employment, cultural practices, and increased vulnerability to discrimination and a feeling of 'otherness' (27,28).

Sexual orientation

In 2019/2020, individuals in Wales who identified as any sexual orientation other than heterosexual/straight had double the level of loneliness (30%) than those who identified as heterosexual/straight (15% [29]). This data was not collected in more recent NSW surveys.

Disability

NSW data for 2022/23 showed that individuals in Wales who had a long-term illness or disability reported loneliness more often (22%) than those without a long-term illness or disability (7% [3]). Sense, a UK based charity for individuals with disabilities, reports that at least 55% of people living with complex disabilities in the UK feel lonely always, often or sometimes, compared to 26% of the general public (30). People with a disability are also more likely to

experience loneliness in the workplace than those with no disability (24% compared to 9% [31]). Poor accessibility of social spaces and limited accessible transport may contribute to loneliness among individuals with disabilities (32).

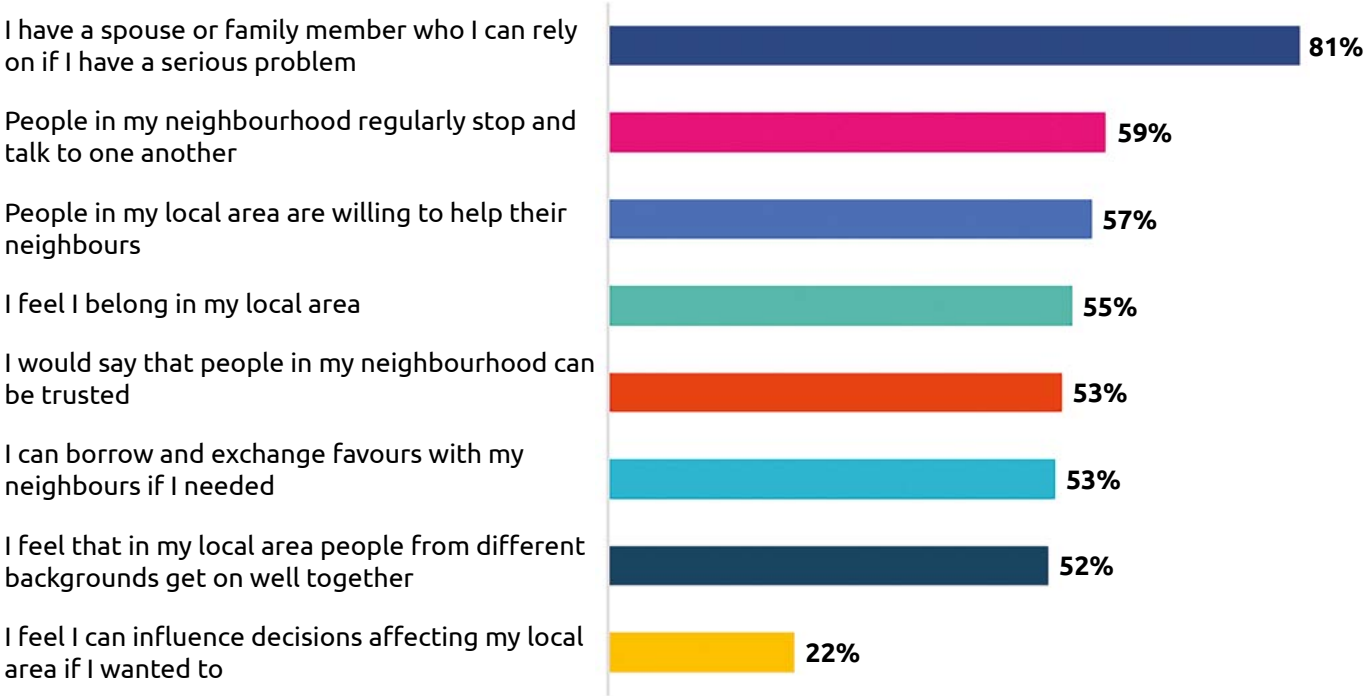
3.4 Additional sources of data collection in Wales

Other bespoke data in Wales is useful for generating a broader understanding of how connected people feel. For instance, a recent nationally representative online survey was conducted in Wales that included data on how connected people felt within their community (33). This included perceptions on neighbourhood trust, feelings of belonging (Box 3.4), helpfulness among community members and general community cohesiveness (Figure 3.2). Overall levels of community connectedness, derived from the elements shown in Figure 3.2, were found to be significantly lower for younger age groups, those living in the most deprived areas of Wales, individuals with a disability and those who reported they had 'very bad' health. However, no significant differences were found between males and females.

Box 3.4: Belonging.

The term 'belonging' refers to a feeling of commonality and shared understanding with others. This does not develop from one specific incidence but instead builds up over time with many small connections, known as 'habitual unifications', where people feel they have things in common with those around them (34). The absence of commonalities can result in a lack of belonging (34), which can contribute to feelings of loneliness. For instance, those who feel a weaker sense of belonging to their neighbourhood are more likely to report being lonely (12). This may help explain why people who may find it harder to identify commonalities with others, such as migrants and asylum seekers, are at higher risk of loneliness (see Chapter 4).

Figure 3.2: Percentage of people aged 18 and over agreeing to statements on community connectedness.



Source: A national conversation about mental wellbeing in Wales: The HAPUS programme (33).

Additional research on social disconnection is being conducted in Wales to raise awareness of how loneliness affects specific populations. For instance, research at the University of South Wales highlights how loneliness is a particular problem for international students studying at Welsh Universities. Using a convenience sample of 232 international students, 19% were classified as having 'very severe loneliness' and a further 30% as having 'severe loneliness'. The study highlighted unique challenges that contributed to these feelings, including language barriers, cultural differences and difficulties establishing friendships with local students. It highlighted a need for novel approaches to support students from diverse ethnic and cultural backgrounds (35).

Conclusion

Social disconnection affects a significant proportion of people in Wales, and it is important to consider why this happens and who may be at higher risk of experiencing it. The variation in prevalence of loneliness across age, deprivation, ethnicity, sexual orientation and disability highlights social disconnection as an inequality issue, reflecting previous research in Wales (17,18). Further investigation into why these inequalities exist, including how they are related to the structure of Welsh society, will help inform prevention strategies. With less information available on social isolation and social connection than on loneliness, further data collection on these issues would help produce a more rounded understanding of the issues in Wales.

Chapter 4: Risk factors for loneliness and social isolation

It is important to identify factors that can increase the risk of loneliness and social isolation to allow for tailored interventions and policies to be developed. A range of modifiable factors have been identified in the international literature (7), and to less of an extent in the Welsh literature, that increase an individual's risk of social disconnection. Most research focuses on loneliness, and future work should investigate which factors increase susceptibility for social isolation. Demographic variation in age group, ethnicity, disability and sexual orientation in Wales are described in Chapter 3 and therefore are not included here.

4.1 The socio-ecological model

The socio-ecological model (SEM) is a framework used to understand the determinants of health (36). The SEM describes health as being broadly influenced by four core domains: individual, relationship, community and societal (36). Examining risk factors and interactions across these four domains can allow for a broader understanding of public health issues, including loneliness and social isolation.

Individual factors include those related to the person themselves, for example psychological, demographic and personality factors. *Relationship* factors include aspects related to an individual's relationship with other people, for example their peer relationships, marital status and family. *Community* factors include aspects of the wider community in which an individual lives, for example their school, workplace, local neighbourhood and health care services. *Societal* factors include those related to the wider society in which an individual exists, for example the social or cultural norms of a country and the public policies that are in place.

4.2 Common risk factors for social disconnection

A summary of common risk factors for loneliness and social isolation are presented in Figure 4.1. Much of the existing literature focuses on loneliness, rather than social isolation, and studies on social isolation often centre on older adults (7). Further research is needed to understand factors associated with social isolation in younger populations.

Individual-level risk factors

Individuals in **poor physical health** are more likely to report loneliness and social isolation, which could be partly explained by limitations to socialisation and accessibility (37,38). Those with **poor mental health** are also at greater risk of loneliness and social isolation (38–40), with depression (38,39) and anxiety (41) identified as particular risk factors. **Poor cognitive function** has also been linked to greater loneliness (37) and social isolation in older age groups (38).

In Wales and the UK, both poor physical and poor mental health have been identified as risk factors for loneliness and social isolation (43–45).

The relationships between poor health and loneliness are bi-directional, and therefore loneliness may worsen health symptoms in turn (see chapter 5) (42).

Figure 4.1: Summary of common risk factors for loneliness and social isolation by socio-ecological level.

