ScotPHN report

Scottish Public Health Network

Social Isolation & Loneliness: What is the Scope for Public Health Action?

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Foreword

Loneliness is a newly recognised and important factor in filling out our picture about what it is to be healthy and well.

For some time, the WHO definition of health has encompassed three dimensions - physical, mental and social. The experience and impact of loneliness, and the more relational community-focussed term ‘social isolation’ has been a relatively late arrival on the public health scene.

This briefing suggests that the relevant literature has emerged only in the past 20 years; it is descriptive and helpful for designing and targeting approaches, but limited on firm guidance toward interventions that are probably effective. Nonetheless, there is action that we can take.

There is the backdrop of inequalities; having or lacking the means to cope and mitigate the effects of loneliness. We should not underestimate these factors. But there are strong pointers toward community-driven and designed approaches rather than top-down large-population interventions, case-finding through local sharing of intelligence, help through shared experience and empathy rather than resorting rapidly to more formal and professional assessment and support.

The report contains many points that question assumptions – loneliness occurs through the life-course, and not just amongst older age groups; it is a dimension of major life events, longer-term conditions and effects of disability and is just as important to address as other dimensions of wellbeing; we can design neighbourhoods and local arrangements to lower the chances of social isolation.

And we are grateful to voluntary sector colleagues across Scotland, not least the British Red Cross and VHS, for leading and collaborating on advocacy; to public health colleagues in NHS Highland and NHS Health Scotland for source text and shared experiences in addressing loneliness.

Loneliness is an important consequence of life - some might say it is one end of a spectrum of normal modern life. But loneliness is a state of existence that undermines quality of life at vulnerable times, and healthy life expectancy, and we can take practical public health approaches to prevent, minimise and mitigate it.

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1 Background

Over the past two decades there has been a growing, international research literature that has explored the phenomenon of social isolation and loneliness. This research has mapped the growing "epidemic" of social isolation and loneliness, explored how it may be caused, and what can be done to reduce the lived experience of being socially unconnected. However, it is the links which have been made in such research to the associations between social isolation, loneliness, and poor health outcomes which have given rise to the identification of social isolation and loneliness as a "public health issue", with the prevention of social isolation and loneliness being seen to have the potential to be a modifiable risk factor for non-communicable disease and loss of wellbeing.

However, whilst there is evidence that social isolation and loneliness is a challenge to public health, work is still needed to characterise the public health response to this challenge. In this short document we explore some of the potential areas for public health action to begin addressing social isolation and loneliness. In doing so we consider:

- how social isolation and loneliness can be defined;
- what are the characteristics of people experiencing loneliness and social isolation; and
- the scope for public health action likely to be needed to move forward in creating greater social connectedness and reducing loneliness.

2 Defining Social Isolation and Loneliness

Understanding who are the socially isolated and lonely within the wider population is an essential pre-requisite for Public Health Action.

Whilst there is no single, universally accepted definition set, it is generally agreed that social isolation and loneliness are not the same phenomenon. Definitions of social isolation tend to focus on the lack of social structures and social interaction/contact with other people, whereas loneliness is subjectively experienced by someone who feels the lack of intimate, supporting, or nurturing relationships with others. This creates the situations where individuals can be socially isolated without being lonely or a socially connected individual who does experience loneliness.

In 2003 Public Health England identified a three-fold definition of social isolation, loneliness, and social inaction[(1)]:

- ***Social isolation*** – characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures;
- ***Loneliness*** – characterised as an individual's personal, subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed; and

- ***Social inaction*** – characterised as a state where individuals choose to , or feel unable to, take part in social action and are disconnected from concepts of 'we-ness' and civic society.

How each of these can be operationalised in a systematic manner is itself a topic for academic study. The tendency has been to use specifically developed social indices for social isolation and for loneliness as a means of describing populations. A recent review by researchers at York and Newcastle Universities has provided a useful means of classifying such instruments and provides a useful introduction to such instruments.[2]

3 The characteristics of people experiencing loneliness and social isolation

The majority of the information which helps describe those who are experiencing either social isolation and/or loneliness is derived from research studies and from systematic reviews, some of them dating back to the late 1990s[a].

