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Social isolation and loneliness of UK veterans: a Delphi study

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Abstract

Background: Evidence increasingly acknowledges the impact of social isolation and loneliness on the lives of military veterans and the wider Armed Forces Community.

Aims: The study gathered expert consensus to (i) Uunderstand if veterans are considered 'unique' in their experiences of social isolation and loneliness; (ii) examine perceived factors leading to social isolation and loneliness of veterans; (iii) identify ways to tackle veterans' social isolation and loneliness.

Methods: This study adopted a three-phase Delphi method. Phase one utilised a qualitative approach and phase two and phase three utilised a mixed-methods approach.

Results: Several outcomes were identified across the three phases. Transition out of the military was viewed as a period to build emotional resilience and raise awareness of relevant services. It was also concluded that veterans would benefit from integrating into services within the wider community, and that social prescribing services could be a vehicle to link veterans to relevant services. Furthermore, access to, and the content of, programmes were also of importance.

Conclusions: These findings illustrate various important interventional aspects to consider when funding and implementing programmes focussed on tackling social isolation and loneliness.

Key words: Social isolation; loneliness; veteran; Delphi; military

Introduction

Social isolation and loneliness are different concepts but are often inaccurately defined and measured as one. Loneliness is a subjective social and emotional experience, characterised as the discrepancy between the social relationships we have and the one ones that we wish to have (1), whereas social isolation is an objective state in which there is minimal social interactions and can be a result of living alone and having few social network ties (2).

Despite there being no direct link between social isolation and loneliness (3), research has found that individuals can experience both social isolation and loneliness together, especially if experiencing factors such as living alone, never being married, widowhood, advanced age, and poor health (4). Whilst the vast majority of evidence has been focussed on the wider population, evidence increasingly acknowledges the impact of social isolation and loneliness on the lives of military veterans and the wider Armed Forces Community (5, 6).

The military is a distinctive institution as it demands complete social integration as part of its culture and purpose (7). The uniqueness of social integration within military institutions has fundamental implications on social participation and social networks, and this in turn has an impact on service leavers (7). Kuwert et al. (8) found that almost half of the study's 2025 US veteran sample reported feeling loneliness 'some of the time' with loneliness being linked to functional limitations, number of lifetime traumatic events, perceived stress and symptoms of depression and post-traumatic stress disorder. This was supported by a survey carried out in the UK, by the Royal British Legion, who reported that 1 in 4 (25%) military veterans 'often' or 'always' felt lonely, and almost as many felt socially isolated (24.5%) (9).

Research carried out by Hatch et al. (7) established that service leavers experience less social participation outside of work, less engagement with military contacts, and more isolation than serving personnel. Reduced social participation and support is associated with heightened Post-Traumatic Stress Disorder and common mental disorders (7, 10), with reservists experiencing more difficulty during post-deployment transition (10). There are

further intrinsic and extrinsic factors related to military service, which present unique experiences of social isolation and loneliness, such as increased number of transitions, military-related trauma, physical health, and losing touch with comrades (5, 6, 11, 12).

Whilst it is possible to highlight the obvious unique military experiences that affect experiences of social isolation and loneliness, there is currently a lack of research in this area, to ascertain if the prevalence of loneliness and social isolation differs between the military and non-military population. It is acknowledged in the 2018 UK's Veteran Strategy, that there is a lack of research looking at the issues of social isolation and loneliness in the Armed Forces Community (13), and therefore the research acknowledged above is primarily non-peer reviewed evidence, and non-UK based. Therefore, there is a necessity to examine experiences of both social isolation and loneliness in the UK veteran community. The studies that are available primarily focus on cause and impact of social isolation and loneliness. In addition there is a lack of literature looking at 'what works' when aiming to tackle social isolation and loneliness in this population (6). Therefore, this study aimed to gather expert consensus relating to the cause, impacts and ways to tackle social isolation and loneliness of military veterans and aimed to:

(i) Understand if veterans are considered 'unique' in their experiences of social isolation and loneliness
(ii) Examine perceived factors leading to social isolation and loneliness of veterans
(iii) Identify ways to tackle veterans' social isolation and loneliness

Methods

A mixed-methods approach, using the Delphi method, was utilized and aimed to achieve expert consensus (14, 15). For the purpose of the study, an expert was defined as a military veteran or an individual who works with military veterans, and has an understanding or experiences of, social isolation and loneliness. In order to minimise sample bias, we purposefully recruited 'experts' from academia, military charities, non-military charities and government officials. The research team identified 24 individuals across the United Kingdom

as experts in the field, and each individual was contacted via email in each phase. Using a snowball technique, participants were asked to forward the study to anyone they knew who fit the study's criteria of 'expert' (16). The same 'experts' were contacted in each phase, however, due to anonymity it is unknown who responded in each phase.

There were no definitions given to the 'experts' on the terminology used throughout all phases of the survey (e.g. social prescribing) to ensure that the 'experts' gave their own opinions on what it meant to them. Prior to each survey being sent to the expert panel, it was piloted with up to five individuals using the Think Aloud technique (17) to ensure accuracy and readability.

The study was conducted online over three phases. Phase one adopted a qualitative approach while phases two and three utilised a mixed-methods approach. Each round was developed separately and was live for three weeks, taking 10-15 minutes to complete.

Phase one aimed to identify participants' opinions of social isolation and loneliness in the veteran population. The questions within phase one were developed from previous evidence, including academic research and grey literature (see Table 1). The data from phase one was analysed using thematic analysis (18) using NVivo 12 software to organise this data. As part of this thematic analysis, three members of the research team (CL, GMcG, GW) separately familiarised themselves with the data, before separately generating initial codes. In an iterative cycle, codes were discussed as a team and themes were generated, presented and reviewed.

In line with the Delphi process, categories and statements used within phase two were developed from data generated in phase one. phases two and three utilised Likert Scales (see Table 1). Each statement was based on a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. Optional open-ended questions were provided at the end of each category. Participants' scores were averaged with a score of 1 equating to 'strongly agree', 2 'agree', 3 'unsure', 4 'disagree', and 5 'strongly disagree'. Consensus of statements in phase two was analysed using a consensus rate of 70% agreement (19), and statements reaching this consensus, based on this calculation, were re-presented in phase

three to identify any further consensus. Descriptive statistics were calculated in phases two and three using IBM SPSS Statistics 25.

The study received full ethical approval from Northumbria University's Ethical Approval System (reference: 12357).

Table 1 here

Results

Phase one posed biographical questions (see Table 2) and five open-ended questions to the expert panel (see Table 1).

Table 2 here

Four themes were generated from participant responses: accessing programmes/activities, management and organisation of programmes/activities, focus of programmes/activities, and transition to civilian life.

Participants highlighted the importance of the ability to access programmes/activities aimed at tackling social isolation and loneliness. Transportation was perceived as an issue for veterans, which had the potential to hinder attendance.

> *"Poor public transport [can lead to social isolation and/or loneliness for older veterans]" (Participant 3, Veteran <60 years old)*

In addition, participants felt that living in a rural area would present further problems in accessing help.

> *"Isolation due to demographics in rural life may increase the risk of isolation with lack of transport a contributing factor" (Participant 12, Veteran <60 years old)*

Due to the issues identified, it was suggested that increasing access and providing transportation would better enable veterans to attend activities.

> *"Provide increased accessibility to transport options to and from social activities" (Participant 12, Veteran <60 years old)*

There were multiple suggestions of how programmes/activities aimed at tackling social isolation and loneliness should be managed and organised, including provision of age-specific activities/programmes.

> *"Programmes for younger veterans may also focus on areas such as employability while for older veterans it is more likely to be on areas such as independent living skills, crafts, hobbies and social activities" (Participant 16, not a veteran)*

It was suggested that veterans should have an integral role in the delivery of programmes/activities in terms of offering support to other veterans who may be struggling with social isolation and loneliness.