Many factors have been found to increase the risk of both loneliness and social isolation. Others are more commonly found in loneliness literature, which is more comprehensive. These are indicated in the figure with "(loneliness)."

Individual

- Poor physical/mental health
- Poor cognitive function
- Low education level
- Unemployment (loneliness)
- Financial stress / low socio-economic status (loneliness)
- Neuroticism (loneliness)
- Migration (loneliness)

Relationship

- Unmarried, no partner or widowed
- Living alone
- Low social support
- Small social network / limited social interactions (loneliness)
- Adverse childhood experiences or bullying (loneliness)

Community

- Poor built environment e.g. low walkability, access to green space, availability of public transport, access to housing
- Lack of third spaces / social infrastructure
- Low neighbourhood safety
- Low community household income / high area deprivation (loneliness)
- Poor neighbourhood relationships (loneliness)

Societal

Levels of loneliness can be influenced by cultural values, e.g. whether a society prioritises individualism or collectivism.

Levels of stigma in society towards people who are lonely or isolated, or people with vulnerabilities such as mental health conditions or disability will likely also influence levels of loneliness and social isolation.

Furthermore, an individual's **personality** can increase their vulnerability to loneliness. Out of the five domains of personality (extraversion, conscientiousness, agreeableness, openness, and neuroticism), neuroticism is most strongly associated with loneliness, with higher neuroticism leading to higher risk (42,46,47).

Individuals who have **migrated** have higher levels of loneliness (37,48), potentially due to a lower sense of belonging (42) (Box 3.4), as well as a higher possibility of social exclusion in this population group (Box 4.1).

In Wales, refugees and asylum seekers have higher levels of social isolation compared to the rest of the population (49).

Box 4.1: Inclusion groups.

Some groups of people in society are often socially excluded and may have multiple interacting risk factors for poor physical and mental health, such as trauma, poverty, discrimination, and being a victim or perpetrator of crime (50). These groups of people are sometimes known as inclusion groups, and include people who experience homelessness, those with drug or alcohol dependency, vulnerable migrants and refugees, sex workers, people in contact with the justice system, and Gypsy, Roma, and Traveller communities. Whilst there is limited research investigating social connection in these communities, it is likely they are more vulnerable to loneliness and isolation due to social exclusion and stigma (Box 4.2). For example, loneliness is common in prisoners and those who have left the prison system (51).

Low **level of education** has been identified as a potential risk factor for loneliness (37,52) and social isolation (38), although these relationships may be explained by other factors, such as financial stress and network size (27).

Those who are **unemployed** are at greater risk of loneliness (52,53), which may be compounded by the fact that **financial stress** and **low socio-economic status** are also linked to loneliness (37,42,54–57).

Having caring responsibilities can also increase the risk of loneliness. Research from Carers Week UK, a charity providing support for carers, suggests that individuals with caring responsibilities are seven times more likely to be lonely always or often compared to the general population (58).

Relationship-level risk factors

One of the most identified risk factors in the global literature is marital status. Adults who are unmarried or without a partner are most likely to be lonely or socially isolated, even when other risk factors are accounted for (7,38,39,59). Those who are divorced or widowed are also at risk of social isolation (38). However, having a poor relationship with a spouse can also increase an individual's risk of loneliness (27).

Household size also influences vulnerability. Adults who live alone have increased risk of loneliness and social isolation (7,41,59). In the UK, living with young children (aged under 5 years) is related to higher levels of loneliness compared to living with children aged 11 to 18 years (22% compared to 17% [26]). Furthermore, research commissioned by the Co-op in the UK suggests that young new mothers may be particularly vulnerable to experiencing loneliness (60). Individuals without children, however, may be more vulnerable to loneliness in older age (Box 3.3 [23,61]).

In Wales, individuals with higher levels of education report higher levels of social loneliness, but emotional loneliness increases as level of education decreases (17).

In Wales, individuals with greater financial difficulties and those who have caring responsibilities are more vulnerable to loneliness and social isolation and have reduced ability to interact with others (49).

In Wales, individuals who are single, separated or divorced are lonelier than other groups. Those who are separated but still legally married or in a civil partnership report the highest levels of loneliness (3,17).

Outside of the home, having a **small social network, limited social interactions** or **low social connectedness** increases vulnerability to loneliness (39,54,55). Furthermore, low **social support** increases risk of loneliness (42) and social isolation (38).

Finally, experience of **adverse childhood experiences (ACEs)** can increase individual's risk of loneliness, which could be related to higher likelihood of developing an anxious attachment style (62). Experiences of **bullying and cyberbullying** during childhood also increase the risk of loneliness (63).

In Wales, individuals from single parent households, and those from single, non-pensioner households (with no children), report higher levels of loneliness than those from other household types (17).

In Wales, young people who spend time in care as a child tend to experience more loneliness and social isolation compared to other young people in society (49).

Community-level risk factors

At a community level, **low community household income and high area deprivation** are related to greater risk of loneliness (52,64). In addition, neighbourhood relationships can impact loneliness; poor **neighbourhood relationships** can increase risk, particularly for certain ethnic groups (40). Moreover, lower **neighbourhood safety** has generally been associated with increased loneliness and social isolation (37,65).

Aspects of the **built environment** in the community can also influence loneliness and social isolation. Such aspects include walkability, access to green spaces, availability of public transport, regional remoteness, and accessibility of housing (see Chapter 6 [37,65–68]). Third spaces (part of social infrastructure, Chapter 6, Box 6.1) are defined as 'places of refuge other than the home or workplace where people can regularly visit and commune with friends, neighbours, coworkers, and even strangers' (69). In general, higher availability of third spaces in the community has been linked to lower levels of loneliness and social isolation (65).

Societal-level risk factors

Differences in **cultural practices, values** and **social norms** can influence risk of loneliness (42,65). For instance, family relationships may have a greater impact on loneliness in cultures where familial relationships are placed at higher value (42). Some studies have identified that general loneliness levels are higher in more individualistic societies (where independence and autonomy of the individual are valued more than collective or community needs) compared to collectivist cultures, although other studies report opposite findings (70-74). Levels of stigma in society attached to certain health conditions or population groups (e.g. individuals with a disability, migrant populations, people experiencing homelessness) can increase the risk of loneliness occurring for these individuals (Box 4.2).

In Wales, the Welsh Centre for Public Policy (WCPP) has highlighted the importance of structural factors in the development of loneliness. This includes aspects such as community attitudes, public policy, demographic diversity, physical environment, social environment and area deprivation (18).

Box 4.2: Stigma and loneliness.

The impact of loneliness is influenced by social stigma and self-stigma. Stigma is defined by the American Psychological Association as 'the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency', and can be directed at others in society, or directed at ourselves (75). Certain inclusion groups in society, such as people with mental health conditions, migrants, individuals with disabilities or people experiencing homelessness are more likely to experience stigma and therefore become ostracised (Box 4.1 [76]). This could be due to stigma from others causing a difficulty forming relationships, or self-isolation due to fear of judgement from others. For example, those who describe feeling social stigma from their mental health disorder have associated this stigma with loneliness and isolation (77).

Furthermore, there is often a social stigma associated with loneliness itself (78). This is caused by the unhelpful misconception that loneliness and isolation are caused by the individual through reclusive behaviour and poor social skills (79). When an individual is labelled as 'lonely', they are more likely to be stigmatised and rated negatively, and less likely to be befriended, particularly if they are viewed as being reclusive (76,78–80). Paired with the suggestion that those who are lonely are also likely to experience self-stigma and shame (79,81), stigma surrounding loneliness can cause those who are lonely to become further isolated and prevent them from seeking relationships or support (76,79).

4.3 Digital technology, loneliness and social isolation

Another factor that may influence levels of loneliness, social isolation and social connection is the rapid advance in the availability and use of digital technology (7). There is still much to learn about how digital technology influences social connection and disconnection. Digital technology can be a facilitator of positive social interactions, allowing people to connect with friends and family who are not physically close to them, and creating an environment for new friendships to be formed online. This can be particularly important for groups of society who may struggle to connect with people face-to-face, such as those with mobility issues or language / communication challenges (7). However, digital technology may also disrupt social connection, and even contribute to loneliness, through reducing quality time spent engaging with people face-to-face or interfering with everyday interactions (e.g. phubbing – ignoring a person due to use of a mobile phone (82–85)). Furthermore, unhealthy use of technology, or consequences of social media such as enhanced social comparisons, cyberbullying and modelling of unhealthy behaviours, may all impact on an individual's well-being, particularly for children and adolescents (86–88).

