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Scoping Review of Interventions to Address Social Isolation and Loneliness among People Experiencing Homelessness

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Abstract

Social isolation and loneliness are linked to adverse health outcomes and premature death, especially for persons experiencing homelessness (PEH). There is an urgent need to reduce these conditions in PEH, but evidence on effective interventions is lacking. This scoping review examined studies investigating interventions to address social isolation or loneliness among PEH. We conducted a comprehensive search of health sciences databases for quantitative and qualitative studies published by June 6, 2025. Eligible studies were English-language, peer-reviewed, original research examining interventions for social isolation and loneliness among PEH. Two reviewers screened titles, abstracts, full texts, and extracted study details from included articles. We reviewed 1408 records of which 50 underwent full-text review. Of these, 6 were included in the final review including 3 quantitative, 2 qualitative, and 1 mixed-method studies. All studies were conducted in Europe or North America. Most studies included group-based interventions with small sample sizes and did not investigate social isolation or loneliness as a primary outcome. The only randomized-controlled trial found that a Housing First intervention did not reduce loneliness, indicating that providing housing alone might be insufficient to reduce isolation or loneliness, however, group-based interventions showed promise for reducing these conditions. This review is the first to investigate evidence for interventions to address social isolation and loneliness in PEH. More studies are needed in non-Western locations, with larger sample sizes, and greater uniformity in measurement of social isolation and loneliness as primary outcomes to advance responsive and effective interventions among PEH.

Introduction

Social isolation and loneliness (SIL) have been linked to adverse physical, mental, and social health outcomes as well as premature death [1–3]. Increasingly, isolation permeates every domain of life, from work to leisure, including rising individualism fueled by online technologies, economic hardship leading to overwork and stress, mental health challenges, and shrinking communal spaces, trends that predated but were intensified by the COVID-19 pandemic [4]. People experiencing homelessness (PEH) face the same societal forces driving increased SIL, but at higher rates than the general population [5, 6].

Two scoping reviews by Lachaud, et al., (2024) and Cummings et al. (2022) describe additional risks to SIL among PEH. These risks include social exclusion, as PEH are often denied full participation in the economic, social, and political life of their society [5]. Further, they are often cut off from family or friends, limiting critical social network membership, which may contribute to becoming homeless[7, 8]. PEH also face discrimination and stigma that can reduce opportunities to be or feel connected to others [5, 8]. Further, PEH are more likely to lack access to cellphones and experience service disruption, which further increases their risk for SIL [9–11].

In addition to the adverse outcomes associated with SIL, persons experiencing homelessness (PEH) have higher rates of chronic illness, accidents, disability, psychiatric, and substance use disorders [12], contributing to 4–6 times greater likelihood of illness, hospitalization, and premature mortality among unhoused persons [13]. These health conditions can decrease mobility, stamina, and communication capacity, making it difficult to nurture relationships and increasing vulnerability to SIL. In turn, SIL among PEH may further complicate engagement in care and recovery [14], potentially contributing to mutually reinforcing interactions between health and social challenges.

Interventions for Social Isolation and Loneliness

Evidence-based interventions to address SIL in general populations, especially among older adults, have proliferated in recent years. Interventions include community-based programs such as group exercise, social clubs, and

volunteer opportunities [15]; psychological therapies such as cognitive-behavioral therapy, mindfulness practices, and group therapy; technology-based interventions such as video calls, social media, and phone-based companionship programs; and health education and support groups and peer support networks [15–17]. Whether interventions effective at reducing SIL in other populations are transferable to persons experiencing homelessness, or whether they have limited impact due to structural and contextual factors unique to this population, remains poorly understood, underscoring the need for further investigation.

Rationale for scoping review.

Given the prevalence and dire consequences of SIL among PEH, there is an urgent need to explore and apply innovative and effective models that address SIL in this population. Yet, evidence is lacking about interventions that specifically address SIL among PEH. Our objective in this study was to identify and synthesize evidence related to this question: **What is the evidence for interventions to address social isolation and loneliness among persons experiencing homelessness?**

Methods

Design

This review is guided by the scoping review design developed by Arksey and O'Malley [18] and Levac, Colquhoun, and O'Brien [19], and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA ScR) [20]. It was conducted with the assistance of a librarian and co-author (EL).