> *"There was a particular benefit to overcoming or preventing loneliness from coming together to participate in activities with other veterans" (Participant 16, not a veteran)*

Participants discussed the issues veterans face in terms of social isolation and loneliness, and how these could be tackled within these programmes/activities. Bereavement was identified as one of the main factors affecting social isolation and loneliness, and this was perceived as being more prevalent for older veterans.

> *"Younger vets will likely still have friends and family and are less likely to feel lonely compared to older vets" (Participant 14, Veteran <60 years old)*

There was also discussion around the use of technology and some assumptions as to the potential barriers faced.

> *"Technology advances is one way in which accessing programs will test the older veteran. Access to the World Wide Web is required and the ability to do this is not possessed by all" (Participant 19, Veteran <60 years old)*

Transition from the military to civilian life was believed to have a significant impact on experiences of social isolation and loneliness.

> *"[There is] no help when leaving the military" (Participant 11, Veteran <60 years old)*

Participants suggested that problems with transitioning from military to civilian life can lead to further problems with veterans struggling to reconnect to civilian life. This was believed to extend to difficulty connecting with civilians as well as local services.

> *"They are a very unique community and often will interact with each other but don't necessarily interact with those who are not veterans" (Participant 20, not a veteran)*

From the findings in phase one, 26 statements were created and presented to participants in phase two (Table 2). Table 3 shows the Mean (M) and Standard Deviation (SD) for each statement, with 1 being strongly agree and 5 being strongly disagree. Ten of the 26 statements achieved the consensus rate.

Table 3 here

The participants' responses to the open-ended questions further supported the statements that achieved consensus. For example, participants agreed that technology should be supplementary within programmes/activities rather than a focus (mean 2.4).

> *Technology can be off-putting to some while others embrace it, so a balance is required" (Phase 2, Participant 1, Veteran ≥60 years old)*

Participants mostly agreed that social prescribing services should link veterans to both community/civilian services (mean 1.8) and military-specific services (mean 2.0). Social prescribing enables GPs, nurses and other primary health care professionals to refer people to a range of local, non-clinical services for practical and emotional support (20).

> *"It is important veterans can receive support from whoever is best placed to provide it, and we often signpost our members to other services and charities who can also help them" (Phase 2, Participant 15, Not a Veteran)*

The ten statements achieving consensus in phase two were re-presented to participants in phase three (see Table 4). This was the method used to gain further consensus of the specific areas agreed upon by the participants in phase two.

Table 4 here

All but one statement reached higher agreement than in the previous round. Once more, the statistics were supported by open-ended responses.

Awareness raising of veteran-specific services (mean 1.8) and of civilian-specific services (mean 1.9) were both viewed as being central to the success in tackling social isolation and/or loneliness.

> *There should be a good mix [of linking veterans to both community/civilian specific services] (Phase 3, Participant 2, not a veteran)*

Participants also 'agreed' that there was a role for social prescribing services to link veterans with both relevant community/civilian services (mean 1.5) and relevant military-specific services (mean 1.8).

> *I believe it would help veterans transition better if they were linked to a mixture of military and civilian services awareness of services (Phase 3, Participant 2, not a veteran)*

Again, the idea that the use of technology in programmes/activities aimed at tackling social isolation and loneliness should be supplementary was agreed upon (mean 2.1).

> *Where technology is available and can enhance the experience it should be available (Phase 3, Participant 10, veteran <60 years old)*

Participants also agreed that transportation should be considered when delivering programmes/activities (mean 1.8), and that the content of the programmes/activities should also be changed frequently (mean 2.4).

> *Where a veteran is physically unable to access services he/she should be facilitated (Phase 3, Participant 1, veteran <60 years old)*

Variety will keep services fresh and interesting (Phase 3, Participant 3, veteran <60 years old)

Discussion

Our study aimed to gather expert consensus relating to the cause, impact and ways to tackle social isolation and loneliness of military veterans. 'Experts' completed three phases of the survey, resulting in consensus of 10 statements. These statements focussed on the importance of the period of transition, the role of social prescribing, and the features of/access to interventions tackling social isolation and loneliness.