Importantly, those who do not have access to the internet or smart devices can be left behind or inadvertently excluded from social interactions or activities that are taking place or being advertised online. In Wales, 4% of people aged 16 and over do not use the internet (data from 2024) (89,90). Whilst not all people wish to use digital technology, particularly those in older age groups, certain populations are more at risk of digital exclusion than others. For example, 33% of people over the age of 75 years do not use the internet, and many do not or cannot use digital communication due to cost, security concerns, lack of accessibility or limited skills (91). *Digital ageism* can contribute to digital exclusion. This refers to age-based bias in technology,

in which the design of products focuses more on the preferences and needs of younger age groups (e.g. small text), resulting in technology that can be inaccessible to people in later life (91,92).

Other groups vulnerable to digital exclusion include people in the criminal justice system (Box 4.1) (93), individuals with disabilities, those with lower educational attainment and those with lower household income (94).

4.4 Increasing understanding of risk in Wales

Much of the understanding around risk has been generated from international literature. This allows us to identify factors that have a good body of evidence across different high-income countries and so are likely to also be relevant to Wales. However, it cannot represent factors, or combinations of factors, that arise from the unique communities, geography, facilities, services and culture present in Wales. For instance, many people in Wales live in small, rural communities, with less facilities and opportunities for connection (Box 4.3). Furthermore, 27% of the Welsh population are able to speak Welsh (95) which may increase a sense of belonging (Box 3.4) and protect against loneliness (42). For instance, research from the Welsh Centre for Public Policy (17) suggests that non-Welsh speakers are lonelier than Welsh speakers. Further Wales-specific research, particularly for social isolation, would be useful to better understand issues in Wales.

Box 4.3: Rural living, digital technology and social connection.

In Wales, many people live in rural communities with few inhabitants, relatively far from main metropolitan areas. In fact, evidence from 2021 suggests that 32% of the population live in rural areas (96). For smaller communities in sparser areas, social connection may be impacted not just due to fewer people in the physical vicinity, but through restricted access to the internet or digital technology. Whilst this is improving, some areas in Wales are still affected by poor internet and broadband connection due to rurality, according to Welsh Government (89).

To help address the issues raised by poor digital connectivity, Welsh Government released its Digital Strategy for Wales in 2021 (89). The strategy has six aims, including improving digital inclusion, fostering digital skills and supporting digital connectivity, all of which are key to enhancing social connection. As a part of this strategy, Digital Communities Wales was established to work with people who could benefit from digital skills and access to the internet, and provides training and support to help such individuals get online (90).

Conclusion

The socio-ecological model allows us to better understand risk factors for experiencing loneliness and social isolation. Through developing an understanding of these risk factors, we can more comprehensively inform the development of effective interventions, and support systems and policy decisions that will have a greater likelihood of reducing social disconnection. Further Wales-specific research would be helpful.

Chapter 5: Impacts of social disconnection and social connection on health

Forms of social disconnection such as loneliness and social isolation can have substantial negative impacts on the health and well-being of individuals, communities and wider societies. Conversely, good social connections can enhance health and well-being and bring benefits to wider communities.

4.1 Mortality risk

Both loneliness and social isolation can increase the risk of all-cause mortality (7). Internationally, across studies, loneliness is estimated to increase the risk of mortality by around 14%, and social isolation by 32% (98). In the UK, loneliness, social isolation, low number of close confidants, infrequent friend or family visits, low frequency of group activities and living alone are all associated with increased risk of mortality (99,100) (Box 5.1).

Box 5.1: The UK Biobank study.

Many of the studies referenced in this chapter use data collected as a part of the UK Biobank (99,100). The Biobank is a large-scale database that contains anonymous genetic and health information from UK participants, with new data being continuously added. Since its inception in 2006, half a million people aged between 40 and 69 have regularly provided blood/urine samples and detailed health information as part of this prospective health study. Data from the Biobank is accessible globally to approved researchers conducting health research.

5.2 Physical health

Loneliness and perceived social exclusion are both related to poor self-rated health in adults (45,101), and more health complaints in children (see Box 5.3 [102]). More specifically, loneliness and social isolation are related to high levels of blood pressure, cortisol, and inflammatory cytokines (103,104). Social disconnection can also contribute to an individual's risk of developing certain health conditions, including acute myocardial infarctions, stroke, cardiovascular disease, heart failure, type 2 diabetes, chronic pain, and glaucoma (7,13,100,105–108). Furthermore, in Wales, loneliness was directly related to increased weight and worsening physical fitness during the COVID-19 pandemic (13). Despite these clear associations, recent research suggests that the relationships between social disconnection and physical health are not entirely causal and are instead partly explained by factors such as socio-economic status, health behaviours and baseline depressive symptoms (106). Additionally, relationships between social disconnection and health can be bi-directional, with poor physical health a known risk factor for loneliness (see Chapter 4; Box 5.2).

Box 5.2: Bi-directionality of social disconnection and health.

Whilst this chapter focuses on how types of social disconnection impact on health, it is important to note the bi-directional nature of these relationships (7). For example, if an individual experiences a decline in their physical, mental or cognitive health, this may result in them becoming isolated due to difficulties leaving the home or attending social activities. This could lead to feelings of loneliness that contribute to further decline in physical and mental health (108).

Box 5.3: Pathways from social disconnection to poor health.

There are three suggested pathways to how social disconnection impacts health and contributes to mortality and poor health outcomes.

In the *biological pathway*, social disconnection can trigger a biological stress response that impacts stress hormones, inflammation and the immune system, which can increase susceptibility to disease. Stress from social disconnection can also lead to changes to gene expression that have long-term impacts on health (10).

Through the *psychological pathway*, social disconnection increases stress levels and risks of mental health issues such as depression and anxiety, which can impact the development of chronic disease. On the other hand, positive social connections can be protective against a harmful build-up of stress and are shown to be associated with emotional well-being (109).

The *behavioural pathway* explains how social disconnection can increase risk of engaging in health risk behaviours, either to cope with the stress of loneliness or due to limited access to health advice due to poor social networks. For example, in Wales and across the UK, loneliness and social isolation are related to increased alcohol consumption, poorer physical fitness, less frequent physical activity, smoking, and other health risk behaviours (13,103,110,111).

5.3 Mental health and well-being

Loneliness and social isolation can also be detrimental to mental health. This was demonstrated in Wales during the COVID-19 pandemic, where the likelihood of poor mental health increased with higher levels of loneliness (13). Loneliness is related to greater risks of depression, anxiety, addiction, self-harm, hopelessness, and suicidality in adults (7,104,112) and to depression and anxiety in children (113,114). Social isolation is also associated with higher levels of thought interference and paranoia (115). These relationships may be further exacerbated for individuals with disabilities (116). Furthermore, data from the UK Biobank suggests that loneliness is also associated with smaller grey matter volumes in brain structures crucial for emotional experience and regulation (117). These national findings are in line with global outcomes; loneliness is associated with higher risk of depression, anxiety, paranoia, psychosis and suicidal ideation according to global meta-analyses (57,118).

5.4 Cognitive health and ageing

As people age, further impacts of loneliness and social isolation can be seen. For example, chances of mild cognitive impairment among older people rise with increased social isolation and poorer social networks (119,120). This has been demonstrated by research on older people in Wales, in which being isolated in later life was found to be detrimental to cognitive function and associated with greater cognitive change over time. The research suggested that lower social interaction could lead to less cognitive stimulation and lower cognitive reserve (the brain's ability to cope with deterioration) (120). Social disconnection has been related to increased risk of dementia, poor cognitive functioning and Parkinson's disease in the UK (121–123) and globally (57,124). In addition, loneliness and social isolation are independently related to greater risk of developing frailty (125,126).

5.5 Use of health and social care services

Relationships between social disconnection and health can have important consequences for the use of health and other public services. Loneliness has been associated with more frequent visits to the GP (49). Furthermore, in the UK and other countries, older people who are lonely have been found to be around 1.8 times more likely to visit their GP, 1.6 times more likely to visit an emergency department and 1.3 times more likely to have emergency hospital admissions than those who are never lonely (127). In England, older people who experience loneliness are also more likely to move into a care home (128).

5.6 Education and employment

In the UK, lonely children and young people have poorer academic outcomes and slightly lower academic self-efficacy than children and young people who are not lonely (102,110). This echoes international findings, with loneliness related to poorer educational attainment, as well as an increased risk of poor health behaviours that can influence educational outcomes (129). In the UK, loneliness has also been related to reduced employability, increased likelihood of unemployment, reduced social status, poorer employee health and increased absence from work (53,130,131).