Selection criteria and definitions

For inclusion criteria, studies had to be English-only, peer-reviewed, original research that investigated interventions for social isolation, loneliness, social disconnection, and/or social connection. We included quantitative and qualitative studies. For exclusion criteria, we excluded systematic and scoping reviews, comments, editorials, and letters. We excluded studies that did not include PEH as a target population. Studies that investigated social networks, social support, and/or social integration were excluded if they did not explicitly evaluate social isolation, loneliness, or social disconnection. Definitions: We defined participants as PEH if they were unhoused or lacked stable housing at the start of the published study. We defined social isolation, loneliness, social disconnection, and/or social connection based on the explicit mention of these terms in the articles.

Search strategy

Databases searched included: Ovid MEDLINE, CINAHL, SocINDEX, and Scopus. Search terms included (Medline): ("social* isolat*" OR "social* depriv*" OR "social* connected*" OR "social* exclu*" OR "psychosocial deprivation" OR loneliness OR "social support" OR "social circumstances" OR "psychosocial support").ab,ti. OR Social Isolation/ OR Social Support/ OR Community Support/ OR Family Support OR Psychosocial Support Systems/) AND ((homeless* OR unhoused OR ill-housed).ab,ti. OR Ill-Housed Persons/ OR Homeless Youth/. The initial search was conducted on July 31, 2024, and an updated search was conducted on June 6, 2025.

Review strategy

In our screening process, we imported our search into the Covidence systematic review software (EL). After removing duplicate articles, two researchers (MS, MM) independently screened the abstracts for inclusion. Two researchers (MS, MM) independently reviewed the abstracts for full-text review. At all stages, differences in voting

were discussed and resolved in meetings. For data extraction, we extracted main-intervention characteristics, research questions, participant characteristics, measurements, and findings of the selected studies in an Excel database file created by the two researchers (MS and MM) and reviewed by the librarian (EL). For data synthesis, we included quantitative, qualitative, and mixed method research studies to provide the full range of evidence around topics of interest.

Results

Search and study selection process

There were 2,219 records initially identified through the database search. Of these, we removed 811 duplicate articles. Of the remaining 1,408 studies screened, we removed 1,358 for not being relevant to this review. Of the remaining 50 articles that underwent full-text review, we excluded 44 for the following reasons: wrong study design (17), wrong outcomes (11), wrong patient population (9), not a research article (4), and not a relevant intervention (3). We included six articles for the scoping review (3 quantitative, 2 qualitative, and 1 mixed-methods article). The PRISMA Flowsheet is shown in Fig. 1.

Figure 1 PRISMA flow diagram of study selection for the scoping review on interventions to address social isolation or loneliness among persons experiencing homelessness.

Study characteristics

The six included studies were published between 1995 and 2023. Studies were based in five different countries across North American and Western Europe. Most studies did not explicitly focus on addressing SIL. Included study interventions, populations, locations, SIL measurements, and key outcomes are detailed and summarized in Table 1.

Quantitative studies

The three quantitative studies in this review include one randomized-controlled trial [21] and two quasi-experimental studies [22, 23] occurring between 1995 and 2021.

Interventions in the quantitative studies included a Housing First (HF) model with multidisciplinary services by Campo Ferreiro et al., who compared this intervention to treatment as usual (TAU) over a 21-month period [21]. Lloyd-Cobb & Dixon evaluated a program using intensive group and individual therapy to improve social skills at a time-limited residential program over a three-month period. No comparison group was included in this study [23]. McWhirter evaluated weekly 90-minute groups teaching cognitive behavioral and Gestalt therapeutic techniques over a five-week period. The comparison group was offered an employee-mentoring and job skills program of unknown duration [22].

Quantitative study locations included Barcelona, Spain [21], Arizona, USA [23], and Georgia, USA [22].

