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REVIEW ARTICLE

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A systematic scoping review of community-based interventions for the prevention of mental ill-health and the promotion of mental health in older adults in the UK

Caroline Lee[1] | Isla Kuhn[2] | Michael McGrath[3] | Olivia Remes[1] | Andy Cowan[1] | Fiona Duncan[4] | Cleo Baskin[5] | Emily J. Oliver[4] | David P. J. Osborn[3] | Jennifer Dykxhoorn[3,5] | Eileen Kaner[6] | Kate Walters[5] | James Kirkbride[3] | Shamini Gnani[5] | Louise Lafortune[1] | the NIHR SPHR Public Mental Health Programme

[1]Cambridge Public Health, University of Cambridge, Cambridge, UK

[2]School of Clinical Medicine, University of Cambridge Medical Library, Cambridge, UK

[3]Division of Psychiatry, UCL, London, UK

[4]Department of Sport and Exercise Sciences, Durham University, Durham, England

[5]Department of Primary Care and Public Health, School of Public Health, Imperial College London, London, UK

[6]Population Health Sciences Institute, Newcastle-upon-Tyne, UK

Correspondence
Caroline Lee, Cambridge Public Health, University of Cambridge, East Forvie Site, Robinson Way, Cambridge CB2 0SR
Email: cyl40@medschl.cam.ac.uk, caroline.lee@cisl.cam.ac.uk

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Abstract

Background: Mental health concerns in older adults are common, with increasing age-related risks to physical health, mobility and social isolation. Community-based approaches are a key focus of public health strategy in the UK, and may reduce the impact of these risks, protecting mental health and promoting wellbeing. We conducted a review of UK community-based interventions to understand the types of intervention studied and mental health/wellbeing impacts reported.

Method: We conducted a scoping review of the literature, systematically searching six electronic databases (2000–2020) to identify academic studies of any non-clinical community intervention to improve mental health or wellbeing outcomes for older adults. Data were extracted, grouped by population targeted, intervention type, and outcomes reported, and synthesised according to a framework categorising community actions targeting older adults.

Results: In total, 1,131 full-text articles were assessed for eligibility and 54 included in the final synthesis. Example interventions included: link workers; telephone helplines; befriending; digital support services; group social activities. These were grouped into: connector services, gateway services/approaches, direct interventions and systems approaches. These interventions aimed to address key risk factors: loneliness, social isolation, being a caregiver and living with long-term health conditions. Outcome measurement varied greatly, confounding strong evidence in favour of particular intervention types.

Conclusion: The literature is wide-ranging in focus and methodology. Greater specificity and consistency in outcome measurement are required to evidence effectiveness – no single category of intervention yet stands out as 'promising'. More robust evidence on the active components of interventions to promote older adult's mental health is required.

KEYWORDS
community interventions, older age, public mental health

1 | INTRODUCTION

Mental health concerns are common in older adults. It is estimated that 37%–43% of older adults have symptoms of anxiety or depression (Braam et al., 2014; Rodda et al., 2011). Yet, mental ill health in older age is sometimes dismissed as part of the ageing process, and normalised as a response to loneliness, illness, bereavement, or pain, and given lower priority than physical illness by both older people with depression and healthcare professionals (World Health Organisation, 2017; Walters et al., 2018).

Conceptual frameworks of public mental health, like socioecological models (Bronfenbrenner, 1979; Dahlgren & Whitehead, 1991) highlight the influence of individual, community, family/relational and structural determinants (Orpana et al., 2016; Walsh, 2016). For example, living in a deprived area increases the likelihood of depression in men (Remes et al., 2019), potentially associated with pressures to achieve and provide in employment and financially (Kendler & Gardner, 2014). Conversely, social networks and relationships are more influential for women (than men) on poor mental health (Kendler & Gardner, 2014). Recognising the complexity of influences, any pre-existing mental health issues continuing into older age are likely subject to additional 'stressors' in the form of physical decline and reduced mobility; onset of ill health; life transitions such as retirement leading to reduced income, or bereavement and social isolation (National Institute for Health & Care Excellence, 2016; World Health Organisation, 2017). These stressors can affect capacity to feel, think, and act in ways that enable us to engage in and value life (Wren-Lewis & Alexandrova, 2021), resulting in feelings of loneliness, psychological distress or depression and decreased mental wellbeing. Older adults may be less likely to seek and receive professional help as a result (Frost et al., 2019; Nair et al., 2020), for example, they are up to seven times less likely to be referred for psychological therapies by GPs (Frost et al., 2019; Nair et al., 2020; Walters et al., 2018). Later life can therefore be a time of particular vulnerability.

With the spectrum of mental ill-health as varied and complex as it is at other life stages, the importance of early intervention, preventive community-based approaches and promotion of mental wellbeing for older adults is clear (Lee, 2006).

Calls to *preventive* action on public mental health go back more than ten years, from the World Health Organisation (WHO) to the Mental Health Policy Commission (Campion & Fitch, 2016; Regan et al., 2016; Royal College of Psychiatrists, 2010; The Mental Health Policy Group, 2019; World Health Organisation, 2017). Increasingly, it is also accepted that interventions to *promote* positive mental health must address individual, community and structural factors if they are to be effective (Crosland & Wallace, 2011). It follows that this should include positive 'assets' as well as vulnerabilities (South, 2015). Indeed, for some people older age means less work-related stress, and increased opportunities for leisure and connections with friends and neighbours, which support mental health (Saeri et al., 2018). The Department of Health and Social Care for England has for some time adopted a framework that considers the individual within their wider community, as well as the structural issues that may impact upon the choices and options available to them (Department of Health, 2001). Yet, significant policy responses and funding for community interventions have not been implemented, despite the economic, health and social burden of poor mental health in older adults (Quilter-Pinner & Reader, 2018; Mental Health Policy Group, 2019).

Interventions for public mental health target different levels of prevention and promotion, including mental health-related information and advice-giving, direct support, as well as broader community engagement to build social connections, mobilise physical and human resources and empower seldom-heard voices (Hosman et al., 2004; South, 2015). There are actions whose strategy is *selective* prevention, that is interventions targeting the psychosocial crises or adversities (as a risk factor), and those who operate according to a *universal* prevention strategy, thereby focusing on older populations more generally (Hosman et al., 2004; South, 2015; World Health Organisation, 2017). This review covers non-clinical interventions for older adults individually, in sub-groups or as part of the wider community, living independently (i.e. outside of formal settings such as residential care or nursing homes) that operate at individual, sub-group or wider community level.

We set out to directly respond to the distinctiveness of the UK context for practice in this field, with regional devolution and major transformation across the public and primary health care sectors

What is known about this topic?

- Community-based approaches are of central interest in UK public health and inclusion policy and practice.
- This study illustrates that the current UK literature covers a wide range of interventions for older adults, both in form and function.

What this paper adds?

- Reliable and consistently measured evidence regarding impact of community interventions on mental health and wellbeing for older adults is missing.
- There is a need for intervention studies to adopt consistent and comparable outcome measurement.
- Reinforces the case for theory-driven evaluation, capable of reflecting the complex experience of preventive interventions by community-dwelling older adults.

favouring place-centred actions (NHS, 2015; South, 2015). The UK has additionally experienced a long and ongoing period of austerity in public spending which can result in enduring structural inequalities. This review focuses on evidence collected prior to the Covid-19 pandemic, although its impacts are significant to the context for this review: exacerbating inequalities (Marmot et al., 2020; Whitehead et al., 2020), disrupting delivery and increasing demand for many community support actions, as well as threatening the financial security of the voluntary and community sector through reduced revenue (National Council for Voluntary Organisations, 2020).

2 | AIM

Responding directly to the specific context for UK prevention and promotion practice, this systematic scoping review explored the breadth and characteristics of the recent UK literature on community-based interventions intended to address (non-clinical) risk factors for poor mental health in older age. First, we ask what kind of community-based interventions for improving mental health or avoiding a deterioration in mental health for older adults appear in the scientific literature; and second, what evidence is collected and presented on outcomes and effectiveness? We were particularly interested in adults at higher risk of poor or deteriorating mental health due to the psychosocial stressors or 'tipping points' more prevalent in older age outlined above. 'Older adult' is intended to mean people who have reached the current UK retirement age of 65. However, as 'ageing' and life events commonly associated with older age can also occur earlier in life, particularly in more deprived areas or population groups, no strict exclusion criteria on the basis of age were applied, as long as the majority of participants were over 65. Given the importance of current context to delivery, we focus on recent (year 2000+) studies of UK interventions.

3 | METHODS

Drawing on recommendations for the conduct of scoping studies (Arksey & O'Malley, 2005), this review followed four steps: identifying relevant studies; study selection; extracting and charting the data; synthesising the evidence. We searched Medline and Embase via OVID, CINAHL and PsycINFO via Ebsco, Web of Science Core Collection and Scopus (2000 to July 2020). We limited to evidence in English and from the UK since 2000. The search terms were structured for individual database searches to maintain an overall search methodology that was consistent across the different databases. The reference lists of any primary studies meeting our inclusion criteria were also screened to identify additional studies. Search results were exported to EndNote, and duplicates were excluded. The full search strategies for all databases are listed in Appendix A.

