Warwickshire County Council

Loneliness and Social Isolation in Warwickshire

Focus on Older People

The full version of this report is available on the Public Health Warwickshire website, as are different versions of the loneliness and social isolation risk maps:

http://publichealth.warwickshire.gov.uk/loneliness-and-social-isolation/

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Contents

Rationale

This document is intended to set out the evidence base around loneliness and social isolation in relation to causes, risk factors, distribution across Warwickshire and the effectiveness of interventions. The document also serves to set the context for the emerging loneliness and social isolation workstream, setting the direction of travel for the county council, and raising awareness of some of the key issues of the topic.

It is hoped that partner organisations across the county will be able to utilise this report to inform the commissioning of initiatives and to support and inform funding bids for projects that aim to tackle loneliness and social isolation.

The mapping work undertaken as part of this report seeks to highlight small areas that house individuals who are at an increased risk of being or becoming lonely or socially isolated; this should allow more informed planning and targeting of interventions.

A summary version of this document is also available, as are a range of different versions of the loneliness and social isolation risk maps. These can be accessed on the Public Health Warwickshire website: http://publichealth.warwickshire.gov.uk/loneliness-and-social-isolation/

Executive Summary

Loneliness and social isolation is now more recognised as being a public health issue. It is associated with harm to mental and physical health, as well as having broader social, financial and community implications. Because of this, there has been a local, national and international consensus that support needs to be provided to individuals and communities in order to tackle loneliness and social isolation.

Whilst loneliness and social isolation is a problem present across all age groups in society, it is a significant and growing issue for older people in particular. It is estimated that approximately 25% of the population will be aged 60 or above within the next 20 to 40 years, so it is important that we intervene now in order to address loneliness and social isolation.

Almost half of adults in England say they experience feelings of loneliness. On average, 10% of the population aged over 65 are often or always lonely. Furthermore, Help the Aged's Spotlight on Older People in the UK 2007 showed that the percentage of over 65s who said that they are often or always lonely was increasing dramatically. The reasons for this are complex, to do with changing family relationships, people living at greater distances from their relatives, and often an altogether less strong desire to be the mainstay of frail older relatives.

The 2014 Living in Warwickshire survey revealed that in Warwickshire, when compared to the population as a whole, those aged 65+ are:

- more likely to know people in their immediate neighbourhood
- more likely to feel that they 'belong' to their immediate neighbourhood
- slightly more likely to volunteer
- less likely to report 'very good' or 'good' health and much more likely to report 'fair' health

This suggests a real difference in perceptions of community, community perception and health across the life course.

Loneliness and social isolation harm physical and mental health by increasing the risk of depression, high blood pressure, sleep problems, reduced immunity and dementia[1]. It has a greater impact than other risk factors such as physical inactivity and obesity. A recent study found that loneliness and social isolation has an equivalent risk factor for early mortality to smoking 15 cigarettes per day[2].

On a positive front, people are able to 'recover' from loneliness, which means that there is scope for interventions to improve the situation for individuals. Loneliness is responsive to a number of effective interventions, which are often low cost, particularly when voluntary effort is harnessed; taking action to address loneliness can reduce the need for health and care services in future.

With reducing budgets and projected increasing demand for services, identifying successful and cost effective early interventions, particularly involving sustainable community and volunteering approaches and initiatives, will present good opportunities for improved outcomes to combat loneliness and social isolation in the future.

What are we going to do?

An action plan outlining how Warwickshire County Council will tackle loneliness and social isolation in the county has been developed, to be delivered via the Loneliness and Social Isolation Working Group, and can be found on the Public Health website. The focus of this phase one action plan is on older people.

However, to effectively tackle loneliness and social isolation, an integrated approach to working must be adopted by all partners in Warwickshire, delivering on the following:

1. Develop and support effective loneliness evidence based interventions, including an evaluation component in all proposals for local interventions;
2. Target interventions at a range of vulnerable groups in the community, particularly older people
3. Ensure that tackling loneliness is a consideration in all relevant policy areas;
4. Support local organisations and partnerships to raise awareness of and tackle loneliness and social isolation;
5. Provide frontline staff within relevant organisations with the skills and knowledge to identify potentially lonely and socially isolated individuals and the confidence and tools to offer solutions.