A selective review of this literature suggests that those most likely to experience social isolation and/or loneliness include those with a range of health issues, including those experiencing mental health issues, people with physical disabilities or limited mobility, and those who have generally "poor" health. Social risk factors include: mothers of young children (especially if in the 18-24 age group); moving into retirement and old age; and being an informal carer. Those who are financially insecure or experiencing socio-economic are also likely to be at risk of socially isolated.

Loneliness itself has been found to be a predictor of higher than average frequency of visits to a GP and has been associated with poorer health outcomes and higher all-cause mortality[3]. Its effect on cardiovascular health has been likened to the equivalent of smoking 15 cigarettes a day.[4] Poor mental health is also related to loneliness, although the association between the two may be co-related[5].

The positive relationship between social isolation, loneliness and age is clear. However, they are also associated with a variety of significant life events across the life course. One of the key factors seems to be a change in an individual's life circumstances which can interact with their personal sense of identity. Associations have been observed following bereavement, becoming a new mother, taking retirement or becoming unemployed, and divorce or the break-up of a long-term relationship.[6] Chronic loneliness can bring about a perceived lack of something to offer, which impacts further on self-worth and the ability to make new or pick up old social connections.[6]

[a] An internal briefing, providing further background on the policy context and descriptive epidemiology, has been produced by NHS Health Scotland. This is available on request to ScotPHN.

Income, education and employment will also act as risk factors for loneliness as they shape lifestyles.[5] While the 2004 English Longitudinal Study of Ageing noted that there were pronounced inequalities in levels of loneliness in older people aged 52-59, those in the lowest economic quintile reported much higher levels of loneliness compared to those in the second lowest.[7] In Scotland, Go Well also found that those who were unemployed due to long-term health conditions suffered from greater loneliness.[5] Those areas experiencing higher levels of deprivation also tend to have fewer facilities to which people can have access for social activities. There is an inequalities aspect to loneliness arising from lack of finances to get out, to use transport or to undertake activities which may cost money.

The impact of poor social connectedness in creating social isolation and/ or loneliness has been established in the literature. Data from Age UK and Go Well[5,8] suggests that nearly 1 in 5 (18%) of people who were socially isolated had limited regular neighbourhood contact, 1 in 17 (6%) had contact with family friends or neighbours less than 1 or 2 times a week, and nearly 1 in 8 (13%) said they had had fewer than three people they could turn to in a personal crisis.

Estimates of social isolation vary greatly, reflecting the differences in instruments used or reporting techniques adopted within studies. Public Health England, using data from the 2011 Census for England and Wales, estimate that the prevalence of social isolation for those aged 18 to 64 years is 7%, whilst for the 65 years and older group it gives a range estimate between 11% and 20%[1]. In Scotland the Lonely Society report[9] suggests that 49% of Scottish adults have felt lonely, with 11% describing themselves as “often lonely” and 38% “sometimes lonely”.

4 The scope for public health action

Whilst the recent literature has commented widely on social isolation and/or loneliness being a public health issue, there is relatively modest evidence for population-based interventions that could prevent or reduce loneliness and social isolation.[10] What evidence that does exist tends to focus on older people. This tends to reinforce the misconception that loneliness is a problem for older people alone.[6] Such misconceptions may also underlie the view that public health action is likely to focus on seeking to use lifestyle group interventions as a means of increasing social interaction and achieving loneliness reduction as a co-benefit. [11]

A more careful consideration of the evidence suggests that there is much that the specialist Public Health and Health Promotion functions could do to address social isolation and loneliness both nationally and locally. These actions can be identified as:

- creating more robust data on social isolation and loneliness;
- being advocates to raise awareness of the problem of social isolation, loneliness, and their consequences;

- facilitating the identification of those already experiencing social isolation and at risk of loneliness; and
- supporting the development of a system-wide approach between Local Authorities, Primary and Community Care and Mental Health services, and the Third Sector.

Creating more robust data

As noted above, there are difficulties with identifying and measuring social isolation and loneliness. In part this is due to the lack of a nationally agreed and validated agreed set of instruments that could be used to measure social isolation and loneliness.[10] Even were such an agreed set of instruments in place, at present there is no mechanism to routinely collect, collate, analyse and publish such data. This gap means that any we have to rely on specific data collection exercises that – if the research literature is anything to go by – tend to be based on small samples of the population form which it is difficult to generate robust population estimates. Such an approach is also prone to bias due to the stigma that is reported to exist across all population groups in admitting to loneliness.[6]

Public Health Action

Public Health in Scotland could lead the work needed to establish a core set of nationally acceptable instruments with which to measure social isolation and loneliness and identify the mechanism(s) by which such data could be routinely collected, collated, analysed and published.