Search strategies were developed by an Information Scientist with expertise in systematic review searching, using a search algorithm consisting of terms for: community-based interventions, mental health, 'psychosocial stressors' and older age, in accordance with those identified by NICE (National Institute for Health & Care Excellence, 2016). The 'stressor' categories employed in the review are aligned with key risk factors identified by research, key charities representing the interests of older adults and practice guidance for mental wellbeing of older adults (Allen & Daly, 2016; Independent Age, 2020). Our definition of community-based intervention included those that operate at: individual, sub-group or wider community level; and draw on resources within communities and beyond healthcare as part of the intervention; and wellbeing as well as mental health outcomes (Castillo et al., 2019).

3.1 | Inclusion criteria

Protocols for scoping reviews are not eligible for publication in PROSPERO but we nevertheless present findings according to PRISMA guidelines (Tricco et al., 2018). Two members of the research team independently conducted title and abstract screening of all papers, based on predefined inclusion and exclusion criteria. Studies with a range of designs were included, with and without comparators, as long as based on existing interventions, or evaluations of pilots and addressed the research questions above. Specifically, we included: (a) interventions where main beneficiaries are older adults (over 65) at risk of or exposed to psychosocial stress, but without a clinical mental health diagnosis, and which report primary data, including health-related outcomes; and (b) interventions where main beneficiaries are older adults regardless of whether there is an identified stressor. Interventions take place in non-clinical settings within a community, for example, a community centre or person's own home, though they could include co-located services such as social prescribing or welfare advice delivered in General Practice (GP) clinics.

Studies without primary data or any attempt to report mental health or wellbeing outcomes were excluded, as were systematic reviews (though reference lists were checked for eligible studies). Full text versions of articles identified for potential inclusion via title and abstract screening were retrieved and reviewed by the same researchers, using the same inclusion and exclusion criteria. There was high level of agreement between the researchers, and initial discrepancies were reconciled through discussion to arrive at a consensus.

3.2 | Analysis approach

A data-charting template was developed from the Template for Intervention Description and Replication Checklist (Hoffmann et al., 2014), and tested independently by the researchers. Data extracted included: participant characteristics and context; intervention type and delivery; study design; and outcomes, including both negative and positive impacts on mental health. We expected studies to report on a range of formally assessed outcomes, derived from, for example: standardised mental health screening tools for symptoms of depression or anxiety; measures of and/or self-reported psychological wellbeing, life satisfaction, social connectedness and loneliness, activity levels; and potentially changes

in health/mental health service utilisation. Secondary outcomes of interest included any reflection of theoretical underpinnings for the intervention, such as concepts of 'social capital', social connectedness, self-efficacy, as well as any attempts to inform an understanding of cost-effectiveness or economic value.

No studies were excluded on the basis of quality, and in keeping with the remit of a scoping review (Munn et al., 2018), no formal quality assessment was undertaken. We therefore make no objective evaluation of the rigour of evidence in favour of one intervention over another. We conducted a narrative synthesis (Popay et al., 2006; Snilstveit et al., 2012), coding the interventions by type, categorising according to a conceptual framework (Jopling, 2020) – see Table 1 – and then drawing out common features and differences in relation to target groups, intervention content, delivery mechanisms, outcomes measured and evidence of effectiveness reported (Tables 2 and 3).

4 | RESULTS

Figure 1 presents the PRISMA diagram of the literature search, with 54 papers included in the synthesis.

4.1 | Interventions overview

Table 2 summarises the list of included studies and key characteristics.

4.2 | Study design

Table 3 details these study designs, outcomes measured and evidence of effectiveness reported. The vast majority of studies had adopted mixed methods (n = 21: Beech et al., 2017; Camic et al., 2013; Camic et al., 2014; Clift et al., 2012; Dayson & Bashir, 2014; Devine et al., 2020; Gandy et al., 2017; Greaves & Farbus, 2006; Haighton et al., 2019; Hallam & Creech, 2016; Hemingway & Jack, 2013; Hind et al., 2014; Houston et al., 2000; Middling et al., 2011; Moore et al., 2015; Mountain & Craig, 2011; Orellana et al., 2020; Sextou & Smith, 2017; Todd et al., 2017; Vogelpoel & Jarrold, 2014; Wilkinson et al., 2020) or qualitative methods (n = 19: Andrews et al., 2003, Callan, 2013; Cattan et al., 2011; Cotterill & Taylor, 2001; Gardiner & Barnes, 2016; Chatters et al., 2017; Goulding, 2013; Heenan, 2011; Henderson et al., 2020; Houston et al., 2000; Lang & Brooks, 2015; McGeechan et al., 2017; Moffatt et al., 2017; Mountain et al., 2008; Mountain et al., 2017; Preston & Moore, 2019; Skingley & Bungay, 2010; Wildman et al., 2019; Wilkens, 2015).

Few included comparators, with only 12 studies using experimental research designs (randomised pilot, pragmatic randomised controlled trial, randomised controlled trials (RCT) or quasi-experimental crossover (Adams et al., 2018; Charlesworth et al., 2016); Clift et al., 2012; Dickens et al., 2011; Haighton et al., 2019; Hind et al., 2014; Johnson et al., 2017; Morton et al., 2018; Mountain et al., 2014; Mountain et al., 2017; Woods et al., 2012; Woods

TABLE 1 Category of community interventions identified

Intervention category	Description	Link to conceptual frameworks and determinants of PMH
Connector interventions (n = 12)	Provide support to access and engage (with direct support available in communities, such as social activities or befriending). Focus can be on: reaching people not currently engaged with services or community activities; spending time to understand a person's situation in order to offer an appropriate response; practical and emotional support to access services	Individual-level and community factors
Gateway interventions (n = 7)	The infrastructure that helps older adults to connect or remain connected with their community. Important for ensuring interventions and services are accessible and appropriate. Examples include the built environment; digital/technology; and community transport.	Community-level drivers (economic built env, community assets)
Direct interventions (Group-based or individual) (n = 36)	Support older adults to maintain and improve social connections and relationships. Includes intervening to directly support forming of new connections and social activities and psychosocial support to change thinking and actions. Group-based interventions often built around a creative or cultural focus, sometimes combined with group support or 'other' social aspects.	Individual-level drivers, majority community level drivers, inc. social capital.
System approaches (n = 4)	Concerned with developing community environments supportive of older adults' mental health. The actions of key stakeholders in public mental health (e.g. local government, NHS, community, voluntary and faith sectors, local businesses) working together to enable and facilitate community-based actions that respond to local strengths, needs and context. Outcomes initially look like outputs and processes – for example new groups, connections and networks, volunteering, awareness-raising, tackling stigma. Interventions might reference community or asset-based approaches.	Individual-level drivers (stigma and discrimination), community level (social capital, assets) and potentially some structural drivers (e.g. commercial, local norms, local economy)

TABLE 2 Summary of included studies

Author	Year	Stressor type	Intervention: Broad category	Intervention: Activity type	Delivery: Sector; location (if not community building)
Connector interventions					
Beech et al.	2017	Impact of a physical health condition	Connector	Individual: Wellbeing coordinator/link worker service	Statutory-NHS- CVS
Cotterill & Taylor	2001	Social Isolation/Loneliness	Connector	Group and individual: Peer mentoring, information and activities	CVS
Dayson & Bashir	2014	Long-term conditions. Other non-specified	Connector	Individual: Link Worker and referral to services/assets	CVS
Devine et al.	2020	Social Isolation/Loneliness	Connector	Individual: Link Worker and referral to services/assets	CVS and social work (LA), and volunteers
Dickens et al.	2011	Social Isolation/Loneliness	Connector	Individual (some group): Community mentoring	CVS
Elston et al.	2019	Frailty/multiple long-term conditions	Connector	Individual: Link Worker and referral to services/assets	CVS
Greaves & Farbus	2006	Social Isolation/Loneliness	Connector + Direct)	Group and individual: Mentoring, & creative/social group activities	CVS
Haighton et al.	2019	Not specified	Connector + Direct	Individual: 1–1 welfare advice & telephone assistance	NHS, Statutory (welfare rights advice) Telephone; Recipient's home
Moffatt et al.	2017	Impact of a physical health condition	Connector	Individual: Personalised support and links to community services	CVS
Moore et al.	2015	Social Isolation/Loneliness	Connector + direct	Individual: Telephone helpline	CVS and volunteers Telephone; Recipient's home
Preston & Moore	2019	Social Isolation/Loneliness	Connector + gateway	Individual: Telephone Helpline	CVS and volunteers Telephone; Recipient's home
Wilkinson et al.	2020	Not specified	Connector	Individual: Link Worker, befriending, and referral to services/assets	NHS, CVS, and Volunteers
Gateway interventions					
Callan	2013	Social Isolation/Loneliness	Direct + gateway	Individual: Telephone helpline and befriending	Community Interest Company (CIC), volunteers Telephone; recipient's home
Haighton et al.	2019	Not specified	Connector, gateway + Direct	Individual: 1–1 welfare advice & telephone assistance	NHS, Statutory (welfare rights advice) Telephone; Recipient's home
Hind et al.	2014	Social Isolation/Loneliness	Direct + gateway	Group and individual: 1–1 & group telephone befriending	CVS Telephone; Recipient's home

