The Campaign to End Loneliness is delighted to feed into the Committee’s inquiry on the vital issue of age and social isolation. Below we offer some thoughts on the issues raised in the committee’s call for evidence. These comments focus on the experience of loneliness among older people as that is the Campaign to End Loneliness’ primary focus.

**Prevalence of social isolation in urban and rural settings**

There is limited information regarding the prevalence of either social isolation or loneliness in Scotland specifically. However a survey for Age UK in 2014 found that more than 80,000 of people aged 65 plus living in Scotland were always or often lonely, around one in six (16%) felt cut off from society, and a quarter said they would like to get out more. This suggests that patterns of loneliness in Scotland are broadly similar to those in the rest of the UK, where, over the past five decades, studies have consistently shown that around 10% of older people are often or always lonely. This means that the absolute numbers of lonely older people continue to grow as the population ages.

Similarly there is relatively little data comparing levels of loneliness in urban and rural areas, however the data that is available - which mainly relates to England and Wales - tends show that the highest levels of loneliness are to be found in urban deprived communities, with lower levels in rural areas. Statistical analysis of the English Longitudinal Study of Ageing (ELSA), currently being undertaken by Age UK confirms that, for England, rurality is not a significant factor in predicting loneliness. However the same analysis also showed that, while some areas of high deprivation also have a high risk of loneliness, there is no correlation overall between levels of deprivation and levels of loneliness.

This means that, despite the physical isolation, living in a rural area does not necessarily lead to people to a higher risk of loneliness. This has led researchers to surmise that either rural-dwellers are protected from loneliness by more closely knit communities, or that those who live in isolated locations do so because they naturally require less company, or come to develop coping mechanisms to ward off loneliness. However researchers emphasise that there is more work to be done on this issue – for example to consider the different experiences of those who live their whole lives in rural communities as compared to those who move to rural areas later in life.

Research into loneliness in rural Wales, which drew on the Bangor Longitudinal Study of Ageing, has identified in detail the factors associated with increases and decreases in loneliness and social isolation in rural communities. One of the most important features of this analysis was that it demonstrated that loneliness can exist in the absence of social isolation, and isolation can exist independently of loneliness.

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4 Age UK – awaiting publication

Across both rural and urban areas, studies show that, aside from age, factors associated with loneliness include living alone, never being married, widowhood, support network type, poor health, cognitive impairment or poor mental health and being female6.

Considering urban loneliness, several studies show that the combination of old age and residence in deprived urban neighbourhoods increases the risks of feeling unsafe, dissatisfied and lonely7. Not enough is yet known about the reasons for heightened risk of loneliness in urban areas, however researchers have put forward three key theories8:

- Older people may be adversely affected by the ways in which our cities and city neighbourhoods are being developed to meet the needs of affluent and more mobile younger consumers
- Older people’s perception of the quality of their relationships may be particularly hard hit by the high rates of population turnover associated with urban areas.
- Older people’s loneliness may be particularly affected by social issues common in urban neighbourhoods, such as changing service infrastructure, or fear of crime.

However even within deprived urban communities, rates of loneliness vary, with higher rates among the oldest age groups (75+); those who are single and have never married; or who are separated or divorced. In one study in urban deprived areas in Liverpool and Manchester particularly high rates of loneliness were reported older Somali people (24% were severely lonely) and Pakistani people (48% were severely lonely).9 The limited available evidence about the prevalence of loneliness among people from BME communities more generally suggests a mixed picture – with very high rates of reported loneliness, ranging from 24% to 50% among older people originating from China, Africa, the Caribbean, Pakistan and Bangladesh, but rates closer to the average for Britain among those of Indian origin10.

**Impacts of social isolation, for instance loneliness, ill-health**

One of the most common mistakes among those seeking to address loneliness and social isolation is to fail to grasp the distinction between the two, and therefore to imagine that the solution to loneliness is always increased social contact. While in some cases the two are linked, it is possible to be lonely, but not socially isolated, and to be socially isolated but not lonely.11 It is therefore inaccurate to view loneliness as simply a consequence of social isolation. It is also important to note that current research does not support the thesis that it is only those who are both lonely and socially isolated whose health is negatively impacted.

While social isolation is an objective state – defined in terms of the quantity of social relationships and contacts – loneliness is a subjective experience. Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.12 It is deeply personal and can only be understood by reference to the individual and their values, wishes and feelings.

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6 Burholt, V (2011), Loneliness of older men and women in rural areas of the UK; Safeguarding the Convoy: a call to action from the Campaign to End Loneliness. Age UK Oxfordshire
The research demonstrates that both loneliness and social isolation have serious impacts on people’s mental and physical health, in two main ways:

1) They have direct negative impacts on health:
   - Loneliness is significantly associated with the development of depression.
   - Low levels of social engagement significantly increase mortality.
   - Loneliness has adverse effects on biological stress mechanisms, including greater fibrinogen production (higher levels of this protein are associated with cardiovascular disease) and changes to cortisol levels.
   - Loneliness and low social interaction are predictive of suicidal behaviours in older age.
   - Adults who live alone (who already have heart disease or are at risk of developing it) are more likely to die from a heart attack or stroke than those who live with others.
   - Loneliness (but not social isolation) is linked to an 64% increased risk of developing clinical dementia.
   - People that feel lonely are more likely to rate their health as poor.
   - Weak social connections are an equivalent risk factor for early mortality to smoking 15 cigarettes a day, and have a greater impact than other risk factors such as physical inactivity and obesity.
   - Loneliness increases the risk of high blood pressure, and this association increases with age.