5.7 Economy

The impact of loneliness and social isolation on physical and mental health, public service use and educational/employment outcomes culminates in a wider impact on the economy. In the UK, severe loneliness is estimated to cost approximately £9,900 per person per year due to impacts on health, productivity and well-being, with lonely people requiring up to £6,000 more in health care service use over the course of 10 years (132). A further UK analysis estimated that the total cost of loneliness to employers was £2.53 billion annually, including costs of: days lost due to health conditions, caring responsibilities (for those with health conditions attributed to loneliness), lower productivity and voluntary staff turnover attributable to loneliness (131).

Examining disconnected communities more widely, the Centre for Economics and Business Research (133) estimated that the total net economic cost of disconnected communities in Wales was £2.6 billion in 2017, including impacts on neighbourliness, health services, policing services, happiness, physical exercise and health, and stress and self-esteem. Total costs across all four nations in the UK were £32 billion. The research estimated that loneliness reduction programmes, such as 'The Big Lunch', could hold an estimated value of £2.7 billion in the UK through reducing the pressure of loneliness on health services (133).

5.8 The benefits of social capital on individual and community health

Whilst social disconnection can impact substantially on health and well-being, having strong connections brings a wealth of benefits for both individuals and their communities. For instance, social capital can protect against mortality (134) and influences the overall physical and mental health of a community (135). Social capital can also protect against juvenile delinquency and victimisation (136). Furthermore, for those exiting the prison system, social capital contributes to justice capital - the social, physical and cultural resources to successfully rejoin society - which can help reduce re-offending (137).

In Wales, the role of social capital and stronger social connections in shaping health is clearly recognised (138). Social capital has been shown to benefit individual and community resilience (the ability of an individual, a community, or a system to withstand stress and challenges), which is linked to overall population health (2). Research has examined how social capital in Wales may be affected in the future by factors such as demographic change, digital transformation, the future of work life, and civic participation and trust, and to identify policy responses that help to retain strong social connections alongside these likely shifts (9).

Conclusion

Loneliness and social isolation have significant, negative impacts on individuals, communities and wider societies. Good social connections on the other hand, can improve individual and community health, and strengthen community resilience. Whilst social disconnection is often considered a health and social care issue, wider impacts on schools and education, employment, criminal justice and the economy highlight its much broader nature and relevance across multiple sectors. Improved understanding of how sectors are impacted by social disconnection, and how they could benefit from stronger social connections, would help raise awareness of the wider impacts and promote action across society.

Chapter 6: Strategies and interventions

A wide range of solutions have been implemented to address social disconnection, particularly loneliness. Globally, evidence on effectiveness is expanding rapidly, accelerated in part by the COVID-19 pandemic.

In the UK, the Campaign to End Loneliness offers a structured framework that organises solutions into four distinct categories (139):

- **System-level approaches:** creating the right conditions in communities to address social disconnection, such as supporting neighbourhoods to build resilience, increasing volunteering and focusing on healthy ageing,
- **Gateway infrastructure:** making it possible for communities to connect, for example technology, good transport systems, the built environment,
- **Connector services:** reaching individuals who are lonely or socially isolated and understanding their needs so they can receive the correct support,
- **Direct solutions:** supporting individuals with making and sustaining relationships.

The WHO Commission on Social Connection follows a similar pattern, but presents solutions in three broad levels based on the socio-ecological model (7):

- **Societal-level:** implementing policies and strategies that address the structural determinants of social disconnection, including national policies on loneliness and social isolation, national campaigns and advocacy.
- **Community-level:** increasing people's access to social interaction, often focusing on infrastructure. This can include interventions that focus on the built environment, community groups and social prescribing, and more widely, on strengthening a community's social infrastructure.
- **Individual- and relationship-level:** implementing direct interventions that help support individuals to make and sustain relationships.

Although there are differing approaches, evidence is strongest for direct or individual- and relationship-level interventions. There is currently less and often varied evidence for other solutions, where aims to improve social connection may be secondary to other goals and evaluations more challenging to implement. There is little evidence on societal-level approaches such as policies and national campaigns. Importantly, action at all levels is needed to best address loneliness and social isolation. More detail on each approach is considered in the following sections.

6.1 Societal-level approaches

Societal-level approaches target the socio-economic and cultural factors that create the environment in which loneliness and isolation can develop, often through national policies and strategies. These can be specific policies targeting loneliness, isolation and social connection, or those with alternative foci that could have secondary impacts on social connection. For example, housing security, travel infrastructure, employment, income, mental health and health care provision can all influence loneliness and social isolation (140) and policies in these areas have the potential for beneficial effects on social connection.

Although policies and strategies are an important part of solutions (141), there is currently little evidence that assesses their effectiveness. In England, introducing an age-friendly transport policy (free bus passes on local services to those aged 60 years or over) was associated with an 8% increase in the use of public transport among older people (142). In turn, use of public transport was associated with reduced loneliness, increased volunteering and increased regular contact with others (142).

Other societal approaches include national campaigns aiming to raise awareness of loneliness and social isolation, address stigma and advocate for action. Whilst more evidence is needed, some success was reported by the UK's nationwide Campaign to End Loneliness (143). The campaign raised awareness of loneliness among those working in Health and Well-being Boards (boards established to promote integrated work across health and social care services) and lobbied for the development of anti-loneliness strategies within plans for local areas. An evaluation compared loneliness and social participation between participants living in local authorities that had implemented anti-loneliness strategies and those in local authorities that had not. Although there were no changes overall, improvements in social participation were noted for older adults with higher education and income levels, possibly due to this group having more time to engage in anti-loneliness activities (143).

Through addressing the structural contributors of social disconnection, societal-level approaches help to prevent loneliness from occurring in the first place (known as primary prevention) (141). It is suggested that interventions that address loneliness at a primary level may be more effective than those that target at-risk groups and individuals who are already lonely or isolated (141).

6.2 Community-level approaches

Communities are an important setting for addressing social disconnection and building stronger social connections (7). Community-level approaches address risk factors and strengthen protective factors in community environments, improving opportunities for people to interact, often through strengthening infrastructure. This can include (7):

- Modifications to the built environment that allow for better social opportunities, such as improving access to green and blue spaces ("natural and semi-natural areas, which include local parks, wild groves and meadows as well as ponds, canals, lakes and coastlines" [144]) or the creation of community hubs that can host social events, programmes and groups,
- Improvements to transport systems that connect people together, such as accessible public transport and increased walkability and safety of pedestrian areas,
- Improvements to digital infrastructure, allowing for greater virtual connection,
- The provision of a range of accessible community activities, groups and events that allow people to meet and form connections with others, including people from different generations or ethnic groups. These can include community choirs, exercise classes, gardening programmes, other shared interest groups and community events such as festivals (see Chapter 7 for further examples of community-based interventions and activities).

Although more evidence is needed for these types of community interventions in terms of reducing loneliness and social isolation, engaging in community groups and other activities that increase social interaction (known as social networking interventions) can be effective (145). For some individuals, support may be needed to attend these groups initially (e.g. supported socialisation [145]).

A related community approach is social prescribing. This is a service designed to improve health and well-being by referring individuals to non-clinical services and activities in the community (often provided by third sectors) via a healthcare professional or community-link-worker. A variety of activities are prescribed, including gardening, art groups and exercise sessions. Social prescribing is challenging to evaluate due to its multiple elements. Furthermore, evidence is difficult to synthesise due to the wide variety of interventions, implementation approaches and evaluation methods. Some evidence shows reductions in loneliness and social isolation, as well as improved well-being. However, across the body of evidence, findings for loneliness and social isolation are mixed, and more evidence is needed (7). The effectiveness of social prescribing may be influenced by the individual's personal interest in the prescribed group and how it aligns with their lifestyle (146).

Other potentially useful community approaches include asset-based approaches, and community campaigns, although more robust evaluations are needed. Asset-based approaches map and develop community assets (e.g. individual skills, networks, clubs and organisations), to address local needs and achieve shared goals for improvement. These can include better social spaces, groups and activities such as lunch clubs or walking groups. Community campaigns have also been trialled that encourage pro-social behaviours. For instance, in the UK, USA and Australia, the KIND challenge encouraged people to provide small acts of kindness to their neighbours. Evaluation found the campaign reduced feelings of disconnection and promoted positive relationships within communities (147).