(Continues)

TABLE 2 (Continued)

Author	Year	Stressor type	Intervention: Broad category	Intervention: Activity type	Delivery: Sector; location (if not community building)
Jones et al.	2015	Social Isolation/Loneliness	Gateway	Group and individual: Support to access internet (group and individualised mentoring)	CVS, volunteers; Recipient's home (and community)
Morton et al.	2018	Not specified	Gateway	Group and individual: Support to access internet (group and individualised mentoring)	Unspecified
Mountain et al.	2014	Social Isolation/Loneliness	Direct + gateway	Group and individual: Telephone befriending (including group-based)	NHS, CVS Telephone; Recipient's home
Orellana et al.	2020	Social Isolation/Loneliness	Gateway + Direct	Group (social) activity	LA, Housing Association, VCS
Direct interventions: Individual					
Andrews et al.	2003	Social Isolation/Loneliness	Direct	Individual: Befriending	CVS; Recipient's home
Callan	2013	Social Isolation/Loneliness	Direct + gateway	Individual: Telephone helpline and befriending	Community Interest Company (CIC), volunteers Telephone; recipient's home
Cattan et al.	2011	Social Isolation/Loneliness	Direct	Individual: Telephone befriending	CVS; Telephone
Gardiner & Barnes	2016	Impact of a physical health condition	Direct	Individual: Befriending	CVS, volunteers; Recipient's home
Haighton et al.	2019	Financial stress	Connector, gateway + Direct	Individual: 1–1 welfare advice & telephone assistance	NHS, Statutory (welfare rights advice) Telephone; Recipient's home
Houston et al.	2000	Social Isolation/Loneliness	Direct	Individual: Creative reminiscence activity (wartime memories)	CVS, community
Direct interventions: Individual + Group					
Greaves &. Farbus	2006	Social Isolation/Loneliness	Connector + Direct	Group and individual: Mentoring, & creative/ social group activities	CVS
Hind et al.	2014	Social Isolation/Loneliness	Direct + gateway	Group and individual: 1–1 & group telephone befriending	CVS Telephone; volunteers Recipient's home
Mountain et al.	2008	Not specified	Direct	Group activities and individual support (Preventive 'Lifestyle Matters' programme)	NHS
Mountain & Craig	2011	Not specified	Direct	Group activities and individual support (Preventive 'Lifestyle Matters' programme)	NHS
Mountain et al.	2014	Social Isolation/Loneliness	Direct + gateway	Group and individual: Telephone befriending (including group-based)	NHS, CVS Telephone; volunteers Recipient's home
Chatters et al.	2017	Not specified	Direct	Individual: Group activities & individual support	NHS

(Continues)

TABLE 2 (Continued)

Author	Year	Stressor type	Intervention: Broad category	Intervention: Activity type	Delivery: Sector; location (if not community building)
Mountain et al.	2017	Not specified	Direct	Group activities and individual support (Preventive 'Lifestyle Matters' programme)	NHS
Direct interventions: Group					
Adams et al.	2019	Impact of a physical health condition	Direct	Group physical activity	Statutory
Beech & Murray	2013	Not specified	Systems + Direct	Facilitated set up of social groups	Academic-statutory-community (Co-production)
Camic et al.	2013	Caregiver burden	Direct	Creative group	NHS, Creative arts
Camic et al. (NB: same study as 2013)	2014	Caregiver burden	Direct	Creative group	NHS, Creative arts
Charlesworth et al.	2016	Caregiver burden	Direct	Group-based peer support	CVS, volunteers
Clift et al.	2012	Not specified	Direct	Singing groups	CVS, professional musicians
Gandy et al.	2017	Social Isolation/Loneliness	Direct	Group-based activities programme	CVS
Goulding	2013	Not specified	Direct	Art gallery visits & group discussion	Creative arts
Greaves & Farbus	2006	Social Isolation/Loneliness	Connector + Direct	Group and individual: Mentoring, & creative/social group activities	CVS
Hallam & Creech	2016	Not specified	Direct	Music-based group activity	Local authority, creative arts
Heenan	2011	Social Isolation/Loneliness	Systems + Direct	Self-directed active ageing group	CVS (Church), community
Hemingway & Jack	2013	Social Isolation/Loneliness	Direct	Group social club	CVS
Henderson et al.	2020	Varied by setting (dementia dyad, non-specified over 50s. Locality: 1x most, 1x least deprived)	Direct	Day centres	CVS
Johnson et al.	2017	Caregiver burden	Direct	Group and paired: Museum/art viewing (object handling and social opportunity)	CVS, volunteers, academia
Lang & Brooks	2005	Impact of a physical health condition	Direct	Audio book group	Local authority (Libraries)
McGeechan et al.	2017	Social Isolation/Loneliness	Direct	Men's social club (Shed)	CVS
Middling et al.	2011	Not specified	Systems + Direct	Group: Community action (gardening focus)	Statutory, CVS
Orellana et al.	2020	Social Isolation/Loneliness	Gatekeeper + Direct	Group (social) activity	LA, Housing Association, CVS
Pearce & Lillyman	2015	Social Isolation/Loneliness	Direct	Creative/arts groups	Unspecified
Sadler et al.	2017	Impact of a physical health condition	Direct	Group-based peer support	CVS, NHS, volunteers
Sextou & Smith	2017	Not specified	Direct	Recreational drama groups	Arts professionals
Skingley & Bungay	2010	Not specified	Direct	Singing groups	Arts professionals, CVS, volunteers
Thomson et al.	2018	Social Isolation/Loneliness	Direct	Museum-based programme ('museums on prescription')	Creative arts

(Continues)

TABLE 2 (Continued)

Author	Year	Stressor type	Intervention: Broad category	Intervention: Activity type	Delivery: Sector; location (if not community building)
Todd et al.	2017	Social Isolation/Loneliness	Direct	Museum-based programme ('museums on prescription')	Creative arts
Vogelpoel & Jarrold	2014	Impact of a physical health condition	Direct	Arts-based participation and voluntary sector support	CVS
Wildman et al.	2019	Social Isolation/Loneliness	Direct + Systems	Group-based mealtime and social activities	CVS, private sector (local businesses)
Wilkens	2015	Social Isolation/Loneliness	Direct	Identity-based social club	CVS
Woods et al.	2012	Caregiver burden	Direct	Group-based reminiscence activities (dementia dyad)	CVS, NHS, volunteers
Woods et al. (NB: same study as above)	2016	Caregiver burden	Direct	Group and paired: Group-based reminiscence activities (dementia dyad)	CVS, NHS, volunteers
Woods et al.	2020	Over 50s deemed at risk of poor mental health and wellbeing	Direct	Group-based psychoeducation plus wellbeing activity	CVS, volunteers and freelancers
Systems interventions					
Beech & Murray	2013	Not specified	Systems + Direct	Facilitated set up of social groups	Academic-statutory-community, & Co-production
Heenan	2011	Social Isolation/Loneliness	Systems + Direct	Self-directed active ageing group	Church, community, & Co-production
Middling et al.	2011	Not specified	Systems + Direct	Group: Community action (gardening focus)	Statutory, CVS, & Co-production
Wildman et al.	2019	Social Isolation/Loneliness	Direct + Systems	Group-based mealtime and social activities	CVS, private sector (local businesses)

TABLE 3 Study design, outcomes and effectiveness

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
Connector interventions						
Beech et al.	**Link Worker and referral to services/assets**	Mixed method: interviews, observations diaries, outcome measures, service utilization data	SWEMWBS	N/A	N/A	Yes (User reported: improvements in wellbeing; access to social networks; maintenance of social identity; valued activities)
Cotterill & Taylor	**Peer mentoring, information and activities**	Qualitative	Narrative analysis (social isolation, wellbeing)	N/A	N/A	Some improvements compared to (unmatched) 'control' group
Dayson & Bashir	**Link Worker and referral to services/assets**	Mixed methods case study	Bespoke well-being measurement tool (baseline & 3-4 month follow-up).	Measures of self-management; Lifestyle; Work, volunteering and	Use of hospital resources. (Inpatient stays, A&E, outpatients)	Yes. 83% Improvements in wellbeing. (not statistically significant) (small sample)
				other activities; Money; Where you live; Family and friends.	Social Value calculation made	Cost: Service use down 1/5 Estimated NHS cost reductions and ROI of 50p to each £1
Devine et al.	**Link Worker and referral to services/assets**	Mixed methods case study	Feedback interviews, narratives, outcomes measured by Older Person's Star™ (Triangle Consulting Social Enterprise)	Clarity IMS,(http://clarityims.org) Bespoke computer system to help match and measure assets and record activity).	N/A	Yes. Sample showed Increased social connectedness & sense of wellness (Outcome Star)
Dickens et al.	**Community mentoring**	RCT	SF12 mental health component score	Quality of life (Eq5D), social participation, social support	N/A	No significant improvement (mental health) Intervention group: less

et al., 2016), 8 employed either controlled or uncontrolled before-after methods and 2 carried out Participatory Action Research (PAR) (Beech & Murray, 2013; Middling et al., 2011). Ten papers reported studies incorporating some element of economic evaluation (Adams et al., 2018; Clift et al., 2012; Dayson & Bashir, 2014; Elston et al., 2019; Gandy et al., 2017; Haighton et al., 2019; Jones et al., 2015; Mountain et al., 2014; Woods et al., 2012, 2016), most often cost-effectiveness analysis.