2) They encourage harmful behaviours
   - Loneliness can make older people uniquely vulnerable to alcohol problems: alcohol may be used as a coping mechanism for loneliness, and may be linked to boredom.
   - Loneliness is linked to alcoholism: it may be significant contributing and maintaining factor in alcohol abuse, and an impediment to attempts to give up drinking.
   - Lonely adults are more likely to be smokers and more likely to be overweight.

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Lonely adults are less likely to engage in physical activity and exercise\textsuperscript{26,27}

Being single or widowed decreases the daily variety of fruit and vegetables eaten (compared to people who live with a spouse or partner). Older adults who live alone and have infrequent contact with friends eat fewer vegetables each day. \textsuperscript{28}

The Campaign to End Loneliness believes the case for action on \textit{both} loneliness \textit{and} social isolation is compelling.

NB: The Campaign urges caution when considering the findings of a study by Steptoe et al\textsuperscript{29} which was widely reported as demonstrating that social isolation, but not loneliness, was associated with mortality. This used an extremely wide definition of “social isolation” which included all forms of social participation including physical activity. It is therefore clear that this study was not looking at the impact of contact alone. Other studies which define social isolation to be the quantity of supportive contacts found that social isolation did not predict mortality, while loneliness did.

Best practice and ideas that could be shared across Scotland, including examples of targeted support or initiatives (including housing, health, third sector)

The Campaign to End Loneliness, jointly with Age UK, has recently published a new report \textit{Promising Approaches to reducing loneliness and isolation in later life}\textsuperscript{30} which sets out a framework for understanding the complex web of loneliness interventions which are needed within communities, and offers a range of best practice case studies, which we would urge the Committee to consider.

The \textit{Promising Approaches} framework is summarised in the diagram below:

\textsuperscript{29} Conklin et al. (2013) ‘Social relationships and healthful dietary behaviour: Evidence from over-50s in the EPIC cohort, UK’ Social Science & Medicine 2013. http://dx.doi.org/10.1016/j.socscimed.2013.08.018
It was built on the insights of a range of experts in tackling loneliness, and demonstrates what a comprehensive approach to loneliness looks like – making clear there is no single solution to loneliness.

The model identifies the need for **foundation services** – which are often framed as “holistic” interventions designed to address older people’s needs in the round, and are well aligned to integration and prevention agenda, but which can be tailored to be responsive to the needs of lonely individuals. These services range from data-matching schemes to identify where lonely people live, to social prescribing and mentoring schemes which can identify, understand and support lonely individuals to change their position.

The model also highlights a range of **structural enablers** which are needed to support effective loneliness responses. These are ways of working within whole communities, which are most conducive to the development of loneliness solutions which are appropriate to local needs, involve local people, and are sustainable. They include Asset-Based Community Development and Positive Ageing approaches.

The model also highlights the three main areas of **direct intervention** on loneliness – including the traditional befriending schemes and social groups which aim to generate new social contact; services which help people change their thinking about their relationships, including programmes based on CBT and Mindfulness; and services which support people to maintain existing relationships, including accessible transport and technology. It also recognises that transport and technology also play a further role as **gateway services** to wider provision in the community, and are neglected to communities’ detriment.

*Promising Approaches* offers a range of case study examples from England which could be used as models for replication in Scotland. In addition we would highlight a few home-grown examples of similar practice:

**Befriending services:**
- Food Train Friends in Dumfries and Galloway, provide links from their befriending service to other services including weekly grocery shopping and doing jobs around the house. They have undertaken extensive evaluation of their work\(^\text{31}\).  

\(^{31}\) [http://www.thefoodtrain.co.uk/documents/research](http://www.thefoodtrain.co.uk/documents/research)
• A number of examples are included within the Befriending Network’s recent report on
the state of befriending in Scotland. Also included here are several mentoring
services (which we would classify as “Foundation Services”)

**Group based, shared interest services:**

• The Craft Café, run by Impact Arts, offers a safe, social and creative environment
where older people can learn new skills, renew social networks, and reconnect with
their communities. An evaluation of the Craft Café has found that it reduces levels of
anxiety and depression, encouraging participants to take greater notice of their
health. It estimates a Social Return on Investment (SROI) of £8.27: £1.

• Scottish Poetry Library “Living Voices” tackles loneliness by running regular groups
for older people, usually in care homes which use poetry, story and song as prompts
for social interaction, conversation, creative activity and reminiscence.