1.0 What is Loneliness and Social Isolation?

The terms ‘loneliness’ and ‘social isolation’ are often used interchangeably, and whilst there are clear links between the two experiences they are distinct concepts. Although the terms have slightly different meanings, the experience of both is generally negative and the resulting impacts are undesirable at the individual, community and societal levels.

As our population ages, loneliness and isolation in older age is becoming a growing public health challenge. Research shows that loneliness and social isolation can be as harmful as smoking 15 cigarettes a day[2] and increases the risk of conditions including dementia, high blood pressure and depression. Socially isolated older adults have longer stays in hospital, a greater number of GP visits and are more dependent on homecare services. Therefore, there is an economic as well as a health related case to be made for tackling social isolation.

1.1 Loneliness

Loneliness can be defined as *a subjective, unwelcome feeling of lack or loss of companionship*. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want[3]. There are different types of loneliness:

- Emotional loneliness is felt when we miss the companionship of one particular person; often a spouse, sibling or best friend.
- Social loneliness is experienced when we lack a wider social network.

Loneliness can be a transient feeling that comes and goes. It can be situational; for example only occurring at certain times like Sundays, bank holidays or Christmas. Loneliness can also be chronic; meaning that it is experienced all or most of the time.

1.2 Social Isolation

Loneliness is linked to social isolation but it is not the same thing. Isolation is an objective state whereby the number of social contacts or interactions a person has can be counted. One way of describing this distinction is that you can be lonely in a crowded room, but you will not be socially isolated[4].

2.0 Background

2.1 Policy

2.1.1 National

Loneliness and social isolation are emerging issues in the national health and social care agenda. In 2012 there was an international “Loneliness Conference” where the Minister for Care Services, launched an online toolkit for local health organisations and councils to address loneliness in older age. This 2012 research conference “What Do We Know About Loneliness?” (hosted by Age UK Oxfordshire and the Campaign to End Loneliness) highlighted that loneliness should be considered a major health issue and investigated the research that brings to light huge numbers of older people affected by loneliness in the UK.

Nationally, 51% of **Health and Wellbeing Boards** are tackling loneliness as a priority area, highlighting the scale of the issue across the UK. **Marmot**’s 2011 Review: Fair Society, Healthy Lives[5], included ‘improve[ing] community capital and reduce social isolation across the social gradient’ as a priority objective, recommending ‘Support [to] locally developed and evidence based community regeneration programmes that emphasise reduce social isolation’. Furthermore, the recent **Care and Support White Paper** recognises loneliness and social isolation as large problem for society as a whole[6].

2.1.2 Warwickshire

- The **Warwickshire Health and Wellbeing Strategy**[7] has specific outcomes related to loneliness and social isolation
- **Warwickshire's Joint Strategic Needs Assessment** (JSNA) has priorities around mental health, dementia, carers and maintaining independence, which are all issues and groups associated with being impacted by loneliness and social isolation.
- **Warwickshire Cares, Better Together** incorporates Warwickshire's **Better Care Fund** plans, including work streams around promoting independence and community resilience, which both have outcomes around reducing loneliness and social isolation.

2.2 Impact on health

The 2014 Living in Warwickshire Survey asked respondents to report on their health. Those aged 65+ were less likely to report that they were in 'very good' or 'good' health than the population as a whole (see table 1), suggesting that experience of health worsens with age.

In general how good would you say your health is?	Aged 65+	All ages	Percentage point difference
Very good	13%	28%	15%
Good	43%	47%	3%
Fair	33%	19%	-14%
Poor	8%	4%	-4%
Very poor	2%	1%	-1%

Table 1: Self-reported health, age 65+ and the general population, the Living in Warwickshire Survey, 2014

2.2.1 Mental health

Evidence suggests that loneliness has strong associations with depression and may be an independent risk factor for depression[1]. It has also been found to be linked to reduced day to day happiness and excitement experienced day to day by older people[8].