Quantitative study populations included 87 participants with concurrent mental health and/or substance use needs who had or could achieve stable income in Ferriero et al. assigned to HF (n = 46) or TAU (n = 41) [21]. Participants were mostly male (HF 84.8%, TAU 82.9%) and middle aged (HF mean age 50.25, TAU mean age 50.51) and from Europe, Asia, Africa, and South America. Participants in Lloyd-Cobb et al., (1995) included 9 male U.S. military veterans (mean age 42.6) without active psychiatric problems and with potential for psychosocial rehabilitation. Though participants had to abstain from using substances for at least 30 days, all participants reported that substance use was a problem for them. McWhirter et al. (2006) enrolled 68 women experiencing major life

transitions. In the intervention group (n = 37), participants had to have been staying in a homeless shelter for at least 90 days. No such requirement was made for the comparison group (n = 31). McWhirter mentions the women in the comparison group were more stably housed, but there is no quantitative data on their housing status. Participants in the intervention group were younger (median age 32) and more racially diverse (51.4% White, 27% Latina, 13.5% Black, 8% Native American), whereas the comparison group was older (median age 51), was mostly White (90.3% White, 6.5% Black, 3.2% Latina), and had completed more education (McWhirter, 2006).

Measurements of SIL in the quantitative studies included, in Campo Ferreiro et al., loneliness as assessed with item number 14 from the Camberwell Assessment of Need Spanish version[24]; loneliness as assessed with the Revised UCLA Loneliness Scale [25] in Lloyd-Cobb and Dixon et al, and social isolation assessed with a single item in the Quality of Social Support Scales in McWhirter et al. [26].

Quantitative study outcomes included no statistically significant difference in loneliness between the HF and TAU groups at 8 months ($\chi^2 = 1.352$, $p = 0.509$) or 21 months ($\chi^2 = 0.366$, $p = 0.833$) in Campo Ferreiro et al. Lloyd-Cobb and Dixon found a statistically significant improvement in loneliness after 3 months of the program ($t(8) = 2.3$, $p < 0.025$). McWhirter found a significant reduction in social isolation in both the intervention and comparison groups over time ($F = 71.18$, $p < .001$) with a greater reduction in isolation found in the comparison group ($F = 9.96$, $p < 0.01$).

Qualitative and mixed method studies

Two qualitative studies [27, 28] and one mixed-method (quantitative and qualitative) study using a one-group, within-subjects design [29] occurred between 2009 and 2023.

Qualitative and mixed method interventions included, by Malden et al. (2019), a community-based program that offered group exercise classes and peer support meetings. Manzana et al. (2023) evaluated a program offering ten 2-hour open-ended group meetings held over a 4-month period. Though the meetings were described as open ended, a psychologist-facilitator ran these and decided their topics based off the needs of the participants and the relationships established between them. Stewart et al. (2009) studied an intervention consisting of four sessions lasting 3–4 hours over an approximately 5-month period. “Professional mentors,” who were either social workers, psychologists, or therapists, facilitated the support groups. The sessions included recreational activities and a free meal. During the recreational activities, participants could approach either professional mentors or “peer mentors” (youths with a history of homelessness that could serve as role models) for support.

Qualitative and mixed method study locations included Edinburgh, Scotland [27], Northern Italy [28], and Edmonton, Alberta, Canada[29].

Qualitative and mixed method study populations included, in Malden et al., (2019), homeless participants who had attended at least 10 sessions of Street Fit Scotland (n = 10, five male and five female, ages 21–36)[27]. Marzana et al. (2023) enrolled women, aged 20 to 64, staying at a shelter in an urban area located in the northern part of Italy (n = 13). Only four of the women in the study were native Italians, with the rest from nine other countries spread across several continents, and nine of the women had children[28]. Stewart et al. enrolled youths between the ages of 16 and 24 with a mean age of 19. Of note, 60% of the participants were described as “Aboriginals" or Canadian Indigenous Peoples. The authors attributed this elevated rate to the high proportion of Indigenous Canadians experiencing homelessness in Edmonton, Canada [29].

Measurements of SIL in the qualitative and mixed method studies included social isolation as assessed by Marzana et al. (2023) using reflexive thematic analyses of semi-structured qualitative interviews and group meetings. Malden

et al. (2014) applied thematic analysis to semi-structured interviews. Stewart et al. assessed loneliness and isolation quantitatively using the Revised UCLA Loneliness Scale and qualitatively applying qualitative descriptive analysis to interview data.