4.3 | Outcomes reported

A wide variety of measures were employed across the literature as a whole (Table 3). In just under half the studies ($n = 25$) outcomes were measured using standardised screening instruments for mental health, wellbeing, anxiety, depression, and quality of life. For example, the Patient Health Questionnaire (PHQ-9), which assesses common mental disorders (Kroenke et al., 2001), or sub-scales of the

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
				(unclear how measured)		improvement in EQ-5D (health status) at follow-up than controls and "getting along with others": deteriorated compared to control
Elston et al.	**Link Worker and referral to services/assets**	Before-and-after study	Well-being Star™, Patient Activation Measure (PAM)®, WEMWBS), Rockwood Clinical Frailty Scale (RCFS) Rockwood et al., 2005).Statistical analyses.	N/A	Before and after cost analysis by service use. (With some exclusions)	Yes. Statistically significant improvements in health and well-being, patient activation and frailty. Mean activity increased for all services. Users with rapid increase in morbidity and frailty accounted for majority of cost increase
Greaves & Farbus	**Mentoring, & creative/social group activities**	Mixed methods	SF12 mental health component score	N/A	N/A	Yes (qual and quant) Improvements to psychological wellbeing and reduced depression. Recommend controlled trial.
Haighton et al.	**1-1 welfare advice in home & telephone assistance**	Mixed method: RCT, cost effectiveness analysis, qualitative process evaluation	Health related quality of life (CASP-19); Depression (PHQ-9)	Social interaction, strength of relationships, social isolation; general health status [EQ-5D-3L]; health behaviours; independence/care service use, mortality; Affordability Index; Standard	Cost–consequence and cost-utility analyses to estimate the incremental cost per quality-adjusted life-year (QALY) gained.	Yes, (Qual) participants and professionals perceived positive impact on health and HRQoL. Uncertain re: cost effectiveness

Short Form Health Survey (SF36) (RAND Corporation, 2019) Short form Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (Child Outcomes Research Consortium, 2012) and other validated scales. Two more recent studies (Devine et al., 2020; Elston et al., 2019) included use of the Older Person's Star™ and the Wellbeing Star™ (tools developed for measuring personal progress and change) respectively (Good & Lamont, 2018). Six also measured loneliness (Adams et al., 2018; Jones et al., 2015; Moore et al., 2015; Morton et al., 2018; Mountain et al., 2014; Woods et al., 2020), and a few attempted to capture impact on social networks (as intermediate outcomes and influencers on MH), though only three measured this, using the Lubben Social Network Scale

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
				of Living Index; and household financial status. New benefits received since baseline.		
Moffatt et al.	**Link Worker and referral to services/assets**	Qualitative: Interviewing	No validated scales. Narrative analysis (feelings of control, self-confidence, reduced social isolation, positive impact on health-related behaviours)	N/A	N/A	Yes (Qual), particularly control, self-confidence, social isolation and health-related behaviours. Insights re: process/implementation
Moore et al.	**Telephone helpline**	Mixed methods evaluation	Wellbeing and Friends Survey (UCLA-3 Loneliness index, ELSA single item); CASP-19 (4 items) Health: two frequently-used measures of self-reported health.	N/A	N/A	Yes, (fall in loneliness statistically significant but small) Qual: positive effect on loneliness
Preston & Moore	**Telephone Helpline**	Qualitative evaluation	No formal measurement.	Thematic analysis (connecting people & forming relationships).	N/A	Qualitative analysis suggests significant influence on older adults at risk of poor mental health
Wilkinson et al.	**Link Worker, befriending, and referral to services/asset**	Service evaluation (interim findings)	Evaluation (based on routine monitoring data and qualitative testimonials).	Qualitative measure: well-being, independence, social isolation, loneliness,	N/A	Early indications (Qual) re: social contact & self-confidence

(Jones et al., 2015; Lubben et al., 2006; Woods et al., 2020), and the Practitioner Assessment of Network Typology (PANT) measure (Charlesworth et al., 2016; Wenger & Tucker, 2002). Four studies reported service utilisation (Clift et al., 2012; Dayson & Bashir, 2014; Elston et al., 2019; Skingley & Bungay, 2010), although in two cases the economic component was abandoned due to negligible impact on QALYS (Woods et al., 2012, 2016), and one via a self-report inventory (Adams et al., 2018). The remaining studies mostly adopted thematic analysis of qualitative data, focusing on narrative evidence of improvements to wellbeing, self-confidence, loneliness, friendships/relationships, social networks and engagement, and social capital.

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
	s			access to wider welfare benefits.		
Gateway interventions						
Callan	**Telephone helpline and befriending**	Evaluation: qualitative interviews.	Self-report indicates benefits	Older people linked up with activities, services, and becoming reconnected.	N/A	Self-report indicates benefits: feeling more able to cope, more connected to other people, 'uplifted', in better mental health. (Small sample (53 beneficiaries), follow up too short to demonstrate significant impact on mental health.
Haighton C et al.	**1-1 welfare advice in home & telephone assistance**	Mixed method: RCT, cost effectiveness analysis, qualitative process evaluation	Health related quality of life (CASP-19); Depression (PHQ-9)	Social interaction, strength of relationships, social isolation; general health status [EQ-5D-3L]; health behaviours; independence/care service use, mortality; Affordability Index; Standard of Living Index; and household financial status. New benefits received since baseline.	Cost–consequence and cost-utility analyses to estimate the incremental cost per quality-adjusted life-year (QALY) gained.	Yes, (Qual) participants and professionals perceived positive impact on health and HRQoL. Uncertain re: cost effectiveness
Hind et al.	**1-1 & group telephone befriending**	RCT with mixed-methods process evaluation.	SF-36 mental health dimension	N/A	N/A	Yes, effect likely within a clinically and socially relevant range (&

4.4 | Target group

Table 2 shows that the majority of papers studied interventions aimed primarily at addressing social isolation or loneliness (23 studies), followed by 13 studies of interventions essentially open to older residents in general, or where no stressor was stated. Six included a focus on older adults who were caregivers, and nine on the impact of long-term health and physical health conditions or sensory disabilities. One intervention study addressed financial issues as a primary source of potential psychosocial stress, and targeted older

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
						maintained at 6 month post). Authors caution that results from pilot trial phase of a discontinued study.
Jones et al.	**Support to access internet** (group and individualised mentoring)	Pre/post study, SROI survey	Validated measures, e.g. SWEMWBS, Lubben Social Network Scale (& loneliness, satisfaction with life, independence)	N/A	Cost of set up and delivery calculated, per person	Yes, significant increase in number of contacts, reduced loneliness and improved mental wellbeing. Implementation insights – peer-delivery, funding longevity and costs
Morton et al.	**Support to access internet**	RCT: pre/post	Validated cognitive, mental health, and wellbeing scales	Two loneliness scales; sense of self and social	N/A	No (direct MH) , 'intermediate' outcomes of increased social
	(group and individualise d mentoring)		(ACE-R; GHQ-12; CES-D; GAI-SF, SWL)	relationships (self-determination theory's basic needs satisfaction questionnaire),		connections and activity observed
Mountain et al. 2014	**Telephone befriending** (including group-based)	Pilot RCT. Parallel group	Mental health (SF-36)	Subjective wellbeing (ONS) approach; health status (EQ-5D) depression (PHQ-9) Self Efficacy (GSE); loneliness (De Jong Gierveld Loneliness	Cost-effectiveness analysis planned but not undertaken	Yes, SF36 6 months post randomisation within clinically and socially relevant range, but authors urge caution

adults in a socio-economically deprived area. One study highlighted a broad 'risk of poor mental health' and another contained a mix of interventions targeting each of carers, low-income groups, and older adults in general. No studies focused on interventions addressing bereavement in later life.