2.2.2 Physical health

Research has identified that the impact of social relationships on the risk of mortality is comparable with major established health risk factors such as smoking and alcohol and exceeds that of physical inactivity and obesity [9].. Research suggests that being lonely or socially isolated can result in higher blood pressure, worse sleep, immune stress responses. worse cognition over time in the elderly[10] and the metabolic syndrome (cardiovascular disease, diabetes, stroke, and mortality). Alongside this, being lonely or socially isolated is associated with a greater risk of being inactive as well as a range of other negative health behaviours including smoking and as such increases risk of premature morbidity and mortality[11], as there is a 50% increased likelihood of survival for people who had stronger social relationships compared to those who had weaker relationships.

2.3 Risk factors

The relationship between social isolation and loneliness is complex, and is subject to change over the life course. Research has identified a number of predictors of loneliness and social isolation; see figure 1[12].. Loneliness and social isolation can be felt by people of all ages, but as we get older, risk factors that might lead to loneliness begin to increase and converge.

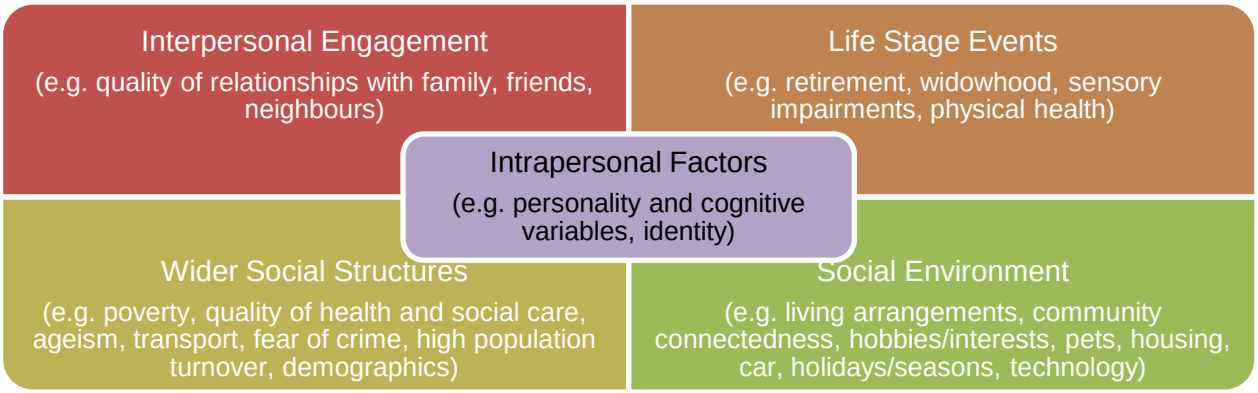


Figure 1: Risk factors for loneliness Source: Sullivan & Victor, 2012

In addition to these tangible risk factors, there are a series of other more holistic risk factors:

- Expectation of loneliness can be a predictor of becoming lonely; people who expect to become lonely do go on to experience loneliness
- Seasons: the highest levels are in the spring and summer when the days are longer and family members may be on holiday
- There are variations by ethnicity. All BME communities have been found to have a higher rating of self-reported loneliness than the White British ethnic group, with the exception of the Indian group who report similar levels of loneliness
- Lesbians and gay men suffer disproportionately from loneliness and isolation as they age[13,14]
- Carers are a group that at particular risk

3.0 Need: The Scale of the Issue

3.1 Measuring Loneliness and Social Isolation

Unlike other physical or mental health conditions, data on the prevalence and incidence of loneliness and social isolation are not routinely collected. Therefore, identifying individuals who are lonely or socially isolated, or are at risk of being so, is a challenge. Surveys have been carried out nationally and locally, which include questions around loneliness and social isolation, the results of which can be used to give an indication of prevalence locally, for example the ELSA (see box 1). Alternatively, a range of indicators and measures collected for other purposes can be used to give a proxy indication of the situation locally.

The English Longitudinal Study of Ageing (ELSA)[1] is a panel study of a representative cohort of men and women living in England aged ≥50 years, involving the collection of economic, social, psychological, cognitive, health, biological and genetic data. The study commenced in 2002, and the sample has been followed up every 2 years.

ELSA shares the weakness with many other general purpose panel studies that the level of detail on any particular health outcome or psychosocial process is not as great as in focused or hypothesis-driven investigations. There are very few ethnic minority participants. Attrition is an ongoing issue. Information about earlier life was collected retrospectively. By its very nature, the study is confined to England, though efforts are underway to establish parallel studies in other parts of the UK.

