

IMPROVING HEALTH AND SOCIAL
ISOLATION IN THE AUSTRALIAN
VETERAN COMMUNITY

A summary of research findings from the
Improving Social Networks Study.

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I M P R O V I N G S O C I A L N E T W O R K S

S u m m a r y R e p o r t

Introduction

The 1994 Baume Report, *A Fair Go*, identified social isolation as a priority concern for the veteran community. Most veterans and war widows are now over 70 years of age and, within a few years, 60% will be over 75 years. Veterans from the Vietnam, Korea, and Malaya conflicts soon will be entering old age. As people grow older they are more likely to experience social isolation as a result of frailty, mobility problems, and losses of friends and family.

In response, the Department of Veterans' Affairs (DVA) commissioned research into the causes and effects on health of social isolation, in order to inform the development of comprehensive interventions to enhance social networks and overcome social isolation.

The Lincoln Gerontology Centre in the School of Public Health at La Trobe University conducted the study from May 1996 to February 1998.

The objectives of the research were to:

- ~ establish the circumstances, causes, and prevalence of isolation;
- ~ establish the links between isolation and health;
- ~ establish health care providers' perceptions of the causes of isolation and possible intervention strategies;
- ~ develop a framework for effective interventions; and
- ~ provide strategies to increase community awareness concerning social isolation.

Research Methods

This national study focused on individuals who experience social isolation and the service providers and community groups who can address their needs. It collected extensive qualitative and quantitative data by:

- ~ conducting a total of 22 **focus groups** with health and welfare service providers and ex-service organisations including: Aged Care Assessment Teams, Psychogeriatric Care Assessment Teams, community health nurses, Home and Community Care coordinators, geriatricians, general practitioners, DVA advisers, representatives from the Returned Services League, Naval Association, War Widows Guild, Legacy, TPI Association and the Australian Vietnam Veterans' Association;
- ~ conducting **in-depth interviews** with 35 individual veterans from four groups - Vietnam and Younger Veterans, World War II veterans, war widows, and carers, regarding their personal views and situations;
- ~ undertaking a **Longitudinal Survey** of more than 1600 respondents from the 1992 DVA Client and Carer Survey, who were surveyed by mail to identify changes of social participation and predictors of social isolation from 1992 to 1996;
- ~ conducting a **Needs and Preferences survey** by interviewing a further 334 respondents at risk of isolation by telephone, to determine constraints on social participation as well as preferences for preventing and responding to isolation; and
- ~ conducting an international review of literature.

The research was conducted in all capital cities and selected rural areas. The study was the most comprehensive investigation undertaken on social isolation in Australia. Comparisons to other Australian studies indicate that the findings apply widely in the broader community, especially to older people.

The international review of literature showed that DVA, by conducting this research, is at the forefront in understanding the issues and developing evidence-based action to address social isolation.

Definition of social isolation

The following definitions were used in the study:

Social isolation: people were defined as socially isolated if they reported low levels of social participation combined with perceived inadequacy of social activity and/or experienced adverse personal consequences. They were considered *at risk* of social isolation if they reported low social participation only. The precise measures were:

1. Low social participation: equivalent to less than two activities per week, including any of eight social activities such as spending time with family or friends, or visiting social or sports clubs.
2. Perceived inadequacy of social activity: self-report that the person's usual level of social activity was not enough.
3. Adverse consequences: self-report of frequently feeling bored, lonely, or unhappy.

These definitions were based on measures in previous studies and they were tested to ensure their practicality for collecting reliable information. The definitions reflect the multi-dimensional nature of social isolation and the importance of focusing on vulnerable people for whom more social activity could make a difference in their lives.

Limitations of the study

Even with the comprehensive research strategy, it was inevitable that some of the most severely isolated people could not be reached, or they chose for their own reasons not to take part in the study. Service providers and other key informants were able to shed some light on the situations of extremely isolated people.

The research was based on samples which are used to estimate the extent of social isolation in the veteran population. The accuracy of these estimates is affected by the low prevalence of isolation and the small size of some groups in the veteran community in the research. For example, many Vietnam and Younger Veterans with jobs and in

good health are not in the DVA treatment population. Carers are important for DVA but they are not separately identified in the treatment population.

Overall, the study provides sound information which goes far beyond previous knowledge of social isolation in the veteran community.