Qualitative and mixed method study outcomes included, in Malden et al. (2014), that participants reported less social isolation after taking part in Street Fit Scotland. Manzana et al. found that participants felt more socially connected with each other and less lonely after taking part in the group meetings. Participants in Stewart et al. reported that the intervention decreased loneliness and a sense of isolation. Further, the intervention was associated with a decrease in loneliness as assessed by the Revised UCLA Loneliness Scale (F = 4.6 [2, 2.6]; p = 0.04). Participants (See Table 1 for a summary description of included studies.)

[Table 1 Summary Of Quantitative, Qualitative, And Mixed-Methods Intervention Studies (n = 6)]

Discussion

To our knowledge, this scoping review is the first to examine interventions to address SIL among PEH. Even though homelessness and social isolation are widespread, international problems [30], we found only six studies meeting our inclusion criteria, and all of these were conducted either in North America or Europe.

Though we employed a broad search strategy, the evidence base for interventions to address SIL among PEH is sparse. Five of the six studies used group-based interventions and enrolled few participants, and most of the studies assessed SIL only as one of many outcomes instead of as the primary outcome. Across studies there was considerable heterogeneity in populations, methodological approaches, measures of SIL, and interventions for SIL. Moreover, the absence of appropriate control groups in the five group-based studies limits generalizability.

Overall, our review demonstrates a need for more research on how to address SIL in PEH with larger more rigorous studies that include more diverse participants, randomized designs, and consistent, validated measurements for SIL to investigate which strategies are effective for reducing SIL among PEH [31].

While few studies met our search criteria, our review yields insight into which interventions might be successful for reducing SIL in PEH. Interestingly, the only randomized controlled study showed that providing housing did not reduce SIL. One possible reason for this finding is that the participants in the Campo Ferreiro et al. (2021) study had concurrent mental health and/or substance use needs, which are estimated to affect up to 67% and 44% of PEH respectively [32]. These factors could have blunted the beneficial impact of housing for SIL. This finding is also consistent with other research showing that housing stability is not associated with a reduction in loneliness [33]. In fact, a transition to permanent housing may paradoxically lead to more isolation[34] with disproportionate impact on different racial and ethnic groups [7].

Though housing on its own might not reduce SIL, this review points to promising interventions that could potentially decrease SIL. Notably, even interventions that were not explicitly designed for SIL were found to benefit participants, especially those that integrated peer-led formats, structured group interaction, and the sharing of personal experiences. Many of the group interventions in our review have been shown to reduce SIL in other populations including exercise groups [35, 36], group therapy, social skills training, mentoring, and cognitive-behavioral techniques[37]. We speculate that the camaraderie fostered by these group-based interventions likely improved SIL in a manner akin to what has been shown in other populations [38, 39] Such group-based interventions might also increase the number of weak social ties for participants, which previous research has shown is associated with a reduction in loneliness [40].

Strengths and limitations

Our review has several limitations. There is a possibility we missed or omitted publications despite a robust and systematic search strategy. We limited our review to English-only articles, so relevant publications in other languages might have been missed. This review adopted a restrictive definition of PEH to focus on unhoused persons. As such, we may have omitted relevant SIL literature for populations experiencing a broader definition of housing insecurity.

Conclusions

Despite these limitations, our findings offer a strong foundation for future research. First, we demonstrate that interventions to address SIL among PEH is a problem of global concern and more research is needed in non-Western populations. Indeed, populations in southern hemisphere low-income nations may face the greatest levels of loneliness [41]. Second, housing on its own will not improve SIL for PEH, and interventions specifically addressing SIL are necessary. Third, more studies are needed that explicitly target SIL as a primary outcome. Consistency in how SIL outcomes are defined and measured across settings and populations would enhance comparability and strengthen the evidence base. Finally, our results suggest that certain group-based interventions might reduce SIL for PEH, and these should be investigated in better-designed studies in more diverse populations.

In conclusion, social isolation and loneliness are a growing public health concern whose consequences are disproportionately borne by persons experiencing homelessness. By mapping what is known and what remains unexplored in interventions address these conditions in PEH, we provide insights and amplify the call to develop effective, responsive, and equitable approaches for reducing social isolation and loneliness in this population that is most vulnerable to their harms.