4.5 | Intervention categories and outcomes

The 54 studies included in the review covered interventions that were diverse and sometimes complex in content. Adapting a recent update of a model put forward for loneliness interventions

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
				Scale. Service utilisation (bespoke health and social care resource use questionnaire).		
Orellana et al.	**Group (social) activity**	Mixed methods case study	Adult Social Care Outcomes Toolkit (ASCOT INT4) validated instrument. Edmonton Frail Scale (EFS), SWEMWBS, Practitioner Assessment of Network Type (PANT).	Qualitative analysis of benefits using NVIVO	N/A	Yes, statistically significant impact on social participation, involvement and meaningful occupation. Qualitative insights re: enabling function of day centres - offsetting loss or isolation, maintaining social connections, compensating for mobility problems and offering
Andrews et al.	**Befriending (home visits)**	Qualitative interview study	Qualitative. No formal assessment of loneliness or wellbeing	N/A	N/A	No evidence presented on outcomes. Some insights regarding implementation.
Callan	**Telephone helpline and befriending**	Evaluation: qualitative interviews.	Self-report indicates benefits	Older people linked up with activities, services, and becoming reconnected.	N/A	Self-report indicates benefits: feeling more able to cope, more connected to other people, 'uplifted', in better mental health. (Small sample (53 beneficiaries), follow up too short to demonstrate significant impact on mental health

(Jopling, 2020), included studies were categorised *posthoc* into four broad categories (See Table 1): connector interventions; gateway approaches; direct interventions; and system approaches.

To summarise Jopling's model, *Connector* interventions provide support to access and engage (with direct support available in communities, such as social activities or befriending). They may focus on reaching people not currently engaged with services or community activities; spending time to understand a person's situation in order to offer an appropriate response; practical and emotional support to access services. *Gateway* approaches highlight the infrastructure that helps older adults to connect or remain connected with their community. This is important to accessibility and appropriateness of interventions and services. Examples include the built environment; digital/technology; and community transport. Direct interventions, which can be 1–1, paired or in groups, support older adults to maintain and improve social connections and relationships, include improving an individual's social engagements and activities as well as psychosocial support to change thinking and actions. Group based interventions are often built around a creative or cultural focus, sometimes combined with group support or 'other' social aspects. *System* approaches are concerned with developing environments that are supportive of older adults' mental health engaging action

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
Cattan et al.	**Telephone befriending**	Qualitative interview study	Narrative analysis re: wellbeing	Narrative analysis (engagement, volunteering)	N/A	Qualitative re: confidence, connections, sense of purpose
Gardiner & Barnes	**Befriending**	Qualitative	Wellbeing, social isolation (method of measurement unclear)	N/A	N/A	Reports emotional and psychological wellbeing, and reduced social isolation
Haighton et al.	**1-1 welfare advice in home & telephone assistance**	Mixed method: RCT, cost effectiveness analysis, qualitative process evaluation	Health related quality of life (CASP-19); Depression (PHQ-9)	Social interaction, strength of relationships, social isolation; general health status [EQ-5D-3L]; health behaviours; independence/care service use, mortality; Affordability Index; Standard of Living Index; and household financial status. New benefits received since baseline.	Cost–consequence and cost-utility analyses to estimate the incremental cost per quality-adjusted life-year (QALY) gained.	Yes, (Qual) participants and professionals perceived positive impact on health and HRQoL. CASP and PHQ results: insufficient evidence of promoting mental health among older people. Uncertain re: cost effectiveness
Houston et al.	**Creative reminiscence activity (wartime memories)**	Mixed methods	Wellbeing (General Health Questionnaire), Narrative analysis (personal relationships)	Attributional style questionnaire for use with older people (EASQ-E)	N/A	Yes (qual), immediately following intervention. (small project)
Gardiner & Barnes	**Befriending**	Qualitative	Wellbeing, social isolation (method of	N/A	N/A	Reports emotional and psychological wellbeing,

by key stakeholders in public mental health (e.g. local government, NHS, community, voluntary and faith sectors, local businesses) working together to enable and facilitate community-based actions that respond to local strengths, needs and context. Outcomes might initially look like outputs and processes – for example new groups, connections and networks, volunteering, awareness-raising, tackling stigma. Interventions might reference community or asset-based approaches.

There were 13 studies with connector interventions, 7 with gateway approaches, 35 with direct support and 4 whole system approaches. Thirteen studies included combinations of one or more the above, for example, Direct and Gateway ($n = 4$); Connector and

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
			measurement unclear)			and reduced social isolation
Direct interventions: Individual + Group						
Hind et al.	**1-1 & group telephone befriending**	RCT with mixed-methods process evaluation.	SF-36 mental health dimension	N/A	N/A	Yes, effect likely within a clinically and socially relevant range (& maintained at 6 month post). Authors caution that results from pilot trial phase of a discontinued study
Chatters et al.	**Group activities & individual support**	Qualitative	Narrative analysis (mental health)	N/A	N/A	Only 2 participants attributed improvement to intervention
Mountain et al. 2008	**Group activities and individual support** (Preventive "Lifestyle Matters" programme)	Qualitative interview study	Narrative analysis (social networks, social contact, activity)	N/A	N/A	No (intervention sample mostly not in psychosocial stress)
Mountain & Craig 2011	**Group activities and individual support** (Preventive "Lifestyle Matters" programme)	Mixed: Survey and before and after interview study	Semi-structured interviews focusing on impact (social participation,	N/A	N/A	Yes, (qual) self-reported: improved confidence, self-efficacy, well-being) attributed to programme
Mountain et al. 2014	**Telephone befriending** (including group-based)	Pilot RCT. Parallel group	Mental health (SF-36)	Subjective wellbeing (ONS) approach; health	Cost-effectiveness analysis planned but	Yes, SF36 6 months post randomisation within clinically and socially relevant range, but authors

Direct support ($n = 4$); Systems and Direct ($n = 4$); Connector and Gateway ($n = 1$).

Table 3 summarises the key characteristics of the interventions, study design and outcomes of interest for the studies, listed in turn by the intervention framework category. Given that quality was not assessed, the reporting of outcomes should be treated as descriptive rather than conclusive. Overall, 16 studies reported positive effects according to measures of mental health, wellbeing, loneliness, or quality of life. Conversely, 10 studies using validated measures found no evidence of impact on mental health

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
				status (EQ-5D) depression (PHQ-9) Self Efficacy (GSE); loneliness (De Jong Gierveld Loneliness Scale. Service utilisation (bespoke health and social care resource use questionnaire).	not undertaken	urge caution
Mountain et al. 2017	**Group activities and individual support** (Preventive	RCT	Mental wellbeing measured (SF-36)	N/A	N/A	No (intervention sample well at baseline)
	'Lifestyle Matters' programme)					
Direct interventions: Group						
Adams et al.	**Group physical activity**	Randomised pilot trial, cost effectiveness analysis	Fear of Falling Scale, Short Falls Efficacy Scale, (EQ-5D-5 L, ICECAP-O)	Including: Anxiety and Depression, QoL, Loneliness	Cost effectiveness analysis, self-report service receipt inventory	No evidence of impact on MH or closely associated outcomes
Beech & Murray	**Facilitated set up of social groups**	Participatory Action Research (PAR) with self-completion questionnaire	Measures of social engagement, wellbeing and community attachment	N/A	N/A	No (Lack of baseline a limitation to demonstrating significance on all measures - particularly loneliness and HR QoL) Statistically significant associations identified between feelings of

or wellbeing. Nineteen studies reported positive effects from analysis of qualitative data. There were no discernible patterns emerging between particular intervention types and positive (or negative) effects on mental health and associated outcomes. No such patterns were noted either in relation to target group/stressor.

4.6 | Connector interventions

There were 12 studies of Connector interventions, of which 11 reported evidence of impact on participants' mental health. Seven reported both qualitative and quantitative improvements to mental health, and a further four reported qualitatively

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
						loneliness, generic quality of life, level of contact with relatives, neighbours & friends & sense of community attachment
Camic et al. 2013	**Creative group**	Mixed method (Feasibility Study)	Standardised measures of anxiety, stress, depression, QoL,	Observational scale (engagement and participation)	N/A	No (measures) Positive qualitative impacts not sufficiently strong indicators of carer mental health
Camic et al. 2014	**Creative group**	Mixed method pre/post design: Interviews and questionnaires	Zarit burden interview (measure of carer burden)	Narrative analysis (impact on relationship)	N/A	No (measures) Positive qualitative impacts not sufficiently strong indicators of carer mental health
Charlesworth et al.	**Group-based peer support**	RCT.	Health-related quality of life Short Form 12 (SF-12) for	Quality of relationship for carers and	N/A	No evidence that, either: peer support, or reminiscence, is effective
			carers collected by blinded assessors at baseline, 5 and 12 months (primary end-point).	people with dementia. Social networks Categorised by Practitioner Assessment of Network Typology (PANT).		in improving the quality of life
Clift et al.	**Singing groups**	Mixed method, including pragmatic RCT	Health related quality of life (SF-12); anxiety and depression (Hospital Anxiety and Depression Scale, HADS);	Service utilisation (Questionnaire)	EQ-5D (Euroqol Five Dimensional Scale) to calculate costs of health and social care (to support different health	Yes (quant), outcome measures higher scoring in intervention than control at 3 months, backed by self-report. Reports likely: cost effective. Short-term intervention without longer-term follow up. Relatively 'well'

assessed improvements only. The connector interventions are dominated by six studies of social prescribing-type interventions involving a Link Worker role and onward connection to community groups (Beech et al., 2017; Dayson & Bashir, 2014; Devine et al., 2020; Elston et al., 2019; Moffatt et al., 2017; Wilkinson et al., 2020). One RCT (Dickens et al., 2011), looked at interventions designed around a mentoring role, but reported no improvements of significance for mental health. The author reported a negative impact on quality of life and social activities (Dickens et al., 2011). Another intervention studied (Greaves & Farbus, 2006), signposted to a range of individually tailored group activities of a social and/or creative nature, and reported