Community-level approaches often overlap with the wider concept of social infrastructure (Box 6.1). Strong social infrastructure that fosters social interaction and helps build social capital is regarded as an important element in developing more connected communities and addressing loneliness and social isolation (7). Community-level approaches can also overlap with the development of:

- Age-friendly cities and communities (Box 6.2), which aim to improve the health and well-being of older residents,
- Dementia-friendly communities, which aim to create environments where dementia is understood and supported.

Loneliness, social isolation and social connection can also be addressed in other types of communities, including schools (e.g. whole-school approaches to mental health and well-being), workplaces (e.g. workplace policies on mental health) and adult learning environments (e.g. English for Speakers of Other Languages [148]). More research on the effectiveness of these approaches would be valuable.

Box 6.1: Social infrastructure.

There is no common definition of social infrastructure. Narrower definitions refer to the places, spaces, groups and institutions that encourage social life. Broader definitions refer to the policies, services, resources and related public spaces that people have access to, which enable them to participate fully in social, civic and economic life without barriers (7). However, it is widely agreed that social infrastructure has potential to influence levels of connection within a community.

Strong social infrastructure can promote social connection through engagement in the community, and increase interactions between people from different sectors, cultures and generations, increasing social capital. This is particularly important for those who may be disproportionately affected by social disconnection, such as older people or those living with disabilities. To strengthen social infrastructure, communities could improve equal access to social infrastructure across neighbourhoods and design social infrastructure with social connection in mind. Examples of social infrastructure that promotes connection include community centres with a programme of social events, well maintained green spaces with amenities, transport infrastructure that connects people together, and seating areas in transition spaces (7). Infrastructure should be diverse, and communities should be actively involved in its development.

While more research is needed, some research suggests improvements to social infrastructure can lead to improved social relations and community cohesion (149).

Box 6.2: Age-friendly cities and communities.

In 2010, the WHO launched a Global Network for Age-friendly Cities and Communities (150). They describe an age-friendly community as "a place in which older people, communities, policies, services, settings and structures work together in partnership to support and enable us all to age well." For a city or community to be a member of the age-friendly network, it must commit to:

- Engaging with stakeholders, including older people,
- Strategically planning to enable all stakeholders to achieve a shared vision,
- Implementing an action plan,
- Measuring the progress and impact of the age-friendly approach.

There are eight essential features of an age-friendly community:

- Outdoor spaces and buildings,
- Transport,
- Housing,
- Social participation,
- Respect and social inclusion,
- Civic participation and employment,
- Communication and information,
- Community support and health services.

Action in each of the eight domains has the potential to improve social connection.

Wales is actively engaged in the WHO Global Network for Age-friendly Cities and Communities via the Older People's Commissioner for Wales and local authority-led partnerships making communities more age-friendly (see Chapter 7; Box 7.8).

6.3 Individual- and relationship-level approaches

Individual- and relationship-level approaches target those experiencing or at risk of experiencing loneliness and social isolation, providing them with direct support. Different types of intervention have been evaluated, with the main ones focused on:

- *Improving social skills*, to help individuals make and maintain social relationships. This can include conversation training and role play exercises and, for children and adolescents, can form part of universally delivered personal, health, social and economic education (PHSE) lessons.
- *Improving social support*, such as information and advice, practical help or emotional support. This includes befriending schemes, peer support, mentoring, home visiting programmes, and animal-based and artificial- intelligence-based companionship (see Box 6.3).
- *Changing social cognitions* that hinder the formation or maintenance of healthy social relationships. This can involve changing negative attitudes towards oneself and others, and support in dealing with distress. Types of approaches include psychological therapies such as cognitive behavioural therapy, and mindfulness approaches.

Individual and relationship-level approaches have a large body of evidence supporting their effectiveness. Review evidence suggests that all three approaches can be effective in addressing loneliness in adults as well as in children, with psychological therapy the most consistently effective approach (145).

Box 6.3: Digital Interventions.

The use of digital technologies in interventions for loneliness and social isolation is rapidly growing (7), and interventions are increasingly delivered through the internet, via smartphone apps or social media. Interventions can be centred around digital technology (e.g. digital skills training or robotic companionship), or technology can be used to deliver interventions, such as online psychological therapy. So far, evidence for the use of digital technology interventions is inconclusive, but some research suggests that method of intervention delivery (such as digital or face-to-face) may not impact effectiveness. Further research is needed.

Digital technology interventions may be helpful for those with limited social access, such as older people or those living with disabilities, reducing barriers to connection (151). However, poor digital literacy, low confidence in using technology, poor access to devices or internet services, and digital ageism (age-based bias in digital technology, see Chapter 4) may hinder some individuals from engaging in technology-based interventions, potentially exacerbating loneliness (92,151). Furthermore, overuse of digital technology for connection may limit opportunities for quality face-to-face contact. It should also be acknowledged that some people do not wish to use technology. For these individuals, ensuring in-person interventions are also available is important.

6.4 Opportunities for partnership working

Whilst many interventions for loneliness and social isolation are centred on health and social care, third sector organisations are heavily involved in solutions, often through the help of trained volunteers. In addition, community solutions involve improvements to transport systems, access to shared spaces, and the design of cities, towns and communities. Opportunities for intervention can extend further. In the housing sector, this can include the design of safe housing for vulnerable individuals that encourages social interactions. In schools, this can involve the provision of social skills training and relationship building, curriculums that focus on inclusion and bullying prevention, and support for pupils experiencing loneliness. In criminal justice services, opportunities include supporting isolated individuals vulnerable to exploitation (e.g. sexual exploitation, involvement in drug trafficking, radicalisation) or supporting offenders to reintegrate into society following detention. Improved understanding of the roles that each sector can play and how best sectors can work together on common solutions, is needed.

Conclusion

Loneliness and social isolation are driven by factors at a societal, community and individual level, and therefore interventions designed to tackle them can also be developed at these levels. The most robust evidence is for interventions at an individual and relationship level that aim to alleviate people's loneliness and social isolation, and social networking interventions that allow people to connect with others in their community. Further research is needed to understand which mechanisms hold greatest value in reducing and preventing loneliness and isolation, and which intervention factors may increase success. It is difficult to evaluate the effectiveness of societal-level interventions. However, research suggests that primary prevention is key, and social connection should be considered and embedded in strategies across sectors to truly address the issue of loneliness and social isolation.

Chapter 7: Action in Wales

Wales, along with other parts of the UK, has been a leader in action on loneliness and social isolation, recognising the important connections with health and the urgency to act. There are many examples of action at societal, community and individual and relationship levels in Wales that demonstrate the level of engagement in this area, some of which are detailed in the following sections.

7.1 Societal-level approaches

Wales is currently one of only a small number of countries that have produced a government strategy with specific focus on reducing loneliness and fostering stronger social connections (Box 7.1). The organisations, interventions and programmes in Wales can be understood through the aims of this strategy.

Box 7.1: Connected Communities strategy.

In 2017, the National Assembly for Wales published its inquiry into loneliness and isolation, detailing key recommendations to reduce social disconnection (152). Following this, in 2020 Welsh Government published Connected Communities, a strategy for tackling loneliness and social isolation and fostering connected and cohesive communities at an individual, community and national level (5). This strategy was informed by public consultation and included four main priorities:

1) Increasing opportunities for people to connect.
This priority aimed to increase the availability of connection opportunities, promote awareness of these opportunities, and encourage people to engage with them (see section 7.3). An example is Welsh Government's work with 'time credits' volunteering, to increase the number of people benefitting from the social connections formed when both giving and receiving volunteer services and encourage pro-social behaviours.

2) A community infrastructure that supports connected communities.
This priority detailed how Welsh Government, along with their partners, aimed to strengthen the social infrastructure that can bring people together. For example, one commitment was to improve transport services to allow people to travel and connect across all areas of Wales (see section 7.2).

3) Cohesive and supportive communities.
In this priority, the government committed to working closely with existing partners to continue work to increase connectedness within individual communities. This included working with 'community hubs' to continue the positive changes they bring to neighbourhoods and individuals in Wales (see section 7.2).

4) Building awareness and promoting positive attitudes.
The fourth priority detailed Welsh Government's aim to raise awareness of social isolation and loneliness, and reduce the stigma associated with it. As a part of this, Welsh Government aimed to include loneliness as a part of their national conversation on mental health and well-being (see section 7.1).

Welsh Government was clear that tackling loneliness and social isolation would be a long-term challenge, with the strategy acting as the first step in addressing these issues. A review into its implementation and what the next steps for Wales might be in terms of tackling loneliness and social isolation is currently underway.

For more information on the Connected Communities strategy, see the Welsh Government website (link opens in new window).