**Foundation Services / Psychological Approaches:**

• Health in Mind run a range of services for all ages that improve mental health but
also have an impact on loneliness and isolation. These include befriending,
“community connecting”, Community Navigators and counselling. The scheme was
evaluated in 2013.

• Potential ideas for improvement and influencing policy

The Campaign to End Loneliness is convinced that action on loneliness is most effectively
driven from the local level, so that it involves local people and is tailored to local
circumstances. It is also clear that loneliness responses must be cross-cutting – with input
from health, social care and local authorities – and delivered in partnership. Therefore the
current work to further integrate health and social, and the development Health and Social
Care Partnerships, create an exciting opportunity to embed commitment to tackling
loneliness and isolation across Scotland as part of an integrated approach to health and
wellbeing.

However these efforts must be supported by national policy which encourages focus on
loneliness specifically. The increasing recognition of the need to support wellbeing as well
as health is extremely welcome, however loneliness must be recognised as a specific
element of wellbeing and efforts should be made to monitor levels of loneliness, to drive
progress. To this end the Campaign to End Loneliness believes that measures of loneliness
should be included in national data sets and monitored as part of national outcomes
measurement.

There is an opportunity to ensure that this is possible, given current work to develop a new
Scottish Longitudinal Study on Ageing – akin to ELSA, which has proved such a rich tool in
understanding older people’s experiences in England. It is vital that this survey includes a
recognised measure of loneliness, and we would argue that Scotland should take a lead in
ensuring that the Gierveld scale is used, as it has been shown to be most effective in
measuring loneliness amongst older people in Europe, particularly when compared to the

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32 http://www.befriending.co.uk/befriendingpublication.php?type=1&id=76
33 http://www.impactarts.co.uk/files/Craft%20Cafe%20SROI%20FINAL%20REVISED%20v2.pdf
34 http://www.scottishpoetrylibrary.org.uk/learn/carers
10.1177/014662168500900307.
UCLA measure\(^{37}\) which is used in ELSA, but which was developed among students in the USA and is therefore not so culturally appropriate to the Scottish context.

**Effective awareness-raising within communities**

It is clear that there is significant interest in the idea of more direct public awareness-raising in relation to the issue of loneliness. However the evidence base about what forms of awareness-raising lead to genuine reductions in loneliness is, as yet, very under-developed.

Often the call to raise awareness of loneliness is driven by a sense that individuals, families and communities are not doing their “duty” in relation to excluded groups – and this is often portrayed in the media as an issue of “the breakdown of communities” or of families “neglecting” their older relatives. However, while there is some truth behind these portrayals, the realities of tackling loneliness are more complicated than simply getting people to be more neighbourly, or ensuring people stay in touch with older relatives. As has been noted above, the solutions to loneliness are as varied as people are. For some, more frequent contact with family members may help reduce their loneliness, but we know, for example, that some older people who live with family members are extremely lonely. Similarly, community events may relieve loneliness for some, but they may not deliver the deeper relationships that others need to feel satisfied.

In addition, for some individuals for whom loneliness has become a long-term and constant state, the reality is that tackling loneliness will not be a simple matter. Research shows that over time loneliness can lead to a loss of confidence and a tendency to reject help.\(^{38}\) These individuals will require the complex web of support set out in the framework above, to identify them, understand their individual needs, and to support them to take up new opportunities for social contact.

However there is still considerable potential in the idea of raising awareness of the need for, and value of, staying connected, and importantly the idea of public awareness-raising is supported by individuals who experience loneliness.\(^{39}\) Furthermore there is reason to be optimistic about the potential of such campaigns, given the success of campaigns like “Time to Change” in tackling stigma around mental health issues.\(^{40}\)

However there is a need for caution in considering the terms in which these issues should be addressed, and what additional support will be needed to ensure communities can effectively deal with the consequences of greater awareness. In a recent action research programme by the Joseph Rowntree Foundation in communities in York and Leeds\(^{41}\), a decision was taken to pursue a neighbourhood-based community development approach to tackling loneliness, with an explicit emphasis on the need to “talk about loneliness”. The research found the impact of using “the l-word” was mixed – in some communities this was found to be very positive, giving people permission to “admit” to an issue which had blighted their lives, but others found the term off-putting, leading to reluctance to engage. The JRF team had enough time to work intensively with their communities, to overcome these issues, but their experience demonstrates the potential risks of raising such a sensitive


\(^{38}\)Goll JC, Scior K, Charlesworth G & Stott J. (in press) Barriers to social participation among lonely older adults: the influence of social fears and identity.


\(^{40}\)http://www.time-to-change.org.uk/

\(^{41}\)http://www.jrf.org.uk/topic/loneliness
issue. The Campaign continues to explore this issue, thinking carefully about the most appropriate way to take forward such work, drawing on evidence and consultation with experts in the field. 

More information about our work to gather evidence on loneliness, to share good practice and to campaign for action can be found at www.campaigntoendloneliness.org.uk

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