Transitional life events, such as parenthood, taking on a caring role, and retirement are well-recognised as periods which can increase risk of social isolation and loneliness (21). Military transition is one transitional life event that is receiving more attention for its links to the potential risk of social isolation, as service leavers can experience reduced social participation, social connection and heightened isolation when leaving the Armed Forces (7).

However, it is also recognised that a positive transition experience can significantly enhance the success of reintegration into civilian society and create less dependency on social support of charitable services, for both the ex-serving personnel, and their family (22). This study highlighted the perceived importance the transition period as being key to improve awareness of social isolation and loneliness, build emotional resilience, and to signpost individuals to relevant military-specific and civilian services. This paper is in support of the Royal British Legion's recommendation to introduce a module on social resilience as part of resettlement provision, with a focus on loneliness and social isolation and preparation for transition (6). Life-long psychological well-being should be recognised and encouraged throughout transition, and as highlighted in this study, utilised as a time to build emotional transition, and signpost to relevant services.

Social prescribing is a holistic approach to health and well-being and recognises that health is primarily determined by social, economic and environmental factors, and aims to support individuals to take greater control of their own health and wellbeing. Findings

demonstrated that experts perceive social prescribing as a useful tool to allow individuals to link to relevant services and support networks. Social prescribing services have been shown to be successful in reducing social isolation and loneliness (23, 24). The renewed focus on social prescribing within the NHS long-term strategy (20) may increase the use of social prescribing as a method of signposting individuals to services, with a focus on developing services for veterans that are designed for their particular needs, including services that are accessible and offer the 'right' care and support regardless of when people leave the armed forces.. There is a vast number of military associations for those who want to retain a connection to the military, many of them offering various programmes and activities, however, it is equally as important to provide for those who wish to integrate into their civilian society and develop a sense of local community (13). Therefore, it is fundamental to provide information on both military-specific and wider programmes/activities associated with reducing social isolation and loneliness

Equity of access to programmes/activities relating to social isolation and loneliness is fundamental. The Campaign to End Loneliness and Age UK have developed a framework conceptualising the importance of transportation as a 'gateway service' that is the 'glue' to keeping people active and engaged and allowing individuals to come together (25, 26). Within this study, assistance with transportation was perceived as an important way to remove some of the barriers to participation. Research specifically focusing on older veterans identified lack of access to services, financial constraints, physical limitations and transportation difficulties as barriers to participation (5, 11, 27). These differences need to be considered when designing interventions aimed at tackling social isolation and loneliness within this sub-population, and one way of doing so is to consider access to, and availability of, transportation (9). Interventions aimed at tackling social isolation and loneliness need to be responsive to the needs of veterans who may struggle to access appropriate transportation.

Whilst the findings have furthered knowledge in the area, there are limitations to the study. The study was designed from non-peer reviewed and non-UK based research due to

the lack of research in the area. Furthermore, whilst a wide range of 'experts' were contacted during the recruitment period, the majority of those who partook in the study were those that work in a military charity, and therefore may create a bias. The number of 'experts' reduced to ten in the final phase may also present problems as conclusions may be hard to draw from a limited sample. Finally, there were no definitions given to participants for each of the concepts introduced to them (e.g. social prescribing). Whilst this was deliberate, with the intended aim of the 'experts' giving their own opinions, it could result in uncertainty in terminology.

Future research should aim to capture veterans' perspectives of the unique factors they face when it comes to social isolation and loneliness to further develop this narrative, and the evidence base. Furthermore, future research must be carried out with the wider Armed Forces Community to better understand the causes, impacts, and methods to tackle social isolation and loneliness in this wider community.

In conclusion, while previous research has shown the negative consequences of social isolation and loneliness on an individual's physical and mental health and the unique factors that veterans face with it, the current study found the importance of the period of transition, the role of social prescribing, and features to be considered within programmes/activities when aiming to tackle social isolation and loneliness.