Box 1: Description and limitations of ELSA

4.1.1 The development of an Index

Public Health Warwickshire have developed a 'Loneliness and Social Isolation Index' using Mosaic customer profiling data. The aim of this Index is to estimate the number of households in Warwickshire that are at an above average risk of experiencing loneliness and social isolation.

The index identified a number of groups who are at a higher than average risk of being lonely or socially isolated (see table 2); 4 of these groups are specific to older people. The groups vary in age, ethnicity, and family and social status but all have a level of deprivation across various domains. The Index has allowed

mapping of these groups at small area level (see section 3.2.3; a full range of maps is available on the Public Health Warwickshire website).

Mosaic Type (group)	Key Feature 1	Key Feature 2	Key Feature 3	Key Feature 4
I38: Asian Heritage	Extended families	Areas with high South Asian population and tradition	Low property value	Never worked and long-term unemployed
L49: Disconnected Youth	Aged under 25, mostly living alone	Have lived at address less than 3 years	Limited employment options	Some lone parents
L50: Renting a Room	Singles and homesharers	Short term private renters in low rent accommodation	Low wage occupations	High index of Multiple Deprivation
M55: Families with Needs	Cohabiting couples and singles with kids	Areas with high unemployment	Pockets of social housing	Very low household income
N57: Seasoned Survivors	Very elderly Age 81-85	Most are living alone	Retired from routine / semi-skilled jobs	Claim support allowance
N60: Dependent Greys	Ageing singles Age 66-70	Vulnerable to poor health	Living on estates with some deprivation	Bad health
O62: Low Income Workers	Older households Age 56-60	Renting low cost semi and terraces	Areas with low levels of employment	Very low household income
O63: Streetwise Singles	Singles and sharers Age 26-30	Low cost social flats	Shortage of opportunities	High index of Multiple Deprivation
O64: High Rise Residents	Singles and sharers Age 31-35	High rise social flats	Very low household income	Least likely to own a car
O65: Crowded Kaleidoscope	Many lone parents with multiple children	Non-nuclear household composition	Socially rented, overcrowded households	Significant proportion of adults not born in the UK
O66: Inner City Stalwarts	Mostly single adults Aged 56+	Health problem or disability limits activities/work	Renting from social landlord	Never worked and long-term unemployed

Table 2: Mosaic groups at a higher than average risk of being lonely or socially isolated

3.2 Incidence and prevalence

3.2.1 National

Loneliness is a common experience, with a 'U' shaped population distribution; those aged under 25 years and those aged over 55 years demonstrate the highest levels of loneliness.

In a national study (Victor et al, 2005) examining the prevalence of loneliness amongst older people in Great Britain, loneliness was measured using a self-rating scale, and measures of socio-demographic status and health/social resources were included. Interviews were undertaken with 999 people aged 65 or more years living in their own homes, and the sample was broadly representative of the population in 2001. The study found the following:

- 61% of people aged 65 and over reported 'never' being lonely
- 31% of people aged 65 and over rated themselves as being 'sometimes' lonely
- 7% of people aged 65 and over reported feeling lonely 'often' or 'always'[15]

Applying these percentages to ONS population data, it can be suggested that in 2001 there may have been 2,329,650 people living in England who would rate themselves as being 'sometimes' lonely and 526,050 people who reported being lonely 'often' or 'always'.

Living alone is one of the factors contributing to a sense of social isolation, which is characterised by a lack of contacts or ties with other people. Isolation is also linked to a more subjective sense of loneliness. ONS

data released in 2012 shows a higher number of people aged 45 – 65 are living alone than ever before. In England as a whole, 53% of all households with people age 65 and over were one person household. The older people get the more likely they are to live within one person household:

- 37% for people age 65-74
- 66% for people age 75-84
- 72% among those age 85+

Furthermore, some British studies suggest that loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities. A study of deprived neighbourhoods of three English cities identified 16% of older people as being severely lonely (Scharf et al., 2002)[16].