Prevalence of Isolation

The research found that social isolation is a substantial problem in the veteran community. Overall, approximately 10% of respondents were classified as socially isolated and another 12% were at risk of isolation:

- ~ Vietnam and Younger Veterans were more likely to be isolated (20%) than the other client groups, and a further 8% were at risk of isolation;
- ~ Among World War II veterans 10% were isolated and 14% at risk of isolation; and
- ~ War widows had the lowest level of isolation (5%) and at risk of isolation (8%), but they were more likely to report loneliness, boredom, or unhappiness (20%). Among those at risk of isolation, war widows were most likely to be categorised as depressed.

These figures correspond closely to those reported in the results of the DVA's 1997 *Survey of Entitled Veterans, War Widows and Carers*.

Client Groups

Vietnam & Younger Veterans

Vietnam and Younger Veterans comprised 7% of the total respondents to the research. Most of them (61%) were Vietnam veterans, 26% were Korean War veterans, and 13% had participated in the Malaya conflict.

At the time of the research these respondents:

- ~ were approaching late middle age, with a mean age of 58 years (range 44-70 years);
- ~ 80% were married or living with a partner;
- ~ 16% were separated or divorced, and 4% were widowers;
- ~ 55% owned their home outright, 36% were paying it off; the remainder were living in public rental accommodation (3%), private rental (3%), or other arrangements; and
- ~ had the largest proportion of respondents living in non-metropolitan locations.

Vietnam and Younger Veterans had the highest proportion (20%) of all the groups classified as socially isolated, with 8% at risk of social isolation 28% (low social participation only). Proportionately more Vietnam and Younger Veterans than the other groups said they did not have enough social activity (30%), and 27% reported they were frequently or very frequently unhappy, bored, or lonely.

The whole thing is a shock to the system. It takes a long time to adjust to it when you come back. You can't adjust to normal life again. I try to treat it as a small event in my (army) career. I've been there and then move on to the next thing.

(Vietnam veteran - Adelaide).

Results from the research showed health status to be the dominant factor associated with social isolation in this group, particularly for those who served in Vietnam. Most of their health problems were reported to result from war experience. Changes in self-rated health had a strong association with movements into, and out, of low social participation and social isolation.

Low self-rated health and a perceived decline in social activity were also factors significantly associated with adverse consequences of unhappiness, boredom, and/or loneliness. Single veterans reported significantly higher rates of adverse consequences.

There are people who have gone to war and are shattered for the rest of their lives.

(Vietnam veteran - Melbourne)

While information about entitlements and services was adequate for the great majority of the Vietnam and Younger Veterans, this was lower than the other client groups. A relatively high proportion said they had experienced difficulty with getting information about DVA entitlements or services.

The research found that a significant proportion of Vietnam and Younger Veterans, including those who are socially isolated, want to increase their social participation. About a third overall, and three quarters of those considered isolated, said their usual social activity was not enough. Almost two thirds (63%) of the sample, the highest proportion of the client groups, said they would like to participate in more activities. A significant proportion wanted more social participation independently of their family, or to increase both family contact and other social participation.

Taking account of individual differences was seen by Vietnam and Younger Veterans as the most important element of any program to enhance social activity. Almost all (87%) of the sample thought that Vietnam and Younger Veterans have different needs to other people the same age. A variety of differences were given but most were related to health and disability resulting from war. The most frequent responses were: pain and suffering, and disability (30%), different experience (17%), psychological problems (15%), and recognition as a veteran (15%).

The biggest thing is talking to someone who's been through the experience. Other people can get so far but no closer.

(Vietnam veteran - Brisbane).

World War II Veterans

World War II veterans comprised over half the DVA treatment population in 1996. DVA statistics show that in 1996 about 55% were 75 years or older, and that approximately 20% were 80 years or more. The great majority (76%) were living in metropolitan areas or large rural centres.

World War II veterans were by far the largest group in the research study, comprising 69% of respondents. The typical profile of the World War II respondents was a man aged over 75 years, married, and living in a metropolitan area or large rural centre.

Respondents at the time of the research:

- ~ had a mean age of 76 years, with the range from 67 to 94 years;
- ~ 81% owned their home outright, 7% were paying it off;
- ~ 6% were living in public rental accommodation, 3% in private rental and 3% with family; and
- ~ 32% were living alone.

Some have wives that are looking after them and others look after their wives.

(World War II veteran with a seriously ill wife - Brisbane)

10% of World War II veterans in the research were classified as socially isolated, with another 14% at risk of social isolation, that is, they reported low social participation. In addition, 16% of World War II veterans said they did not have enough social activity, and 15% reported they were frequently or very frequently unhappy, bored, or lonely.