Key learning points

What is already known about this subject:

- Social isolation and loneliness impact on the lives of military veterans and the wider Armed Forces Community.
- Veterans experience social isolation and loneliness in a unique way due to the increased number of transitions, military-related trauma, physical health, and losing touch with comrades.

What this study adds:

- Veterans would benefit from integrating into the wider community, and social prescribing services should link veterans to relevant services. Transition out of the military was viewed as a period to build emotional resilience and raise awareness of relevant services.
- Access to, and the content of, programmes were also of importance. The value of consultation with veterans themselves (or the target population) is fundamental to success.
- There is a need for further understanding of the cause and impact of social isolation and loneliness of veterans. An initial lack of consensus demonstrated the varying views of experts, some of which was significantly contrary to developed evidence.

What impact this may have on practice or policy:

- Transition from the military is a key period to highlight the impact of social isolation and loneliness, and to increase emotional resilience. Lifelong psychosocial well-being should be recognised and promoted throughout transition.
- Veterans should be made aware of both civilian and military-specific services available to them across the UK. Both social prescribing and transition are key to this. The Ministry of Defence, and Health and Social Care service providers must understand the severity of these issues, and their consequences, throughout the life course.
- Activities/programmes for social isolation and loneliness should consider how individuals access them. Transportation and access to activities are fundamental to their success, to ensure that those who live in rural areas or have trouble with transportation can attend.

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Table 1: Participant demographics

	Phase One (n=27) n (%)	Phase Two (n=19) n (%)	Phase Three (n=10) n (%)
Veteran Status			
Veteran <60 years old	15 (55)	8 (42)	3 (30)
Veteran ≥60 years old	4 (15)	3 (16)	1 (10)
Not a veteran	7 (26)	6 (31)	4 (40)
Undisclosed	1 (4)	2 (11)	2 (20)
Area of Work			
Military Charity	14 (51)	8 (42)	4 (40)
Academia	4 (15)	3 (16)	1 (10)
Ministry of Defence	2 (7)	1 (5)	1 (10)
Local Government	2 (7)	1 (5)	1 (10)
Non-Military Charity	1 (4)	2 (11)	0 (0)
NHS	1 (4)	0 (0)	0 (0)
Aftercare Service	1 (4)	0 (0)	0 (0)
Carer	1 (4)	0 (0)	0 (0)
Covenant	0 (0)	1 (5)	0 (0)
Undisclosed	1 (4)	3 (16)	3 (3)

Questions
‘From your experience, do you believe that older veterans (aged 60+) experience social isolation and/or loneliness in a different way to older adults in the wider population? Please explain’
‘From your experience, do you believe that older veterans (aged 60+) access programmes to tackle social isolation and/or loneliness in a different way to older adults in the general population? Please explain’
‘From your experience, do you believe that younger veterans and older veterans (aged 60+) experience social isolation and/or loneliness, or access programs to tackle social isolation and/or loneliness in different ways? Please explain’
‘From your experience, what do you believe are the factors that lead to social isolation and/or loneliness for older veterans? Please explain’
‘From your experience, how would you tackle social isolation and/or loneliness in older veterans? Please explain’.

Table 2. Questions presented to the expert panel in Phase One.

Table 3. The statements presented to participants (n=19) in Phase Two with range, mean (SD)