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
					states)	intervention group
Gandy et al.	**Group-based activities programme**	Mixed methods, 3 stage Survey, focus groups, cost effectiveness analysis	Health and Wellbeing, QoL, social isolation measures (self-completion questionnaires)	N/A	Cost analysis of delivery undertaken	Quantitative analysis reports improved social well-being, quality of life, and reduced social isolation. Qual: increased social engagement and activity linked to improved mental health Costs approximated @£482pp
Goulding	**Art gallery visits & group discussion**	Qualitative	Narrative analysis (wellbeing, social capital)	N/A	N/A	Reports some evidence of impact on social capital.
Greaves & Farbus	**Mentoring, & creative/socia**	Mixed methods	SF12 mental health component score	N/A	N/A	Yes (qual and quant) Quant - Significant
	l group activities					improvements to psychological wellbeing and reduced depression. Qual - increased alertness, social activity, self-worth, optimism about life, and health behaviour. Controlled trial recommended
Hallam & Creech	**Music-based group activity**	Mixed methods	CASP-12 measure of QOL, Basic Psychological Needs Scale	N/A	N/A	Yes, reports improvements on scales compared to social groups without music component
Heenan	**Self-directed active ageing group**	Qualitative	Narrative analysis (sense of community, social networks)	N/A	N/A	Narrative of improved community capacity and feelings of empowerment. No evidence reported
Hemingway	**Group social**	Mixed methods	Narrative analysis	N/A	N/A	Participation in social

significant improvements in mental health assessments as well as qualitative data and recommend a follow-up trial. Three qualitative studies (Cotterill & Taylor, 2001; Moffatt et al., 2017; Wilkinson et al., 2020) cited evidence of improvement in intermediate outcomes associated with improved mental health, such as self-confidence and wellbeing.

The only other RCT in this category studied a service combining 'connecting' with Direct support to individuals – a welfare advice and support service delivered both in a person's home, including telephone support (Haighton et al., 2019). The qualitative arm of the study reported positive impact on health and related quality of life, yet cost-effectiveness remained

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
& Jack	**club**		(wellbeing, social support)			clubs reportedly provides social support and enhances social skills
Henderson et al.	**Day centres (social enterprises)**	Qualitative semi-structured interviews	Thematic analysis - impact on health and wellbeing: especially sense of purpose, social support, connectedness and inclusion.	N/A	N/A	Authors report findings 'suggestive rather than conclusive' Impact of involvement beneficial to health and wellbeing, and increased participants' sense of purpose, social support, connectedness and inclusion
Johnson et al.	**Museum/art viewing, object handling and social**	Quasi-experimental crossover design	Visual analogue scale to measure subjective wellbeing	N/A	N/A	Immediate subjective wellbeing impacts recorded for object handling, (during intervention), no impact
	opportunity.					from social aspect. Longevity of outcomes not assessed or proven
Lang & Brooks	**Audio book group**	Qualitative	Narrative analysis (friendships and belonging, sense of self, equality)	N/A	N/A	Reported impact on engagement in 'meaningful activity', positive sense of self, reduced social isolation (associated with sight loss)
McGeechan et al.	Men's social **club (Shed)**	Qualitative focus group study.	Narrative analysis (social networks, social contact)	N/A	N/A	Focus group evidence of Social connectedness)
Middling et al.	**Community action (gardening focus)**	PAR, including mixed methods	Narrative analysis (social engagement)	N/A	N/A	No direct evidence of impact on mental health. Qualitative exploration: enhanced well-being, socialisation, learning and empowerment.

unproven. The final Connector intervention studies also employed telephone helplines (Moore et al., 2015; Preston & Moore, 2019), but as the sole activity. One reported a statistically significant fall in loneliness, while the other focused on exploring intermediate outcomes, specifically impact on connections and relationships.

4.7 | Gateway interventions

The seven studies whose interventions included aspects characterised as Gateway approaches included two digital projects focusing on support for older adults to get online and use the internet (Jones et al., 2015; Morton et al., 2018) as an 'enabler' to social connections.

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
						Implementation insights: engagement and maintaining interest, external support
Orellana et al.	**Group (social) activity**	Mixed methods case study	Adult Social Care Outcomes Toolkit (ASCOT INT4) validated instrument. Edmonton Frail Scale (EFS), SWEMWBS, Practitioner Assessment of Network Type (PANT).	Qualitative analysis of benefits using NVIVO	N/A	Yes, statistically significant impact on social participation, involvement and meaningful occupation. Qualitative insights re: enabling function of day centres - offsetting loss or isolation, maintaining social connections, compensating for mobility problems and offering opportunity for fun & laughter
Pearce & Lillyman	**Creative/arts groups**	Evaluation Survey	Non-validated measures of loneliness, relationships, activity (self-report)	N/A	N/A	Reports increased levels of self-worth and self-esteem
Sadler et al.	**Group-based peer support**	Feasibility study (inc. pre-post outcomes).	Standardised questionnaires for baseline and post-intervention outcomes (6 weeks): Brief Resilience Scale (Smith et al. 2008)	Physical and mental health-related quality of life (SF12), and mental health (Hospital Anxiety and Depression Scale, HADS)	N/A	No strong changes reported
Sextou & Smith	**Recreational drama groups**	Mixed method: Semi-structured interviews and observations	(Soft) Narrative analysis (happiness, social belonging, social interactions)	N/A	N/A	Reports happiness, social belonging and improvement of interaction

The two pre-post design 'access-to-internet' studies both reported positive outcomes, one survey-based highlighted significant improvements to loneliness and wellbeing (Jones et al., 2015) while the other – an RCT – had no direct evidence of improved mental health, but emphasised associated intermediate outcomes, specifically increased social connections (Morton et al., 2018). Four other interventions studied mobilised the telephone as a mechanism for providing support (Callan, 2013; Haighton et al., 2019; Hind et al., 2014; Mountain et al., 2014). The telephone interventions incorporated befriending, and as such were also Direct interventions, reported below. We also included in this category a study of the impact on day centres for older adults (Orellana et al., 2020). While

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
Skingley & Bungay	**Singing groups**	Qualitative: Interviews, focus groups, observations	Narrative analysis (enjoyment; mental health and wellbeing; social interaction; physical health; cognitive stimulation and learning; memory and recall)	N/A	N/A	Participant interview data attributed attendance to: enjoyment; improved mental health and wellbeing; physical health; cognitive stimulation and learning; memory and recall, and increased social interaction
Thomson et al.	**Museum-based programme** ("museums **on** prescription")	Quantitative: Pre-mid-post outcome measurement	Psychological wellbeing (Museum Wellbeing Measure for Older Adults (MWM-OA))	N/A	N/A	Multivariate analyses: significant participant improvements pre-post session in emotions associated with psychological wellbeing (Underpinned by theory of change)
Todd et al.	**Museum-based programme** ("museums **on** prescription")	Mixed methods: Qualitative interviews, pre-mid-post quantitative outcome measurement	Grounded theory analysis (wellbeing, social interaction)	N/A	N/A	Insights into social and relational mechanisms of change
Vogelpoel & Jarrold	**Arts-based participation and voluntary sector support**	Mixed method: Qualitative interviewing, quantitative outcome measurement	Wellbeing (WEMWBS). Observational tool (to observe experience of wellbeing in an arts-health intersection)	Individual case studies constructed incorporating multiple perspectives to convey complexity of experience of health and wellbeing	N/A	Yes, reports participants improving wellbeing scores. (not significant - very small sample)

day centres clearly provide a direct support function, their physical presence in local communities is a vital part of gateway infrastructure. In addition to statistically significant reported impact on social participation, involvement and meaningful occupation, the study offered qualitative insights about the enabling function of day centres in offsetting loss or isolation, maintaining social connections, and compensating for lack of mobility.