3.2.2 Warwickshire

According to Warwickshire's JSNA[17] the highest rates of projected population growth in Warwickshire are in the groups aged 65 years and over. The rate of growth increases with age, with the oldest age group, those aged 85 and over, projected to increase by more than 40% between 2011 and 2021. Population projections help inform the planning of services and decisions about the future allocation of resources. An ageing population in particular, has implications for the future provision of many health and social services.

	% increase 2012 to 2037	65+ population as % of total (2037)
Warwickshire	66.7%	27.9%
North Warwickshire	65.5%	29.2%
Nuneaton and Bedworth	65.0%	25.5%
Rugby	73.8%	26.5%
Stratford-on-Avon	69.9%	35.6%
Warwick	61.1%	24.1%
England	65.1%	24.0%

Table 3: Percentage increase in population and percentage of population aged 65+, Warwickshire. Source: ONS

Table 3 shows the projected population increase for those aged 65+ over the next 22 years. In the majority of districts and boroughs in Warwickshire, the population is projected to rise at the same level or higher than the England figure. The table also shows the proportion of the population that will be aged 65+ in 2037; the proportions for each of the districts and boroughs in Warwickshire are higher than the proportion for England as a whole, highlighting the scale of the issue for Warwickshire. The table also shows inequalities between the districts and boroughs; Rugby Borough is projected to see the largest percentage increase in the population aged 65+ and in 2037 is projected to have the largest proportion of the population who are aged 65+, at 35.6%.

In terms of the proportion of the population who are at risk of being lonely or socially isolated, using the figures indicated in Victor's 2005 survey, mentioned above, the figures in table 4 could be suggested for the scale of the issue in Warwickshire:

	Total population aged 65+	Lonely 'all of the time' or 'often'	Lonely 'some of the time'
North Warwickshire	9,000	630	2,790
Nuneaton & Bedworth	17,200	1,204	5,332
Rugby	13,500	945	4,185
Stratford-on-Avon	19,300	1,351	5,983
Warwick	19,700	1,379	6,107
Warwickshire	**78,900**	**5,523**	**24,459**

Table 4: Varying degrees of loneliness, Warwickshire

3.2.2.1 Living in Warwickshire survey data

The 2014 Living in Warwickshire survey revealed that in Warwickshire, when compared to the population as a whole, those aged 65+ are:

- more likely to know people in their immediate neighbourhood
- more likely to feel that they 'belong' to their immediate neighbourhood
- slightly more likely to volunteer

This suggests higher level of self-reported community involvement amongst older people, which is associated with lower levels of loneliness and social isolation.

The survey asked respondents to rate their wellbeing, using the WEMWBS scale, as shown in table 5. Responses to the questions can give an indication about individual mental wellbeing and resilience, both of which are factors to consider when thinking about loneliness and social isolation.

The survey responses have been disaggregated by age to show some of the differences in response between the general population and those aged 65+, with percentage point differences of 5% highlighted in red to show where responses differ most. Those aged 65+ were notably less likely to respond 'often' to the majority of the questions, suggesting relatively lower levels of mental wellbeing amongst people of this age.

One of the WEMWBS questions asks respondents to report how often they have been 'feeling close to other people', which, within the question set, is the strongest indicator of loneliness. The responses to this question were relatively similar in terms of percentages falling into each category, for those aged 65+ and for the general population. This suggests that feeling close to people, or not, is experienced at a relatively consistent level across the life course.

		None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about my future	Age 65+	9%	14%	41%	27%	10%
	All age	4%	11%	37%	38%	11%
	% diff	-4%	-3%	-4%	11%	1%
I've been feeling useful	Age 65+	4%	9%	39%	34%	13%
	All age	3%	7%	34%	44%	13%
	% diff	-2%	-2%	-5%	10%	-1%
I've been feeling relaxed	Age 65+	3%	8%	40%	39%	11%
	All age	3%	14%	42%	34%	6%
	% diff	0%	7%	2%	-5%	-5%
I've been dealing with problems well	Age 65+	2%	4%	33%	44%	17%
	All age	1%	5%	35%	47%	11%
	% diff	-1%	1%	2%	4%	-6%
I've been thinking clearly	Age 65+	1%	3%	25%	43%	28%
	All age	1%	4%	27%	50%	19%
	% diff	0%	1%	2%	7%	-9%
I've been feeling close to other people	Age 65+	2%	7%	31%	38%	21%
	All age	2%	8%	27%	43%	19%
	% diff	0%	1%	-4%	5%	-2%
I've been able to make my mind up about things	Age 65+	2%	3%	20%	41%	35%
	All age	1%	4%	23%	47%	25%
	% diff	-1%	1%	3%	6%	-10%

