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 | Isla Kuhn | Michael McGrath | Olivia Remes | Andy Cowan | Fiona Duncan | Cleo Baskin | Emily J. Oliver | David P. J. Osborn | Jennifer Dykxhoorn | Eileen Kaner | Kate Walters | James Kirkbride | Shamini Gnani | Louise Lafortune | the NIHR SPHR Public Mental Health Programme

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 & Pitch, 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
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; evaluation of the rigour of evidence in favour of one intervention quality assessment was undertaken. We therefore make no objective ing with the remit of a scoping review (Munn et al., 2018), no formaling of cost- effectiveness or economic value.

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.

### 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) |

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; Highton 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
| Author                  | Year | Stressor type                          | Interventions: Broad category | Interventions: Activity type                                                                 | Delivery: Sector; location (if not community building)                                                                 |
|-------------------------|------|---------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| 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                                                                                                 |
| 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)
| 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                                                   |
| 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                                                   |
| 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) | 2013 | 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            | 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                                        |
| Orelanna 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)
| 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                                |
| Wildman et al.  | 2019 | Over 50s deemed at risk of poor mental health and wellbeing | Direct                       | Group-based psychoeducation plus wellbeing activity                                       | CVS, volunteers and freelancers                     |
| Woods et al.    | 2016 | Caregiver burden                     | Direct                       | Group and paired: Group-based reminiscence activities (dementia dyad)                    | CVS, NHS, volunteers                                |
| 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)              |
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.

### Table 3: Study design, outcomes and effectiveness

| Author          | Intervention: Activity type | Study design          | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|-----------------|-----------------------------|-----------------------|------------------|--------------------|-------------------|---------------------------|
| Beech et al.    | **Link Worker and referral to services/asset s** | 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/asset s** | Mixed methods case study | Bespoke well-being measurement tool (baseline & 3-4 month follow-up). | Measures of self-management; Lifestyle; Work, volunteering and other activities; Money; Where you live; Family and friends. | Use of hospital resources. (Inpatient stays, A&E, outpatients) | Yes. 83% Improvements in wellbeing. (not statistically significant) (small sample) |
| Devine et al.   | **Link Worker and referral to services/asset s** | 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 |

#### 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
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 Well-being 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.

| Author          | Intervention: Activity type | Study design          | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|-----------------|-----------------------------|-----------------------|------------------|--------------------|-------------------|---------------------------|
| Elston et al.   | Link Worker and referral to services/asset s | Before-and-after study | Well-being Star™, Patient Activation Measure (PAM)®, WEMWBS, Rockwood Clinical Frailty Scale (RCFS) Rockwood et al., 2005). Statistical analyses. | (unclear how measured) | 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 |
(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? |
|--------|-----------------------------|--------------|------------------|-------------------|------------------|---------------------------|
| Moffatt et al. | **Link Worker and referral to services/asset**s | 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: wellbeing, independence, social isolation, loneliness, | N/A | Early indications (Qual) re: social contact & self-confidence |
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?                                                                 |
|--------------------|-----------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| 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. |
| Haughton 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;               | Cost–consequence and cost-utility analyses to estimate the effectiveness            | 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
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.

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**TABLE 3 (Continued)**

| Author | Intervention: Activity type | Study design | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|--------|-----------------------------|--------------|------------------|--------------------|-------------------|--------------------------|
| 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 (group and individualised mentoring) | 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 |
| 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 |
(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...
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

| 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/ca | Cost–consequence and cost-utility analyses to estimate the incremental cost per quality-adjusted life-year (QALY) | 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,                                           |
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, well-being, loneliness, or quality of life. Conversely, 10 studies using validated measures found no evidence of impact on mental health.