4.8 | Direct interventions

The 36 studies of interventions classified as Direct support were broken down into: individualised support; group support; and a combination of the two. Befriending dominated individual interventions (Andrews et al., 2003; Callan, 2013; Cattan et al., 2011; Gardiner & Barnes, 2016), featuring visits or telephoning people at home. All but

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
				improvements		
Wildman et al.	**Group based mealtime and social activities.**	Qualitative Case study: semi-structured interviews	Narrative analysis (impact on social network, social isolation)	Searches for evidence of theoretical underpinnings (social capital, 'active citizenship', inclusion, sustainability) [and] socially included'	Focus on older adults as customers with spending power, & source of human capital, not passive recipients of help.	Qualitative highlights social inclusion, and social capital outcomes
Wilkens	**Identity-based social club**	Qualitative: focus groups, interviews	Narrative analysis (loneliness, belongingness/connectedness)	N/A	N/A	Some evidence from narratives collected re: sense of belonging
Woods et al. 2012	**Group-based reminiscence**	Pragmatic Multi-Centre Randomised	Psychological distress (GHQ-28)	Carer stress, mood,	Service use/Eqol-5	No evidence of effectiveness.
	activities (dementia dyad)	Trial, cost effectiveness analysis.		relationship quality,		Evidence of increased stress in carers. Economic analysis abandoned - negligible difference in QALYs
Woods et al. 2016 (NB: same study as above)	**Group-based reminiscence activities** (dementia dyad)	Pragmatic Multi-Centre Randomised Trial, cost effectiveness analysis.	Psychological distress (GHQ-28)	Carer stress, mood, relationship quality,	Service use/Eqol-5	No evidence of effectiveness. Evidence of increased stress in carers. Economic analysis abandoned - negligible difference in QALYs
Woods et al. 2020	**Group-based psychoeducation plus wellbeing activity**	Service evaluation (four site; multiple cohort; baseline, post-intervention and follow-up)	SWEMWBS (Stewart-Brown et al., 2009)ONS-4 'wellbeing' (Tinkler & Hicks, 2011); Recovering Quality	The extent of social networks was assessed with the Lubben Social Network Scale (Lubben et	N/A	Yes. (well-being, self-efficacy, social networks and aspects of loneliness) Significance unclear. Insights re: improved recruitment of more at risk

one reported positive impact on psychological wellbeing and mainly intermediate outcomes associated with improved mental health. The other (Callan, 2013) warned that there was insufficient follow-up to confirm initial self-reported benefits to mental health.

The studies of Direct support interventions were mostly small scale, bar one (Haighton et al., 2019) – a large trial offering welfare advice and connected support and onward referral, thereby straddling Direct support, Connector and Gateway functions. Qualitative evidence supported a positive impact on health and health related quality of life, though scores recorded by validated measures provided insufficient evidence that domiciliary welfare rights advice promoted mental health among older people, and cost effectiveness was unproven.

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary outcomes	Secondary outcomes	Economic outcomes	Evidence of effectiveness?
			of Life - ReQoL-10 (Keetharuth et al., 2018): De Jong Gierveld Loneliness Scale (De Jong Gierveld & van Tilburg, 2006): UCLA Loneliness Scale (Hughes et al., 2004)	al., 2006)		populations through third sector (compared to Chatters 2017)
Systems interventions						
Beech & Murray	**Facilitated set up of social groups**	Participatory Action Research (PAR) with self-completion questionnaire	Measures of social engagement, wellbeing and community attachment	N/A	N/A	No (No baseline was a limitation to demonstrating statistical significance on all measures - particularly loneliness and HR QoL) Statistically significant associations were
						identified between a person's feelings of loneliness and generic quality of life and their level of contact with relatives, neighbours and friends and their sense of community attachment
Heenan	**Self-directed active ageing group**	Qualitative	Narrative analysis (sense of community, social networks)	N/A	N/A	Narrative of improved community capacity and feelings of empowerment. No direct evidence of intervention impact reported
Middling et al.	**Community action (gardening focus)**	PAR, including mixed methods	Narrative analysis (social engagement)	N/A	N/A	No direct evidence of intervention impact on mental health. Qualitative exploration:

Five studies focused on interventions that combined individualised support with group work, though four reported different studies of the same 'Lifestyle Matters' programme (Chatters et al., 2017; Mountain & Craig, 2011; Mountain et al., 2008, 2017), only one of which attributed any mental health outcome improvements to the programme (Mountain & Craig, 2011). The RCT (Mountain et al., 2017) and qualitative study (Mountain et al., 2008) both highlighted that difficulties in targeting individuals experiencing psychosocial stress affected demonstration of significant change in mental health outcomes. The remaining two papers reported the same Befriending pilot RCT (Hind et al., 2014; Mountain et al., 2014), which combined one to one telephone calls with facilitated

TABLE 3 (Continued)

Author	Intervention: Activity type	Study design	Primary Outcomes	Secondary Outcomes	Economic outcomes	Evidence of effectiveness?
						enhanced well-being, socialisation, learning and empowerment. Implementation insights: engagement and maintaining interest, external support

Key:

- Studies reporting positive outcomes according to objective measures of mental health and related outcomes.
- Studies reporting qualitative evidence of impact and related outcomes.
- Studies reporting no positive outcomes associated with the intervention.
- Studies reporting negative mental health or health-related outcomes for the intervention.

telephone-based friendship groups. Both papers reported significance in mental health outcomes at six months, yet urged caution due to the pilot nature of the study.

Group-based support and activities made up the remaining 30 'direct' interventions, the vast majority involving creative or cultural activities, such as music or singing, and museum or arts-based viewing or activities. Five of the music or arts-based group activities recorded positive effects on the measures assessed (Clift et al., 2012; Greaves & Farbus, 2006; Hallam & Creech, 2016; Thomson et al., 2018; Vogelpoel & Jarrold, 2014), however, only one reported the improvements as significant according to a measure of wellbeing specific to museum settings. The others each employed different scales again, and strength of findings were limited by small or relatively 'well' intervention samples, and lack of longer term follow up. Additional qualitative studies reported positive changes associated with mental health improvement, such as greater social connections and enhanced self-esteem (Johnson et al., 2017; Pearce & Lillyman, 2015; Skingley & Bungay, 2010).

Studies of group interventions offering more mixed activities, from social, to arts and crafts and learning also reported positive change on mental health measures (Woods et al., 2012, 2016), self-report questionnaires (Gandy et al., 2017) and interview feedback (Henderson et al., 2020). Others were mostly small-scale qualitative studies of specific types of social or creative group activity, and tended to highlight positive change in factors potentially supportive or participants' mental health such as sense of belonging, happiness, self-esteem, empowerment (McGeechan et al., 2017; Middling et al., 2011; Skingley & Bungay, 2010). The remaining Direct group intervention studies included two reporting social capital impacts (Goulding, 2013; Wildman et al., 2019), and narratives around the influence of process/delivery on intermediate outcomes (Beech & Murray, 2013; Camic et al., 2013,

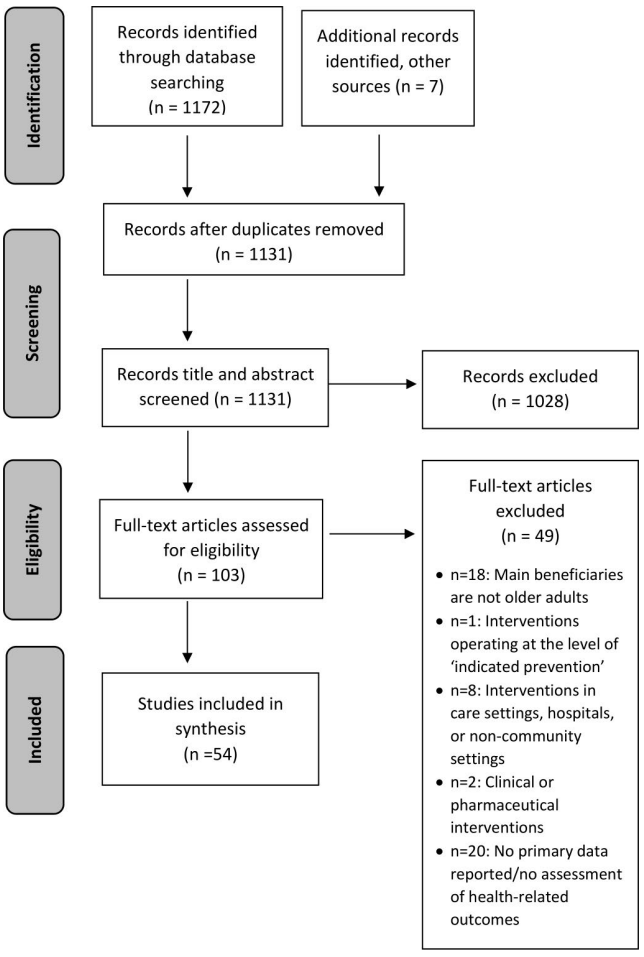

FIGURE 1 PRISMA flow diagram of the selection process

2014; Heenan, 2011; Hemingway & Jack, 2013; Todd et al., 2017), yet providing no supporting evidence. Two studies reported a negative impact specifically on carers participating alongside their partners living with dementia in the intervention (Woods et al., 2012, 2016).

4.9 | Systems interventions

The final group of four studies shared features of 'asset-based' approaches and intervention development in response to identified population need, including the active outreach and involvement of older people in designing responses and drawing on available resources – physical, organisational and human (Beech et al., 2017; Wildman et al., 2019). These studies were underpinned by more a complex theory of change, where mental health is a more distal outcome influenced by individual, community and structural determinants.

Two of the four studies in this category undertook participatory action research (Beech & Murray, 2013; Middling et al., 2011) involving a period of deep community engagement to understand underlying strengths and challenges, and co-production of tailored interventions (with older residents). The other studies (Heenan, 2011; Wildman et al., 2019) examined similar processes using a case study approach.

