A Moral Imperative: Invest in Eradicating Loneliness

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> *We are driven by five genetic needs: survival,*
> *love and belonging,*
> *power, freedom, and fun.*
>
> William Glasser

> *People with Disabilities Need Fewer Therapists*
> *and More Friends.*
>
> David Pitonyak

In the 21st century, we are told that individuals are more connected than ever. Is this true? We certainly have more *potential* to be connected. Friendships are the heart of living a better life (Holt-Lunstad, Smith, & Layton, 2010) and yet, studies show that having hundreds of friends or followers on social media has given rise to feelings of isolation and loneliness and increased depression and anxiety (University of Pennsylvania, 2018). To be clear, this is not a rant against social media, which also has many benefits.

My point is this: more than half of the people in the United States feel lonely on a regular basis (Cigna, 2018). In Britain, the same percentage of individuals with disabilities feel there are barriers that make it difficult for them to make and keep friends, and one in four are likely to experience loneliness on a daily basis (Sense, 2015). One-third of adults 45 and older feel lonely, according to AARP's study on loneliness and social isolation (AARP Research and GfK Custom Research, 2018). And according to the Cigna U.S. Loneliness Index, younger generations are outpacing older adults in feeling lonely and isolated (Cigna, 2018).

In a 1992 *Boston Globe* article about the dire need for flexible support for people with intellectual and developmental disabilities, as assistant commissioner at the Department of Developmental Services in Massachusetts, I gave the following quote: "Clearly the needs are far greater than we are succeeding in meeting. Our role is to provide the support that each person needs, and our support should change as a person's needs change." While services have made important strides, those words still ring true today—just as we have not made significant strides in impacting competitive employment for people with IDD, social isolation and a lack of meaningful friendships and intimate relationships significantly impacts the quality of life for too many people.

There is evidence that social networks shrink when there is functional or cognitive decline (Aartsen, Van Tilburg, Smits, & Knopscheer,

2004). The lack of closeness to others is shown to be damaging to our health. Just as social connections help a person recover when they are ill, persistent loneliness causes cognitive decline and increases the likelihood of mortality by 26 percent (Holt-Lunstad et al., 2010). Studies show that isolation is associated with increased risk of high blood pressure, developing coronary heart disease and stroke, and is as damaging as smoking 15 cigarettes a day (Holt-Lunstad et al., 2010).

The first step in making change of any kind is to recognize that there is a problem—and not just within the realm of human services. Within every community are people with disabilities who make up a fading population, which is wholly preventable. While many people with I/DD and mental health conditions are living in communities, they often do not participate fully in community life.

It is not enough for policies and funding to provide basic needs. The British government has recognized the epidemic of loneliness among its disabled citizens as well as evidence that "the loneliness they endure on a daily basis is a direct consequence of Government policy" (Shipley, 2018). In January 2018, a minister of loneliness was appointed in the UK.

As a people, we must remember that freedom, belonging, and love are among everyone's basic needs. Insurers and government budgets must treat the creating of opportunities for friendship and services that tackle loneliness as preventative measures for good health.

Such initiatives need not be dismissed as "feel good" ideas. Set outcomes. Gather data. Measure success: Do the care teams and informal networks of people with disabilities expand? Do emergency room and physician visits and 911 calls decrease?

Improving the quality of life for millions of people with IDD is very achievable. Tragically, there is little incentive to invest in policy and programs that will truly affect change on this issue because that change is unlikely to be immediate.

Loneliness contributes to the annual costs of major depressive disorder, suicide, and addiction ($960 billion), as calculated by the Centers for Disease Control and the National Institute of Mental Health (The Cost of Loneliness, 2018).

As science shows the negative health effects of loneliness, healthcare dollars must be allocated to cover the costs of what is shown to ease loneliness. Assistive technology has been shown to be beneficial for 37 percent of non-elderly adults with disabilities (Kaye, Yeager, & Reed, n.d.).

To turn the growing tide of loneliness, healthcare providers and community-based human service organizations would do well to integrate the principles of the person-centered planning, circle of supports, and supported decision-making in the creation of the person's care plan. Who would an individual call if they had a problem in the middle of the night? Who would that person call to share good news? To ensure success, this approach should be flexible, innovative, and grounded in community.

The challenge of social isolation is particularly acute for people with IDD and mental health conditions. As a society we should not remain complacent when nearly 50% of people with disabilities say they are lonely on any given day (Campaign to End Loneliness, n.d.). We all need support in order to make connections and live a full life. With the dramatic growth of managed care across the country and with more and more research connecting loneliness and isolation to increased physical health and behavioral health costs, we must not miss the opportunity to take aggressive action to combat isolation.

Using the person-centered planning process as the framework, people should be supported to have a goal(s), if they so choose, in their care plan around enhancing friendships and more intimate relationships. This should also include strategies, resources, and how outcomes, as identified by the person, will be monitored. Many commercial health plans offer robust wellness programs as one strategy to improve members' health and reduce most costly health care expenditures. This could serve as a model for the creation of initiatives to respond to and prevent social isolation.

We must simply decide that not taking aggressive action is unacceptable and that taking action is good use of public dollars, good for state developmental services agencies, good for Medicaid agencies, good for managed care entities, good for the community and, most importantly, good for people.

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