Question	Range	Mean (SD)	Agreed Upon Cumulative %
Social prescribing services should link veterans to relevant community/civilian services	1-4	1.8 (0.5)	94.1
Building emotional resilience during transition is an important part of transitioning to civilian life	1-4	1.8 (0.8)	88.2
Veterans would benefit from integrating into the wider community	1-4	1.8 (0.8)	88.2
During transition, it is important to raise individuals' awareness of services across the UK, as well as geographically-specific services	1-4	1.8 (1.0)	76.5
Awareness raising of veteran-specific services during transition is central to the success in tackling social isolation and/or loneliness	1-4	1.9 (0.9)	82.4
Access and transportation should be considered when delivering programmes/activities	1-4	1.9 (1.0)	82.4
Awareness raising of civilian-specific services during transition is central to the success in tackling social isolation and/or loneliness	1-4	1.9 (1.0)	82.4
Social prescribing services should link veterans to relevant military-specific services	1-4	2.0 (0.9)	76.5
Programmes/activities should solely aim to bring people together and interact with one another	1-4	2.3 (1.0)	52.9
Programmes/activities should also aim to tackle other personal issues, such as bereavement, employment, emotional resilience etc.	1-4	2.3 (1.0)	64.7
Technology should be supplementary within programmes/activities	1-4	2.4 (0.8)	70.6
The content of regular programmes/activities	1-4	2.4 (0.8)	70.6

should change frequently			
Programmes/activities should be inter-generational	1-4	2.4 (1.0)	64.7
Programmes/activities should be peer-led	1-4	2.5 (1.0)	64.7
Programmes/activities should be led by third sector military specific charities/organisations	2-4	2.6 (0.7)	47.1
The content of programmes/activities should mirror community/civilian services	1-4	2.6 (0.9)	52.9
It does not matter which third sector charity/organisation leads the programme/activity	1-5	2.6 (1.3)	52.9
Separate programmes/activities should be carried out for those living in urban areas and those living in rural areas	1-4	2.7 (1.1)	41.2
Programmes/activities should involve age-specific activities	2-4	3.0 (1.0)	17.6
Programmes/activities should be based in a city/town centre	1-4	3.1 (1.0)	35.3
Technology should be the focus of programmes/activities	1-4	3.3 (0.9)	17.6
Programmes/activities should be veteran exclusive	1-4	3.4 (1.0)	23.5
Programmes/activities should be age-specific	2-4	3.5 (0.8)	47.1
Programmes/activities should be held in one continuous geographical location	2-5	3.5 (1.1)	23.5
Programmes/activities should be skill-based	2-5	3.5 (0.8)	11.8
Programmes/activities should be based in the person's own home	2-5	3.7 (0.8)	11.8

Table 4: Range, Mean and SD Participant responses (n=10) to the ten statements in Phase Three

Question	Range	Mean (SD)
In Phase Two, 94.1% of participants either agreed or strongly agreed that social prescribing services should link veterans to relevant community/civilian services.	1-2	1.5 (0.5)
In Phase Two, 88.2% of participants either agreed or strongly agreed that building emotional resilience during transition is an important part of transitioning to civilian life.	1-2	1.6 (0.5)
In Phase Two, 88.2% of participants either agreed or strongly agreed that veterans would benefit from integrating into the wider community.	1-4	1.6 (1.1)
In Phase Two, 76.5% of participants either agreed or strongly agreed that during transition, it is important to raise individuals' awareness of services across the UK, as well as geographically-specific services.	1-2	1.8 (0.5)
In Phase Two, 82.4% of participants either agreed or strongly agreed that awareness raising of veteran-specific services during transition is central to the success in tackling social isolation and/or loneliness.	1-2	1.8 (0.5)
In Phase Two, 82.4% of participants either agreed or strongly agreed that access and transportation should be considered when delivering programmes/activities.	1-2	1.8 (0.5)
In Phase Two, 76.5% of participants either agreed or strongly agreed that social prescribing services should link veterans to relevant military-specific services.	1-3	1.8 (0.7)
In Phase Two, 82.4% of participants either agreed or strongly agreed that awareness raising of civilian-specific services during transition is central to the success in tackling social isolation and/or loneliness.	1-3	1.9 (0.6)
In Phase Two, 70.6% of participants either agreed or strongly agreed that technology should be supplementary within programmes/activities.	2-3	2.1 (0.4)
In Phase Two, 70.6% of participants either agreed or strongly agreed that the content of regular programmes/activities should change frequently.	2-4	2.4 (0.7)