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Tables

Table 1 is available in the Supplementary Files section.

Figures

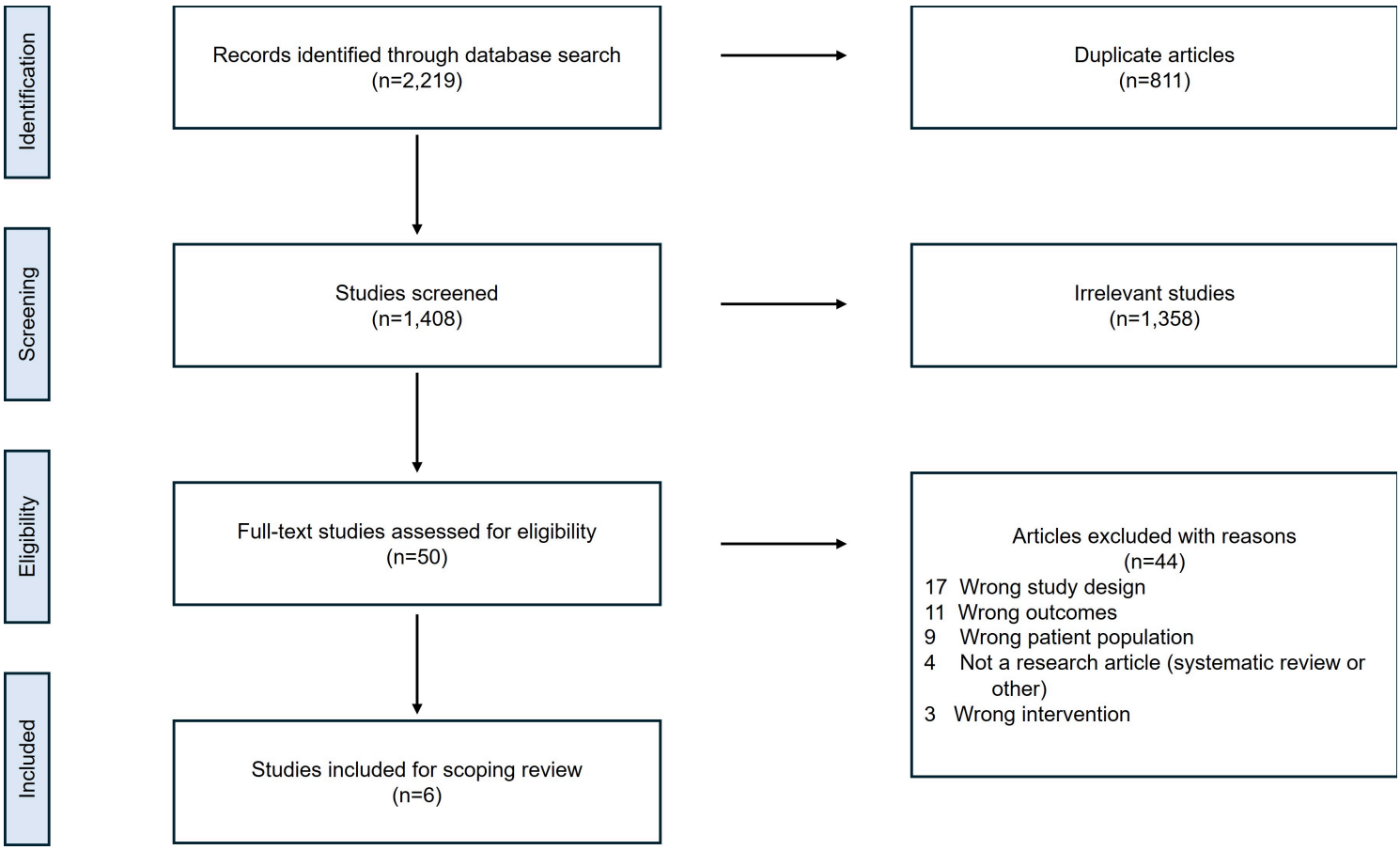


Figure 1

PRISMA flow diagram of study selection for the scoping review on interventions to address social isolation or loneliness among persons experiencing homelessness.

Supplementary Files

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- Table1SILinPEHJUH.docx