Being advocates to raise awareness

Since the 2015 Public Health Review for Scotland, the Public Health community is re-energising its role as advocates for the health of Scotland's people. Being advocates to raising awareness around social isolation and loneliness both nationally and locally would address two issues:

I. the public perception that social isolation and/or loneliness is something that *only* affects older people.[6] Public health advocacy would help clarify that while social isolation and loneliness may have a specific impact on older people due to the way in which it interacts with reduced mobility or lower levels of general health, they can and do affect all parts of Scottish society, with potential consequences for the mental and physical health of those who experience social isolation or loneliness; and

II. the perception amongst those affected by loneliness or social isolation that there is nothing that that can be done and therefore have a poor awareness of the support that may already be available.[6,10] This is a "classic" access problem for which Public Health has a wealth of insight and experience to bring to bear, not least of which is in relation to advocating for existing approaches to the person-centred approach to health and social care to become competent to deal with issues of social isolation or loneliness.

Public Health Action

Public Health in Scotland needs to find its advocacy voice to raise awareness around aspects of social isolation and / or loneliness. Being thoughtful about how existing approaches need to be able to address the issues that are created by a lack of social connection should be at the heart of such advocacy.

Facilitating the identification of those socially isolated

Given the way in which social isolation can affect a very broad range of people and situations, more attention needs to be paid to how we can make best use of the health, social and community service workforces that come into contact with people to help identify those experiencing social isolation and loneliness. However, we have to recognise that such "asks" increase the burden on front-line teams. If we are to seek to use primary and community health care staff and the social care and community service workforce to help to identify those most at risk, we will have to develop the types of systems that make such identification and – where necessary – onward referral for service and support – straight-forward and reliable. Focusing on points of transition and identity change and offering support at these times may be a preventative for loneliness and worsening mental and physical health.[6]

Public Health Action

Public Health in Scotland could help develop approaches that help front-line service staff identify those experiencing social isolation and loneliness, or those who are at risk. Helping to integrate such identification into onward pathways for support services would need to occur.

Supporting the development of a system-wide approach

A key request from those experiencing social isolation or loneliness is for services to be reliable and sustainable with a pathway that moves forward from identification, into an initial service, and then onto reintegration and social connection.[3] Such a pathway will require that there is effective collaboration between the key partners in local Integration Joint Boards and Community Planning Partnerships that bring together Local Authorities, Primary and Community Care and Mental Health Services, and the Third Sector. However, just as there is no single way into social isolation and becoming lonely, there is no one, ideal pathway out that will effect social connection.

As may be expected, the literature on "the problem of social isolation" is much broader that that on "what works to reduce social isolation". Evaluations of the impact of interventions to reduce or eliminate social isolation and loneliness interventions, such as the one undertaken by University of Lancaster for the Men in Sheds initiative [12], remain the exception. Where programmes have recorded benefit, they tend to have been either run at a small scale in one town or area, making work on an individual level or for small scale community.[3] Suggestions of approaches that might provide benefit include befriending, social prescribing (for lifestyle risk factors), or group work approaches.

All of which suggests that Public Health may have a crucial role in helping interpret the limited evidence-base to help create the necessary system-wide approach to addressing social isolation and loneliness.

The starting point for any system-wide response is most likely to focus on the identification of social isolation and/or loneliness. Using the social, economic and life circumstances that can act as "triggers" for entering social isolation and experiencing loneliness, it is possible to set out an approach that naturally lends itself to the establishment of a tiered preventative framework for service objectives, reflecting the differing circumstances for the individual.

These can focus on: [3, 6, 8]

- ***Preventative support*** – preventing people before becoming chronically socially isolated or experiencing loneliness (primary prevention);
- ***Responsive support*** – preventing developing chronic social isolation or loneliness following one of the known "triggers" (secondary prevention); and
- ***Restorative support*** – preventing those who are chronically lonely and socially isolated from experiencing poor social or health outcomes (tertiary prevention).

System wide approaches to services that can provide such types of support are described in the literature as tending to focus on interventions that provide individual support, community connection, and structural changes. To achieve this, we can add the need for local planning that can deliver such an approach.