The research showed health status to be the main factor associated with social isolation. A decline in social activity over the previous five years, and being a man, were also significant. Older male veterans (75 years and over) were more likely to report low social participation, that is, they were more at risk of social isolation. Also, a higher proportion of single people said they did not have enough social activity and reported the adverse consequences of unhappiness, boredom, and/or loneliness.

A change in self-rated health had a strong association with movements into, and out of social isolation and low social participation.

I used to go dancing 7 nights a week before the war. Definitely the war changed me. I couldn't be bothered doing anything after the war. I'm a bit of a loner and I like to keep to myself a fair bit.

(Rural World War II veteran with diagnosed PTSD).

The research found that a significant proportion of World War II veterans, particularly those who are socially isolated, want to increase their social participation. Nearly three quarters of isolated World War II veterans said their usual social activity was not enough, and wanted more. While about a third of isolated older veterans said they were only interested in more contact with family, about 40% wanted more social participation independently of their family, or in addition to family contact.

I changed (after the war). I got cranky when I came back. Coming back into civilian life was completely different. In the war you were amongst men, the language was different. When I got home I was disappointed with life.

(World War II veteran - Sydney)

War Widows

In 1996 about a quarter of the DVA treatment population were war widows. The great majority are the widows of World War II veterans, with some widows of Vietnam and Younger Veterans. Most are quite old, DVA statistics show that more than half were 75 years or older, and over a quarter were 80 years or more. The great majority were living in metropolitan areas or large rural centres.

War widows comprised almost a quarter (24%) of the research study. The war widows have a similar age profile to the older veterans, with a mean age of 76 years (range 46 to 100 years).

At the time of the research:

- ~ 79% lived alone;
- ~ 61% owned their home outright;
- ~ 15% lived in private rental; and
- ~ 9% lived with family.

Of all the client groups, the war widows had the lowest proportion (13%) reporting low social participation, and only 5% classified as socially isolated. However, proportionately more war widows than older veterans said they were frequently or very frequently unhappy, bored, or lonely (20%).

The research showed that subjective health was the most important influence on the social participation of war widows. Two thirds of the low social participators had decreased their social activity in the past four years, with declining health the most common reason for a drop in activity. Other reasons given were old age (10%) and difficulties with transport (10%). Two thirds of the war widows had cared for their spouse before his death, and 68% of them said that their caring role had led to a decrease in social activity.

I really don't remember much about the first two years (after husband's death). I didn't want to go about and start joining things and doing things....The War Widows Guild is a place where they can be amongst like minded people in the area. Although they have different backgrounds, common interests tie them together.

(Widow of World War II veteran–Melbourne).

Lack of, or difficulties using transport, were given by 10% of the war widows as a reason for declining social activity in the past four years. This group was much less likely than the other groups to be car drivers (only 42%), and more likely to be dependent on getting lifts as passengers, public transport, and taxis. About 20% of those who were drivers had given up driving in later life, with poor health and age/loss of confidence the main reasons given. Not driving had a marked effect, particularly for low social participators, on their social activity – 60% of the low social participators who had been drivers said that stopping driving reduced their social activity a lot.

Neighbourhood and security factors impacted on the social activity of war widows more than the other client groups. The neighbourhood was a constraint on social activity for nearly half (42%) of the low social participators among widows in the research.

I'm fortunate to be in my new house. I don't want to live with other Air Force widows. I don't seem to be able to manage. I don't like asking for people. I'd prefer to have someone to call on. I need a health monitor arrangement but I can't afford it.

(Widow of World War II veteran–Adelaide).

War widows were less likely than the other groups to think they had different needs. Less than half (42%) of the sample thought that war widows have different needs to other widows the same age. Although war widows were the most socially connected of the veteran groups, they also wanted to increase their social activity. Over two thirds of the sample, including over half of those who were socially isolated, wanted to increase their social activity.

Carers

The great majority of the carers in the research were spouses (83%) and the remainder were children of the veteran or war widow. All carers interviewed lived with the person they cared for.

At the time of the research:

- ~ 61% were over 65 years of age;
- ~ 89% were female;
- ~ 83% were married;
- ~ 17% rated their health as poor/very poor;
- ~ 17% had problems with mobility; and
- ~ 11% needed help with shopping or cooking.

There were conflicting findings regarding the impact of caring responsibilities on social activity. Only 12% said their social activity had decreased as a result of taking on the caring role, 41% reported an increase, and 47% said it remained the same. However, nearly all of the sample also said that taking on the caring responsibilities restricted their life either a lot (41%) or placed some restrictions on it (47%). Over half of carers in the sample saw themselves as less active than others their age, and 39% of the sample said their social activity had decreased noticeably. The reasons given for a decline in social activity were spouse health and caring responsibilities.