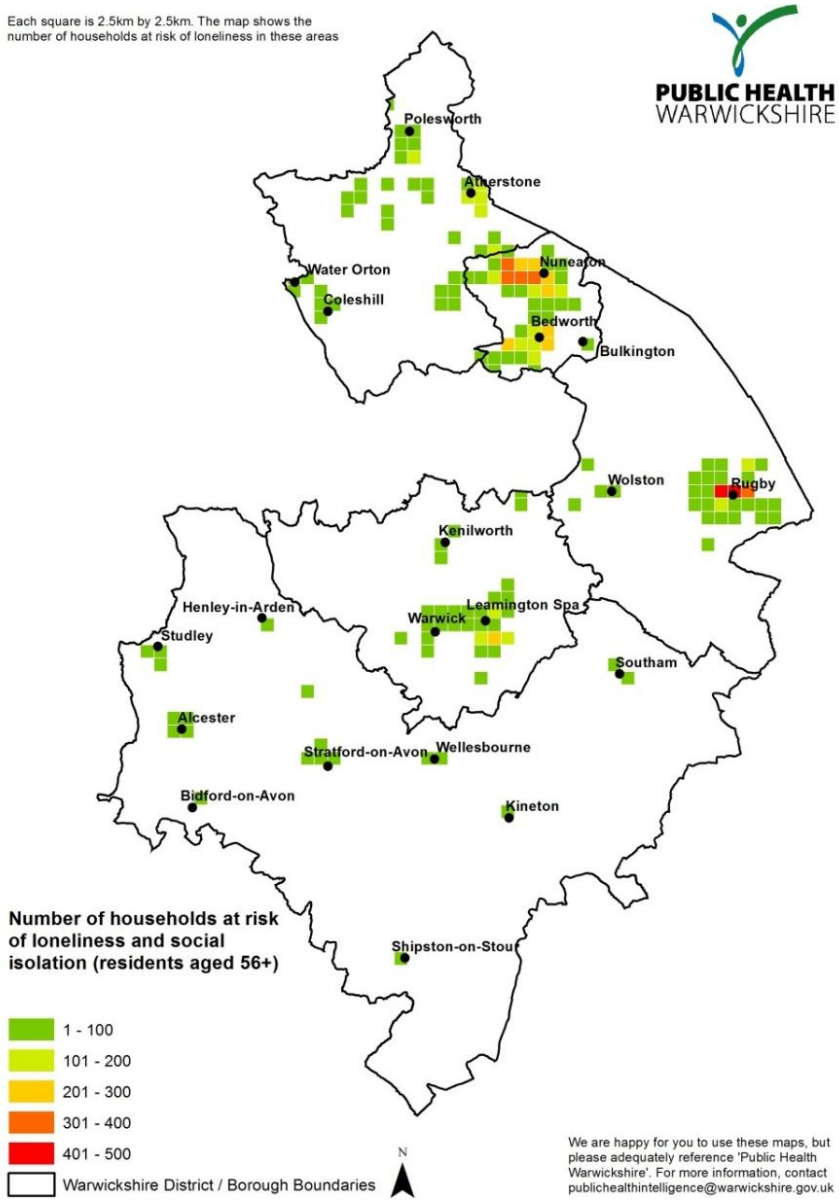
Table 5: WEMWBS responses from the Living in Warwickshire Survey 2014, for those aged 65+ and for the population as a whole

3.2.3 The Index of Loneliness and Social Isolation

The index has allowed the identification of small areas of Warwickshire where individuals are at a higher than average risk of being lonely or socially isolated (see Maps 1 to 7).

The mapping suggests that there are higher numbers of households at an increased risk in urban areas, which is what would be expected given the higher density of housing in these areas. However, some more rural areas have been identified.