Statistically significant associations between feelings of loneliness, quality of life, social contacts and sense of community attachment were reported (Beech & Murray, 2013), but lack of baseline data collection meant none of these were attributable to the interventions. Other studies shared a narrative of improved community capacity, empowerment and inclusion of marginalised older adults, evidenced through qualitative data collection and thematic analysis highlighting enhanced well-being, socialisation, learning and empowerment (Heenan, 2011; Middling et al., 2011; Wildman et al., 2019).

4.10 | Intervention delivery

Organisational and cross-sectoral partnerships were important aspects of these community interventions. Many described in this scoping review involved multiple partner organisations (Table 2). For example, the community and voluntary sector (CVS) was involved in 11 of the 12 connector services, and as sole provider in 6 of these. It was also the most common provider of Direct community interventions, with no other partner in 9. Nonetheless, partnerships between National Health Service (NHS) bodies, and CVS organisations were the next most common arrangement, with five interventions spanning different categories. Local government authorities (LA) were involved in nine interventions, and in one library-intervention as sole provider. They were involved in just 2 Connector interventions. Community volunteers were also a key resource in 12 unique interventions: 9 Direct, 1 Gateway only and 2 Connector only. As noted above, co-production engaging older adults in design and delivery was a feature of some 'Systems' approaches.

Two important benefits highlighted by delivery partnerships are multi-disciplinarity - informing intervention design and provision – and co-location. Recognition of the influence of wider determinants (on ability to cope with and manage physical and mental health conditions), underlines the importance of being able to offer practical and financial alongside social support. The Link Worker model is one example of this, where multi-morbidity, mental health, social isolation, and related socioeconomic issues could be tackled concurrently, firstly understanding and then linking to a wide range of formal and informal support services (Moffatt et al., 2017). The rapport and quality of relationship between worker and beneficiary was nevertheless also deemed crucial to achieving this. Co-located delivery of services combines and facilitates access by being a constant physical reminder to professionals of the availability of complementary support (Beech et al., 2017). This was not a common feature amongst most of the interventions reviewed, however.

Conversely, a lack of ability to identify and appropriately target the 'at risk' sub-populations for support, was a key constraint to demonstrating clear impact in some cases (Chatters et al., 2017; Haighton et al., 2019; Mountain & Craig, 2011; Mountain et al., 2008, 2017). In these studies, flaws in recruiting people with higher risk profiles meant that beneficiaries were relatively healthier at the outset than the intervention design intended.

5 | DISCUSSION

This review identified 54 community interventions relevant to the current UK context which target some, but by no means comprehensively all, stressors that might trigger poor mental health in older age. The scoping identified several studies of interventions which may address family and relationship drivers for poor mental health. For example: direct support to carers; facilitating/enabling relationships through connecting interventions; and befriending interventions. It is possible that Connector interventions also address individual-level drivers, for example through Link Workers taking the time to understand individuals' and their unique circumstances, and refer to appropriately tailored support. Community-level drivers such as availability of physical and organisational assets, or resources, social capital and strength of connections could be enhanced through Direct interventions, particularly where delivery is in group settings. In a very small number of interventions studied, essentially those with a 'systems' approach, contextual factors are very much central, with action focusing on the mobilisation of existing 'assets' to build more supportive communities in general, and integrating considerations of future sustainability. An example, previously found to positively influence outcomes such as loneliness, is co-production, where service users are engaged in developing activities in response to needs (Gardiner & Barnes, 2016). Perhaps unsurprisingly due to the focus on community interventions, interventions addressing socioeconomic determinants of poor mental health were largely absent from scientific literature returned by the search. There was only one study with a focus on income, poverty and financial stress as

a driver of poor mental health. That said, the literature did contain examples of interventions being purposefully developed in areas of socio-economic disadvantage (and rurality), and person-centred approaches which take into account both physical and mental health, and social and economic issues, responding with a 'package' of support (Middling et al., 2011; Moffatt et al., 2017). The majority of studies did not however target, measure or discuss impacts on inequalities.

There were additional insights into aspects of successful implementation and delivery of interventions. Firstly, it is important to acknowledge that Connector services invariably connect 'to' something – usually one or more of a myriad of 'Direct' interventions, such as social groups or befriending. The effectiveness of the interventions we identified are therefore likely the result of a combination of inputs potentially involving Connector, Gateway and Direct intervention components. One study highlighted the influence of different aspects within a package of support and the importance of each to addressing individual circumstances and stressors, and ultimately achieving positive outcomes (Greaves & Farbus, 2006).

Together these cross-category interventions may provide some of the building blocks for local systems of services and support to prevent poor, and promote good mental health in older age. For commissioners and providers of interventions in support of population mental health, understanding the potential of a range of interacting interventions, or multi-component interventions, which together address the complexity of drivers is likely to be as important as knowing which individual interventions result in positive mental health outcomes. Hence, we feel it is important to acknowledge whole system approaches, and the presence of 'Gateway' infrastructure as a facilitator in delivering support and services. For example, accessible transportation, community venues and public spaces, human resources and volunteers, as well as non-physical infrastructure such as digital platforms and telephone helplines are all important elements with a bearing on successful delivery and outcomes. As we have seen during the Covid-19 pandemic, agility and innovation to change how to reach those in need of support is an important consideration to sustainability going forward.

The not-for-profit sector and volunteering featured strongly (40 and 12 studies respectively), particularly in the Direct intervention category, highlighting a potential vulnerability to local government funding cuts, or cancellation of charity fundraising events, as we have seen during the current pandemic. Coronavirus has exacerbated inequalities. With the impact of austerity in public spending, and increased competition for scarce financial resources, preventive community approaches are even more vital for investment.

6 | RECOMMENDATIONS

While we have suggested that a breadth of support and services across Connector, Gateway, Direct and Systems approaches is important in responding to the complexities of influencers on mental health in older age (as at any age), the lack of consistent measurement of outcomes, even within categories, is a challenge for service development and commissioning. Some commonality in measures and scales for assessing change in mental health and wellbeing would enable greater comparability across settings and actions. To some extent the limitations in study design that we observed may reflect: the limited resources of small-scale delivery organisations often engaged in these types of activities; time-limited grant funding to provide services; the time needed to build trust with marginalised groups (before collecting data); and challenges in attributing impacts to complex and developmental interventions. At the same time, there is also a need to identify the influence of context, and better understand which interventions and/or combination of interventions, and modes of delivery, are effective, for whom, and in what circumstances. Even amongst Direct interventions, multiple potentially active components are involved, not only the content, for example, gardening, singing, art-based activities, welfare advice, eating, mending, constructing, socialising, but also the delivery mechanism (Befriender/Peer, Group work, Co-location), which individually or together may fundamentally influence mental health outcomes. Despite the UK focus and context-specific nature of funding and implementation, the broad framework, typologies, and content examples described may also be applicable beyond the UK thanks to its theoretical underpinning and 'whole system' framing (Stansfield et al., 2020).

7 | LIMITATIONS

As a systematic scoping review to inform development and delivery in the current UK public health context, we excluded any literature published before 2000, as well as papers from outside the UK. This may mean that we have missed both earlier work, and studies from other countries that could have had some relevance to the current UK context. Whilst care was taken to ensure the search strategy was as inclusive as possible within our parameters, it is possible that some literature was missed through indexing, or other reasons. Additional interventions and insights may also be held in the body of grey literature.

8 | CONCLUSION

This review has scoped and identified a range of community-interventions to support the mental health of older adults in the UK. It highlights a diversity in form of delivery (individual or group, telephone, face-to-face or online) as well as function (connecting, facilitating, direct support, help, advice or signposting). The heterogeneity in interventions, as well as study design and reported outcomes, means no strong conclusions regarding effectiveness were possible. A wide array of outcome measures, small samples, absence of comparators and lack of longer-term follow-up results in little generalisability, including of evidence in relation to impact and sustainability of the impact of interventions on mental health.

There is, however, some evidence of positive mental health outcomes of 'Connector' and Direct support interventions, including intermediate outcomes, wellbeing and social connections. Yet, frequently the interventions combined elements of multiple types and delivery models, which is increasingly likely to be the case given the growth of social prescribing and asset-based approaches in the UK. Consequently, it is perhaps more important to think about which combinations are best fitted to context and sustainability, and how to best develop them, given varied needs and 'assets' across communities.

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CONFLICTS OF INTEREST

The authors have no conflict of interest to declare.

AUTHORS CONTRIBUTIONS

EO and DO are the Principal Investigators. JD is the Programme Manager. FD, MM, EO, SG, DO, KW, LL, CL, JK, JD and EK were involved with designing the methods. IK and CL devised the searches and search strategy. CL, MM and OR screened the literature and charted the data. CL led on analysis, synthesis and writing of the manuscript. All authors contributed to the writing and editing of the manuscript for publication, and read and approved the final manuscript. In addition, AC finalised the manuscript for submission.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

ORCID

Caroline Lee https://orcid.org/0000-0002-5730-4350
Andy Cowan https://orcid.org/0000-0002-8981-5673

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