Since he's become ill it's very restrictive. I try to see my friends on my own but I don't like going out at night. Our social life is visiting the hospital and the doctor.

(Wife of World War II veteran - Melbourne).

In common with the war widows, the other predominantly female group, neighbourhood and security were also important factors affecting the social participation of carers. The neighbourhood was a constraint on social activity for a third of carers in the study.

Carers appear to be the least informed of the client groups. A relatively low proportion were satisfied with the information from DVA and a high proportion had never tried to obtain information from DVA.

Almost all carers in the study said it was at least somewhat important to help carers who want to increase their social activity. Almost all respondents thought that carers have different needs to other people the same age. A variety of differences were given but most were related to the caring role.

Social isolation among carers appeared to be influenced by the nature and severity of the condition of the person needing care, as well as the health of carers themselves. Illnesses such as PTSD and dementia are particularly demanding, and they increase the chances of isolation for the carer and their family. The declining health of carers also affected their social activity.

I'm getting close to the end of my tether. I have knee problems and problems with lifting. I have to do everything and also be the man about the house.

(Carer of World War II veteran with Parkinson's disease - Perth).

Predictors of Isolation

The most important predictor of social isolation was poor health, with poor self rated health the most significant indicator of isolation. Men were more likely to be isolated than women, and isolation was associated with a decline in activity over the past five years.

Socially isolated people were identified in a diverse range of circumstances. A number of factors which might have been expected to increase the chance of isolation such as old age, living alone, or living in a rural/remote location were not significantly associated with social isolation.

The case studies, research, and focus groups consistently revealed differences of needs between the client groups:

- ~ War-related trauma was a significant isolating factor for Vietnam and Younger Veterans and their families;
- ~ Among older veterans and war widows, mobility limitations due to ill health was the major factor, followed by low social participation levels, inability to maintain their own private cars and/or difficulty using public transport;
- ~ Personal security, particularly at night, was a major constraint on social activity for war widows; and
- ~ For carers, the emotional and time pressures raised risks of isolation which can continue into their widowed years.

Information gaps were also identified as a restriction on social participation. Carers and Vietnam and Younger Veterans in particular, reported difficulties in getting adequate information from DVA. A number of service providers said there was a need for more information about DVA services and mainstream social support programs to match the particular needs of the different DVA client groups.

Changes in Isolation

An encouraging finding was that two thirds of respondents remained socially active over the four year period:

- ~ 9% had changed from a low to higher level of participation, i.e., they naturally moved out of risk of social isolation;
- ~ 9% had moved from a higher to low level of social participation; and
- ~ 15% remained at a low level.

Maintenance or improvement in the person's health status was found to be the most important factor for social participation.

Low social activity was found to have adverse consequences for well-being. Respondents who reported low social participation levels were more likely to report they were frequently bored, lonely, and/or unhappy. Respondents classified as socially isolated reported higher rates of depression.

Implications for interventions

The research indicates the importance of addressing the needs of the estimated 34,000 DVA clients who are socially isolated and the estimated 41,000 who are at risk of isolation.

The four main areas which emerged as having the most potential to enhance social networks are:

- ~ health (physical and mental);
- ~ social support;
- ~ transport; and
- ~ information.

Each of the veteran groups have specific needs under these main headings.

Health

Overcoming social isolation needs to be an integral part of a whole of Government approach. Encouraging social activity, especially through a preventive health approach, potentially can result in better health and lower use of health services.

Health professionals are in contact with almost all veterans and war widows and can therefore identify people at risk of social isolation and refer them to appropriate resources. Improving health, through preventive as well as treatment and rehabilitation programs, will enable more social participation and assist in overcoming isolation.

Social support

Programs addressing social isolation need to be tailored for the individual (in their own home setting) and for groups in a social/community setting. When programs are delivered in a

social/community setting, other issues such as transport, safety and personal confidence also need to be addressed as part of the program to ensure success.

Transport

Older veterans and war widows are increasingly giving up driving and many have difficulties using public transport. Providing transport assistance for social activity programs was seen as important, particularly in targeting existing transport resources to include people with intense social needs.

Information

Many respondents at risk of isolation reported a lack of information about DVA entitlements and services. Information campaigns to veterans can fill some of these information gaps and reinforce the importance of social activity in preventing and overcoming isolation.