Wider policies, strategies and frameworks

Social connection is considered across a variety of wider government strategies, directing Wales towards a primary prevention approach to loneliness and isolation. For example, the Connected Communities strategy details how social connection should be considered in policy regarding transport, housing, volunteering, health care and digital infrastructure to prevent the development of an environment that fosters loneliness (5).

A key aspect of the Connected Communities strategy is the aim to improve social infrastructure in a way that facilitates, and increases access to, social connections. An example is the implementation of a 20mph speed limit in built-up areas. This aimed to improve safety, encourage active travel and increase the opportunities for people to have positive social interactions. In addition, rail travel was made free to under 11s travelling with an adult to reduce young people's barriers to playing and socialising (5), and £1 bus fares were introduced for 5 to 15-year-olds (153).

Loneliness has also been considered within school and workplace environments. For instance, the Connected Communities strategy notes that loneliness should be integrated within the Mental Health Framework for schools, and that creating an inclusive environment in which no child feels left out or isolated should be a priority (5). This is reflected in the current Curriculum for Wales and the anti-bullying strategy, which prioritise the development of healthy relationships and a positive school environment (154,155). Welsh Government has also developed guidance for dealing with loneliness in the workplace and encouraged employers to foster a mentally supportive environment in the Healthy Working Wales document (156).

Provisions have also been put in place to support the health and well-being of population groups disproportionately affected by loneliness and social isolation. Examples include: Age-friendly Wales, the Physical Activity Partnership, Action on Disability, The Plan for Carers, and Sanctuary for Refugees (5). Public Health Wales has published recommendations for improving the social relationships of older people in Wales, including systemic interventions such as the development of an intergenerational toolkit (138).

Provision of resources

Systemic intervention on social connection in Wales also includes the provision of grants and funding from the government to enact change. In 2021, a three-year loneliness and social isolation fund of £1.5 million was split between local authorities, with the aim of supporting groups to run face-to-face activities with under-served populations and promote social connection within local communities (157). A further £1.5 million was also allocated to support the development of community hubs (see section 7.2) (158). An additional fund, known as the Fusion Challenge Grant Scheme (159) provided funding for cultural and educational initiatives that encouraged social connection through integrated cultural practice. An example of this funding in action was the Young Promoters Programme, a six-week initiative that aimed to involve young people who may be vulnerable to isolation and mental health difficulties in the arts, building their confidence and improving their social skills (159).

Raising awareness

As set out by the aims of the strategy, as well as calls from organisations such as the Jo Cox Commission for Loneliness, raising public awareness of loneliness, addressing stigma, and promoting positive attitudes towards social connection is a priority (5,160). To do this, loneliness was integrated into Wales' national conversation for well-being, with the mental health impacts of loneliness being brought to the forefront. The government also aimed to develop guidance for best practice in tackling loneliness and improving social connection, using evidence and experience-based information to understand how interventions are working, and why. Furthermore, a commitment was made to develop evidence on social prescribing programmes to allow them to be broadly taken up and supported.

7.2 Community-level approaches

Community-level approaches are key to implementing the goals of the Connected Communities strategy and improving outcomes for those living with loneliness. Such approaches are sometimes driven by community-led or asset-based action, in which interventions are informed and motivated by members of the local community. Although community-level approaches are rarely evaluated in terms of loneliness and social isolation, some positive findings have been identified for certain approaches. The use of social value methods, which are increasingly being used in Wales, will help to generate evidence on community approaches and services in terms of social health and well-being (Box 7.2).

Box 7.2: Social value of interventions.

One way of measuring the effectiveness of an intervention is to estimate its social value. Social value refers to the relative importance that individuals and organisations place on the well-being changes they experience because of an intervention (161). This approach provides a more holistic evaluation, considering factors beyond the simple cost-effectiveness or outcomes of an intervention to assess the overall improvement to well-being. To do this, the social return on investment (SROI) is calculated. This is a framework for valuing change and impact in a way that is significant and relatable to those involved, including improvements in areas such as social connection. Through this, a net value of benefits can be calculated and compared to the net input needed for the intervention.

Social value evaluations that consider the impact of social connection have been completed in Wales. For example, the Down-to-Earth re-connect social prescribing programme in South Wales (see Social prescribing, section 7.2) was estimated to have £1,478,480 of social value compared to £161,788 total financial input, making the SROI for the programme £9 for every £1 of investment (162). Loneliness and social connection are also considered in the assessment of social value for other projects, including The Health Precinct community hub for people living with chronic conditions in North Wales (163). This was estimated to be creating £5 for every £1 invested, with £9,713 of value specifically attributed to improved social connections.

Community hubs

Recognising the value of community spaces, Welsh Government has provided funding to develop community hubs. These hubs can host social and educational activities, provide well-being sessions and be a source of advice, whilst providing a space for people to meet and interact. An example of a community hub is Aberdare Cynon Linc (Box 7.3) (164). Some community hubs, such as Oasis Hubs, provide support for vulnerable groups including refugees and asylum seekers (e.g. English for Speakers of Other Language courses and social activities) (165).

Box 7.3: Aberdare Cynon Linc.

This centre began as an older people's day care centre and has now been developed into a community asset by Age Connects Morgannwg, based on the skills and needs of the community. The centre hosts a community kitchen and café, a play area, community activities, and provides a base for Age Connects.

Other examples are the Talking Shop in Blackwood (Box 7.4) (166), and the Hive in Newport (Box 7.5). 'Warm hubs' (also known as warm banks or warm spaces) have also been used in Wales. These spaces provide safe, warm environments for those who cannot afford to heat their homes during the day, and offer food, shelter and social interaction for those who use them (167). Anecdotal evidence suggests that warm hubs may work best when they involve an activity e.g. watching a film or engaging in a quiz, since this can reduce the risk of stigmatising individuals who need to use them.

Box 7.4: The Talking Shop.

The Talking Shop in Blackwood is a centre that holds community activities, signposts to activities in the local area, provides information on democratic issues and encourages community involvement in local issues. Through this, the Talking Shop has become a place in which people can become more involved in their community and foster valuable social connections in the process.

Box 7.5: The Hive.

The Hive is a community centre in Newport that opened in early 2024 (168). With growing development of both social and non-social housing in Newport city centre, Pobl housing association were aware of the importance of support being readily available for those moving into the city. In response, the Hive was developed to become a 'home on the high street' for the community, providing a laundrette, kitchen area and community space. The aim of the Hive is to provide an accessible third space in Newport, providing skills training, social connections, peer support and affordable facilities.

Some frequenters of the Hive are users of Pobl independent living service (ILS), a service which supports adults with additional needs to live more independent lives. Since its inception, Pobl ILS users have been encouraged to receive some, if not all, of their support hours at the Hive, rather than in their homes. This can help provide users with valuable social connections, as well as independence, and time outside of the home that they may not otherwise have.

Those using this service have described how it has been beneficial in improving their mental health, increasing their independence to travel to and from home, and providing them with friendships.

"I didn't have any friends until I came to the Hive. I used to spend most of my time at Wetherspoon's in town but now I prefer to come here." Pobl ILS individual.

The Hive runs regular low-cost breakfast mornings and community lunches for those in the neighbourhood. The Hive kitchen has been a space where those living in temporary accommodation can cook for themselves.

In addition to their own activities, the Hive hosts partner organisations to run sessions. For example, Barnardo's and Housing Justice run 'home life' sessions for those living in temporary accommodation, Riverside Advice offer free financial advice and Momentwm run weekly well-being walks along the riverfront.

Improving social networks through community groups

There are many examples of community groups and programmes that offer opportunities to improve social networks, many of which will involve the use of community hubs and centres. One example is Growing Space, a multi-centre programme that provides those with mental-health difficulties, autism or learning difficulties with socialisation, group activities and training in social and employability skills (169). Another is the New Bridge Foundation, that supports prisoners to re-integrate into the community (Box 7.6).

Improving online skills is also key for those who may be less digitally skilled or have less access to the internet and therefore may miss out on the potential for interacting with friends and family online and increasing their social networks. Digital Communities Wales is a programme which aims to work with organisations that can help engage digitally excluded people, such as older people, people with disabilities and unemployed people (170).

Box 7.6: The New Bridge Foundation.

The New Bridge Foundation is an organisation that supports those who are in prison and those who have recently left the prison system (171). The organisation uses volunteers to support people reintegrating into the community following release and aims to promote self-worth, improve mental health and strengthen social connections. As a part of this work, it runs a befriending scheme, in which trained volunteers form a pen-pal relationship with a prisoner, often visiting them whilst they are incarcerated. This helps combat prisoner loneliness and encourages long-term friendships, as pen-pal relationships continue even if the person is moved around the prison system.