Individual support

One of the mainstays of individual support services are Befriending schemes. These can work either as one to one visits by various types of volunteers or by phone calls. A study conducted by Windle *et al* [13] estimated that a befriending scheme costing £80 per person resulted in £300 pound savings per person per year. Such schemes are not, however, a universal panacea. For example, older people in particular do not want to be seen as a burden which can make such one to one schemes less effective.[10] It is important that these schemes when planned take into account barriers or possible stigma that may already have produced the original loneliness and work around this.[8,10]

Community connection

Participation in specific group and community based schemes can allow people to forge new relationships or to become more integrated into their community. Volunteering has been seen as particularly beneficial as it is peer-led and allows lonely people the chance to connect with people who have "been in the same boat" and also to give something back which is felt to be important.[6] If such schemes are seeking to reduce social isolation and loneliness as a co-benefit, care is needed to ensure that this is a realisable outcome.

Structural change

Opportunities exist for redefining approaches to accommodation and shared living. Converting buildings into shared residence for older people or creating housing schemes that co-locate housing for younger people and families alongside provision for older people are all being actively explored as a means of creating life-long housing arrangements. More broadly, approaches to reintegrating people within the immediate built environment so that neighbourhood and streets are redesigned with older people and children in mind. Approaches which provide more places to cross the road, more toilets, less traffic, outdoor seating and, greater walkability may all provide not only better physical activity and preserve mobility, they may also prevent the loss of social connection.[3,5] Transport is a frequent problem for rural areas, but also for areas of deprivation where people cannot afford transport frequently or it does not run often enough or does not link up with other services to enable them to move around.[5] Structural change that supports social connectedness by reducing transport problems may have an impact on reducing the loss of social connection and present social isolation. Employability and promoting financial resilience is also a major component in achieving and sustaining structural change which supports individuals and communities. Effective action in this area may see reduction in social isolation as a co-benefit.

Planning for a system-wide approach

Whilst work on social isolation and loneliness has been a feature of public health work in Scotland over the past few years, the publication of the NHS Highland's DPH Annual Report on Social Isolation and Loneliness [14] is the first articulation of a framework for Public Health that recognises the problem and proposes ways to tackle it, focusing on increased social interaction, particularly for older people. The NHS Highland approach puts joint working across health and social care at the heart of what is needed; however, it is notable in that is also recognises that the idea that a "top-down" population-wide strategy is unlikely to have an impact. It is also possible that rather than imposing a strategy, amending existing strategies may prove a fruitful way of making more rapid changes that could impact on loneliness or social isolation.

Clearly local planning between the NHS, the Local Authority, and the Third Sector, especially in the context of the integration arrangements for the area, will be important. However, a key concern will be to encourage partners to work together to ensure there is no duplication of local programmes / projects for the support of those who are isolated or lonely.[3]

Given the nature of social isolation and the links to approaches that improve community connection and effect structural change, there are potential opportunities for more community focussed, local planning undertaken with the framework set out by the Community Empowerment Act (2015). Such an approach could provide a more flexible and community focused approach that is more responsive to meeting local needs. By mapping those service and community assets already available to a particular community, and linking in community plans to deliver social connectedness outcomes, it may be more possible to drive forward services that support individuals, connect the community, and bring about structural changes in housing, transport, employability and financial resilience

that help prevent social isolation. Given that Public Health benefits that are seen to be an essential component of Local Improvement and Outcome Plans, there are opportunities for local Public Health teams to facilitate the co-production of such approaches.

Public Health Action
Public Health in Scotland should be an essential partner in helping integrated, local planning and service delivery arrangements develop an approach to providing preventative, responsive, and restorative support in a way that supports individuals, connects communities, and facilitates structural change that will reduce social isolation and loneliness.

5 Conclusion

In September 2016 the Scottish Summit on Social Isolation concluded with the Scottish Government pledging to create a national social isolation strategy in response to calls for action from a range of Third Sector organisations. The publication of the new strategy, along with the sort of local policies developed by NHS Highland, will re-emphasise that these are public health issues and seek to set out ways in which recognition of the problem leads to actions that increase social connection and reduce social isolation and loneliness.

How the Public Health system in Scotland can work to help prevent social isolation and loneliness may not require a “traditional” public health response, but there is clearly much we can do to address the issue nationally and locally.

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