### Direct interventions: Individual + Group

| Author          | Intervention: Activity type | Study design                                                                 | Primary outcomes                                                                 | Secondary outcomes | Economic outcomes | Evidence of 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 (& 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 |
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

| Author | Intervention: Activity type | Study design | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|--------|-----------------------------|--------------|------------------|--------------------|-------------------|---------------------------|
| 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**

| Author | Intervention: Activity type | Study design | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|--------|-----------------------------|--------------|------------------|--------------------|-------------------|---------------------------|
| 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 |

**TABLE 3 (Continued)**

| Author | 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).
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

| Author            | Intervention: Activity type | Study design                  | Primary outcomes                                                                 | Secondary outcomes                                  | Economic outcomes | Evidence of effectiveness?                      |
|-------------------|-----------------------------|-------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------|-------------------|------------------------------------------------|
| 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 carers collected by blinded assessors at baseline, 5 and 12 months (primary end-point). | Quality of relationship for carers and | N/A | No evidence that, either: peer support, or reminiscence, is effective 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’ |

TABLE 3 (Continued)
TABLE 3 (Continued)

| Author                  | Intervention: Activity type | Study design                      | Primary outcomes                                                                 | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|-------------------------|----------------------------|-----------------------------------|----------------------------------------------------------------------------------|--------------------|-------------------|--------------------------|
| 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/social activities | Mixed methods                     | SF12 mental health component score                                                | N/A                | N/A               | Yes (qual and quant) Quant - Significant |
| 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
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.
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

| Author          | Intervention: Activity type | Study design                  | Primary outcomes                                                                 | Secondary outcomes                                                                 | Economic outcomes | Evidence of effectiveness?                  |
|-----------------|----------------------------|-------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------|--------------------------------------------|
| 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               | Implementation insights: engagement and maintaining interest, external support |
| 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 |
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
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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.

| Author | Intervention: Activity type | Study design | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|--------|-----------------------------|--------------|------------------|-------------------|------------------|--------------------------|
| 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/connessedness) | N/A | N/A | Some evidence from narratives collected re: sense of belonging |
| Woods et al. 2012 | Group-based reminiscence activities (dementia dyad) | Pragmatic Multi-Centre Randomised | Psychological distress (GHQ-28) | Carer stress, mood, relationship quality, | Service use/Eqol-5 | No evidence of effectiveness. |
| Woods et al. 2016 (NB: same study as above) | Group-based reminiscence activities (dementia dyad) | Pragmatic Multi-Centre Randomised | Psychological distress (GHQ-28) | Carer stress, mood, relationship quality, | Service use/Eqol-5 | No evidence of effectiveness. |
| 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 al.) | N/A | Yes. (well-being, self-efficacy, social networks and aspects of loneliness) Significance unclear. Insights re: improved recruitment of more at risk |

TABLE 3 (Continued)
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

| Author | Intervention: Activity type | Study design | Primary outcomes | Secondary outcomes | Economic outcomes | Evidence of effectiveness? |
|--------|-----------------------------|--------------|------------------|-------------------|------------------|---------------------------|
| 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 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: |

**TABLE 3** (Continued)
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,

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**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 |

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**FIGURE 1** PRISMA flow diagram of the selection process
was a feature of some ‘Systems’ approaches. Above, co-production engaging older adults in design and delivery interventions: 9 Direct, 1 Gateway only and 2 Connector only. As noted, they were involved in just 2 Connector interventions. Local government authorities (LA) were the next most common arrangement, with five interventions spanning different categories. National Health Service (NHS) bodies, and CVS organisations were never the most common provider of Direct community interventions. The community and voluntary sector (CVS) was involved in 11 of the 12 connector services, and as sole provider in 6 of these. In these studies, flaws in recruiting people with higher risk was a key constraint to demonstrating clear impact in some cases. In these studies, flaws in recruiting people with higher risk of services combines and facilitates access by being a constant physical reminder to professionals of the availability of complementary support. 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 understanding and then linking to a wide range of formal and informal support services. 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.

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 report 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 the interventions reviewed, however.

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 ofphysical 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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