Social prescribing

In 2024, Welsh Government published their National Framework for Social Prescribing, which aimed to develop a shared understanding of social prescribing across Wales, improve practitioner skills and improve the quality of activity provision (172). Both 'green' (nature-based) and 'blue' (sea/water-based) social prescribing interventions have been evaluated in Wales and have been shown to improve social connection and general well-being (173). An example of such a scheme is the Down to Earth programme (Box 7.7).

Box 7.7: Down to Earth.

Down to Earth is a nature-based programme in South Wales for under-served groups such as unemployed young people, those who have been unemployed for long periods and asylum seekers. Individuals take part in group-based sustainable building projects across multiple sites, whilst engaging with staff to improve group and individual construction skills. Down to Earth was evaluated in 2019, and participants were shown to have improvements to both their mental health and social connection following the programme (see also Box 7.2) (174).

Another example of a social prescribing activity is the Swansea Marina Social Walk, organised by Ageing Well Swansea and Action for Elders (175). The walk is a regularly organised group activity, followed by coffee and cake, which allows older people, organisation members, and members of local government to socialise, whilst also incorporating physical activity.

Community campaigns

The Connect to Kindness campaign put forward by Hywel Dda University Health board promotes active citizenship and acts of kindness to help contribute to stronger community connections (176). The campaign was developed through the Healthier West Wales Transformation Fund, and involves a partnership between Pembrokeshire, Ceredigion and Carmarthenshire County Councils, the Pembrokeshire, Ceredigion and Carmarthenshire Associations of Voluntary Services, Hywel Dda University Health Board, Public Health Wales and the West Wales Care Partnership. A guide to kindness in the workplace, with the partial aim of bringing people together, was also developed as a part of this campaign (177).

Age-friendly community approaches

Wales is one of thirteen age-friendly community network affiliate states globally, meaning Wales is working towards promoting an age-friendly environment at a national level (Box 7.8). This is operated through the Welsh Government strategy for older people, Age-friendly Wales (178), and the Older People's Commissioner for Wales (179). In addition to this, ten local authorities in Wales are members of the WHO Global Network for Age-friendly Cities and Communities.

Box 7.8: Age-friendly cities and communities.

Age-Friendly work in Wales has been underway since all 22 local authorities signed the 'Dublin Declaration' (link opens in new window) in 2013, committing to working to become more age-friendly. This was followed by the 'Ageing Well in Wales' programme hosted by the Older People's Commissioner between 2014 and 2019. Since Welsh Government's 2021 Age Friendly Wales: Our Strategy for an Ageing Society (link opens in new window), all local authorities have been funded to engage older people and partners in developing their Global Network applications.

The strategy for promoting age-friendly cities and communities in Wales has an overt focus on building social connections. Older people are included at every stage of the process to ensure that activities are suitable and meet their needs. Within local communities a range of organisations, members of the community and local government co-produce strategies for improving social involvement for older people. These communities then work together to share learning and progress. This demonstrates a commitment to community-led development. For example, when the Swansea Summer Programme funding was allocated for community activities, local organisations and older people worked together to produce a timetable including a variety of different opportunities for socialisation, community building and physical activity, ensuring that there was no overlap in activities and that a wide range of opportunities were offered.

Intergenerational practice is key to the social inclusion work in Wales' age-friendly cities and communities. An example of this is the Intergenerational Recipe Book in Rhondda Cynon Taf (180). In this activity, children worked with older people to produce a book of recipes and then invited the older people to their school for a community lunch, at which the children cooked and served meals from the recipe book itself. Work such as this fosters valuable connections between generations and provides opportunities for both older and younger people to socialise and engage with their community.

7.3 Individual- and relationship-level approaches

Interventions that focus on individuals and their relationships with others are seen in multiple forms across Wales. Many of these interventions focus on directly supporting those experiencing, or at risk of experiencing, loneliness and social isolation. Although some interventions focus on a single approach, such as providing social support, most have multiple aims, for instance providing social support alongside developing social skills and improving social interactions.

Providing social support

There are many examples of social support provision, often taking the form of befriending schemes. Here, volunteers regularly meet with an isolated person, providing friendship, support and encouragement for the person to become more involved in their community. Examples include: Linking Lives Wales (181), Age Cymru Friendship Calls (182), Age Connects Befriending Scheme (183), Gig Buddies (184), Cadwyn Môn (Box 7.9) and Ffrind i Mi (185) (Box 7.10). A befriending scheme for children, known as Building Connections, is also run by NSPCC Cymru (186). Social engagement can also be facilitated through support groups, such as the National Autistic Society support group (187). Academic research finds that befriending interventions have promise in Wales, such as Cadwyn Môn (Box 7.9).

Box 7.9: Cadwyn Môn.

Cadwyn Môn, a befriending service run by Age Gwynedd and Môn, was evaluated in 2020 (188). The service involved volunteers befriending an individual, regularly checking in with them, and encouraging them to take part in community activities during a 10-to-15-week intervention period. Following the programme, those who took part had improved social networks, were less lonely, and felt an increased sense of well-being. Participants reported that the intervention had made them happier and changed their social life for the better.

Box 7.10: Ffrind i Mi.

Ffrind i Mi (or 'Friend of Mine') is a befriending service developed by Aneurin Bevan University Health Board (185). Consisting mainly of volunteers, Ffrind i Mi works with partner organisations and existing befriending services to recruit volunteers that can commit an hour a week to befriending someone that is lonely or socially isolated.
The types of support that a befriender gives differs depending on the recipient. Some individuals ask for someone to accompany them out and about, for help with walking their dog or gardening, or for regular catch ups over the phone. Through this support, volunteers help people reconnect with their communities and engage with activities and services provided by Ffrind i Mi's partner organisations.
Ffrind i Mi is committed to intergenerational practice, meaning that it encourages purposeful, shared activities between members of all generations to bring about positive social connections and help build connected communities. To this end, they have published an Intergenerational Strategy, setting out their commitment to fostering relationships between older and younger people through programmes such as 'professional pen pal', in which vulnerable young people are paired with an older person that can provide positive encouragement throughout their education.

For more information, see the Ffrind i Mi website (link opens in new window).

Improving social skills

In Wales, opportunities to improve social skills often form part of other types of intervention (e.g. see *Improving social networks through community groups*, section 7.2). For children and adolescents, social skills are part of the National Curriculum for Wales. In the area of health and well-being, explicit focus is given to developing healthy relationships and acknowledging the influence of social relationships (189). In this part of the curriculum, children are taught to act pro-socially and understand social norms, make friends, and maintain positive relationships (189).

Changing social cognitions

Psychological support for individuals experiencing distress due to loneliness or social isolation is available through the National Health Service (NHS) Wales. Individuals can self-refer for talking therapies, such as Cognitive Behavioural Therapy, if they would like support for loneliness and associated mental health difficulties (190). Furthermore, self-help guides provided by iCAN NHS mental health support give advice for dealing with social anxiety and mental health difficulties related to loneliness, such as depression (190).

Focusing on the promotion of mental well-being more generally, evidence-based mental well-being support is also available from Hapus Wales (Box 7.11).

Box 7.11: Hapus Wales.

Hapus is an initiative delivered by Public Health Wales that aims to promote positive mental well-being, spark conversations, and signpost to support services (191). Hapus provides online well-being tools and 'insights' into well-being, including the importance of, and resources for developing, strong social connections. They work with organisations, known as 'supporters', to promote the values and messages that Hapus provide.

Conclusion

The examples in this chapter highlight some of the comprehensive support for loneliness, social isolation and social connection in Wales at a societal, community, and individual levels. Where these interventions have been evaluated, they are often shown to influence loneliness and improve social connectivity. For Wales to productively tackle loneliness and isolation, it is key that work continues to address the wider determinants that contribute to loneliness at a community and systemic level, as well as providing support for those groups that are currently experiencing loneliness and isolation.

Chapter 8: Conclusions and areas of future action

Wales has demonstrated a strong commitment to addressing loneliness and social isolation. There is already a good level of understanding of loneliness in Wales, and on-going action at societal, community and individual levels. Using a public health perspective and drawing on the work of the WHO Commission on Social Connection, this report aimed to further understanding of the issues and their solutions. Wales is actively engaging in many of the internationally recognised solutions. Building on this positive foundation, several areas for further action are considered below.