A second area of information needs to be directed to health and welfare service providers, including mental health providers. They need the capacity to identify and provide referrals for people at risk of isolation, and to take account of the consequences of war-related stress for social isolation.

Future Directions

There are several levels on which DVA should consider intervention strategies.

Broad strategies

- ~ Incorporate improving social networks as an integral part of preventive health.
- ~ Build on existing programs with community development, preventive health, and social support approaches.
- ~ Work with Government to develop a new vision for health incorporating social isolation e.g., review the Victorian Social Support Strategy with the view to extension or modification for veterans; develop strategies to make the best use of transport options.

- ~ Develop all programs with a view to targeting those in most need i.e., targeting based on severity of isolation.

Key Policy Themes

Maintaining or improving health (both physical and mental) is paramount for being able to maintain social networks.

- ~ Programs need to be tailored:
 - for the individual–in their own home setting
 - for groups–in a social/community setting
- ~ When programs are tailored in a social/community setting, transport, safety and personal confidence issues need also to be addressed in context for the particular group of veterans involved.
- ~ Information regarding the Department is important in several contexts:
 - to provide the individual with knowledge on which to make lifestyle choices
 - to promote an awareness that DVA is aware of, and involved in, programs which promote health and social activity.

Specific Action Areas for Individual Gaps

Providers

- ~ enhance knowledge to enable the detection of social isolation;
- ~ develop a screening tool and clinical protocols;
- ~ raise awareness regarding the effects of social isolation to facilitate appropriate referrals;
- ~ incorporate the recognition of social isolation into contract specifications.

DVA Staff

Provide information to raise awareness of the issues around social isolation, especially the risk factors.

Younger & Vietnam Veterans

- ~ explore suitable approaches to providing this group with DVA information;
- ~ develop more mental health programs especially for trauma, substance abuse, and depression;
- ~ develop models to connect veterans e.g., mentor or buddy programs, using technology such as the Internet.

WW II veterans

- ~ use existing DVA grant programs to support people with priority needs;
- ~ develop models of integrated outreach programs from day centres, ESOs, senior citizens centres etc;
- ~ provide programs which link social support and medical support in the veteran's home situation;
- ~ develop programs incorporating technologies such as the telephone and computers to facilitate contact.

War Widows

- ~ develop mental health programs, especially for depression;
- ~ develop models for safe and confident living programs, including housing options.

Carers

- ~ explore ways to better integrate DVA carers and community carers initiatives to provide a comprehensive package;
- ~ work with ESOs to enrich social activities for this group;
- ~ consider creative respite options;
- ~ consider creative transport options for both carer and client;
- ~ conduct an information campaign regarding available resources and options.

A Staged Approach

A staged approach to the implementation of programs may be the best way to proceed. The next steps for DVA should be to:

- ~ develop an information campaign to raise the awareness of social isolation as an issue, with the veteran community and health providers. Preventive health education should be incorporated in this campaign;
- ~ modify or extend existing DVA services and programs to focus better on social isolation;
- ~ fund a wider range of new pilot projects which will provide a strong evidence base for program development. It is important to trial approaches in a variety of locations (e.g., urban and rural) as well as a variety of groups within the veteran community (e.g., Vietnam and Younger Veterans and World War II veterans);
- ~ fully compare the results from this social isolation research against the *1997 Survey of Entitled Veterans, War Widows and Carers*. An initial analysis reveals a close correlation between the levels of isolation found in this research and that of the DVA survey. The next DVA Provider Survey can reveal how knowledge and perceptions of health care professionals may differ to that of the veteran community; and
- ~ place an emphasis on monitoring and evaluation of established and new programs to ensure that support is directed to people with priority needs. An independent review could be conducted after three years to determine the overall impact of programs aimed at improving social networks.

In conclusion, this study has examined the extent and causes of social isolation in the veteran community. The optimistic message is that, in many cases, social isolation can be prevented or the adverse consequences can be lessened. A variety of responses are needed to build on (and reinforce) the natural affinities within veteran groups, and the esteem in which veterans are held by the broader public. Comprehensive action requires interlocking efforts by DVA, ESOs, and mainstream health and social service providers.

The long term aim is to raise awareness and capacities of the entire community to address social isolation. Programs addressing social isolation should be an integral part of DVA's health strategy by 1999, the International Year of Older Persons, and beyond.

Thanks to participants

The research team would like to thank all of the individual veterans, war widows, and carers who contributed to our research and case studies. We also appreciate the contribution from DVA staff (participants and organisers), representatives from ex-service organisations, and service providers to the focus groups.