Data collection: a focus on social isolation and social connection

While loneliness is routinely measured via the National Survey for Wales, social isolation is not, despite research highlighting its independent relationship with health and well-being. Production of this report leveraged the Public Health Wales' *Time to Talk Public Health Panel* to explore social isolation using three short questions. It is worth considering whether to collect data on social isolation routinely, alongside loneliness, and find agreement on the most appropriate method of measurement. A key question is whether levels will shift over time as populations age and digital technology evolves further. A closer look at demographic variation in social isolation would be helpful, particularly since isolation is itself a risk factor for loneliness.

Although the data collected on social connection for this report offers a starting point, the use of more comprehensive measures would be beneficial. New data sources in Wales, especially those measuring community-level connection (33), could provide deeper insights into social connection. Mapping existing data collection efforts and the measures used would be a helpful step in improving understanding of social connection. Furthermore, creating a central data point for current and historical data on loneliness, social isolation and social connection would improve knowledge of, and access to, available data sources and trends.

Research: a focus on Wales-specific factors and impact across sectors

Much of the research conducted in Wales focuses on loneliness. More research is needed on social isolation, including its risk factors and impacts on health. Further, although international evidence on risk factors for social disconnection is growing, understanding in Wales could be improved through more exploration of factors unique to the Welsh context. It is also important to explore how loneliness and social isolation may impact on sectors wider than health, including education, criminal justice, housing and employment, and the role each sector may play in solutions.

An additional and important area requiring further research is the role of digital technology in social connection. A better understanding of how technology influences opportunities to interact and the quality of social exchanges is needed, along with improved knowledge of subsequent impacts on social connection, loneliness and social isolation. This is particularly important for population groups most affected by social disconnection. Understanding how technology can be used effectively to promote social connection whilst avoiding unintended isolation, exclusion and other harms to health is essential.

Interventions: a focus on evaluation and opportunity

Wales is among a small number of countries with a national strategy to address loneliness and social isolation. With good supportive legislation, Wales is in a strong position to progress work further. Numerous local and national solutions are already in place, particularly those addressing loneliness. However, whilst the international evidence base is growing, evaluation of Welsh approaches is generally lacking. Evaluating what works, and for whom, is critical. This includes understanding how interventions impact across different population groups and locations (e.g. urban versus rural areas) and identifying barriers and enablers to implementation and participation. Evaluations of community-level initiatives, such as improvements to transport systems or environmental design, could also contribute to international evidence, with existing evidence limited. Social value approaches could also be a useful tool in Wales to evaluate the wider social effects of community interventions.

Importantly, there are likely to be initiatives in Wales that contribute to addressing social disconnection and improving connection, without these issues being a primary aim. For instance, interventions may focus on improving mental health, expanding access to services, or increasing the accessibility of transport. Raising awareness of these indirect interventions and identifying small changes that could increase their impact on social connection, could be an efficient way to help expand action in Wales.

Opportunities also exist to align action on social connection with solutions for other public health issues. For example, Rotterdam's water square project was designed to protect against flooding whilst providing a vibrant space for socialising (192). Further opportunities may arise through projects that require communities to come together for a shared purpose e.g. community-led regeneration or renewable energy projects. Facilitating social connections within these initiatives would benefit both project outcomes and community cohesion.

Partnerships and networks: a focus on inter-sector working and collaboration

The effects of social connection span health, social, community and economic domains. Addressing it effectively requires cross-sector collaboration. Building strong networks and holding regular networking events that enable improved understanding of the issues, the sharing of research, insights and practical experience, will be vital for continued progress. Including a focus on social connection within relevant networks in Wales, such as the age-friendly cities and communities or dementia-friendly networks, would also be of benefit. Wales is already actively engaged in the WHO Global Network for Age-friendly Cities and Communities, contributing to and learning from, international partners. Ensuring Welsh participation in other global initiatives (7), would offer valuable opportunities for both learning and sharing expertise.

There are clear opportunities within Wales to deepen and expand work on social connection through more comprehensive data collection, Wales-specific research, improved evaluation and strong partnership working. By doing so, Wales can help build more connected, healthier and more resilient environments for current and future generations.

Key considerations

Data collection

1. Collect data on social isolation in Wales routinely, finding agreement on the most appropriate methods and measures.
2. Allow for data on loneliness and social isolation to be disaggregated into narrower age-bands, particularly for older age groups.
3. Map existing sources of data collection on social connection in Wales to develop a more comprehensive understanding of the issue.
4. In the longer term, consider creating a central location (e.g. online tool) for data on loneliness, social isolation and social connection in Wales to increase knowledge of, and access to, data sources.

Research

5. Conduct further research on social isolation in Wales, including demographic variation, risk factors and impacts on health.
6. Explore how loneliness, social isolation and social connection impact across different sectors, and the role each sector may play in solutions.
7. Improve understanding of the role of digital technology in social connection and how technology can be best used to build connections whilst avoiding harms.

Interventions

8. Ensure targeted interventions for population groups at higher risk of loneliness and/or social isolation, e.g. those living in deprived areas, individuals with a disability, people in poorer health.
9. Identify and encourage opportunities to evaluate action in Wales, including how interventions impact across population groups and locations, and barriers and enablers to implementation and participation.
10. Raise awareness of the importance of indirect interventions (initiatives that contribute to social connection without this being a primary aim), and ways in which small changes to these initiatives could influence social connection further.
11. Identify opportunities to align action on social connection with solutions for other public health issues.
12. Ensure that interventions are co-produced with representatives from the target population.

Partnerships/networks

13. Raise awareness of the health, social and economic impacts of social disconnection and connection across sectors for example through webinars/events in Wales.
14. Create the opportunity for regular cross-sector meetings to share research and experiences, network, and enable new opportunities for action on social connection.
15. Identify further opportunities, alongside current engagement with the WHO Global Network for Age-friendly Cities and Communities, to feed into international initiatives and agendas.

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Appendix

Measures used to quantify loneliness, social isolation and social connection in Wales

The most used measure of loneliness in Wales, as used by the National Survey for Wales, is the *De Jong Gierveld Scale of Loneliness* (11). This scale consists of six statements, to which respondents can answer 'yes' or 'no'. The six statements are:

- 'I experience a general sense of emptiness',
- 'I miss having people around',
- 'I often feel rejected',
- 'There are plenty of people I can rely on when I have problems',
- 'There are many people I can trust completely'
- 'There are enough people I feel close to'.

Respondents are given one point for each 'yes' answer to the first three statements, and one point for each 'no' answer to the last three statements, for a total score out of six. Those with a score of four and above are classified as lonely.

Several reports, including the Health Behaviours in School Children Welsh report, use the *UCLA 3-item measure* of loneliness (193). There are three items in this scale:

- 'How often do you feel that you have no one to talk to?',
- 'How often do you feel left out?'
- 'How often do you feel alone?'

Respondents can answer 'hardly ever or never', 'some of the time' or 'often'. Item responses are assigned a score from 1 to 3, with an overall score derived from the total from each item. Scores can range between 3 and 9, with a higher score indicating more frequent loneliness.

The *Multiple Dimensional Scale of Perceived Peer Support* (194) is a 12-item scale to measure an individual's perceived support from family and friends. Each item can be given an individual score out of seven, with the scores for each item being summed to generate a total score out of 84. This measure is used by the European Health Information Gateway (21).

Single item measures of loneliness are also included in the UK Opinions and Lifestyle Survey from the Office for National Statistics (ONS (12)). This measure uses a single question, 'how often, if at all, do you feel lonely', to which respondents answer 'never/rarely/sometimes/often/always'. Those who answer 'often' or 'always' are classified as chronically lonely.

Limited data has been collected around social isolation and social connection specifically in Wales. Therefore, we included several questions to quantify this in the Time to Talk Public Health February 2025 survey (link opens in new window). These questions were based upon those used to measure social isolation in several studies using the UK Biobank (121,123,195).

The following items were used to assess social isolation:

1. How many people, including yourself, live in your household? (one point given for living alone).
2. How often do you visit friends or family or have them visit you? (Daily/2-4 times a week/ weekly/monthly/every three months/almost never/never) (one point given for every three months/almost never/never).
3. Which of the following do you engage in once a week or more often? (Sports club or gym/ pub or social club/religious group/adult education class/other group activity/none of the above) (one point given for none of the above).

Social isolation was assessed by summing the score of the three items to give a total score out of 3. Participants were considered socially isolated if they had a total score of 2-3.

Social connection was assessed using one item adapted from (196):

- In general, how connected do you feel to people? (Not at all connected, a little connected, fairly connected, very connected).

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