3.2.3.1 Warwickshire

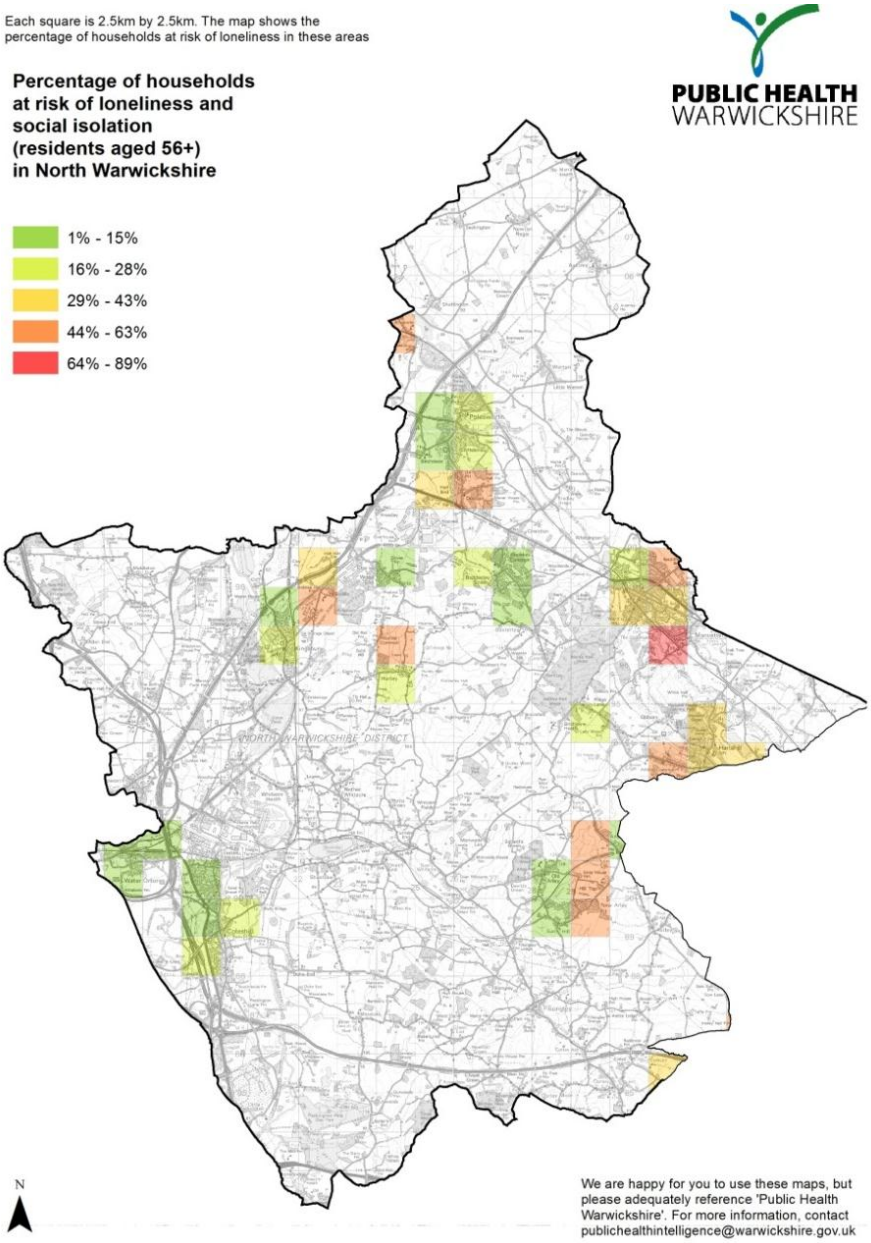


Map 1: Households at risk of loneliness and social isolation in Warwickshire, residents aged 56+

Map 1 shows that, in terms of gross numbers, households with residents aged 56+ at 'above average' (Level 1-2) or 'high' (Level 3-4) risk of loneliness and social isolation according to the Mosaic Types are clustered around the more densely populated urbanised areas of the county, with the highest numbers in the urban areas of Rugby and Nuneaton, Leamington Spa and Bedworth towns.

The highlighted areas in Leamington Spa have comparatively more households at risk of loneliness and social isolation for those aged 56+ when compared to the population as a whole. The geographical distribution for areas at risk in Nuneaton and Bedworth towns is also different to the distribution for the population as a whole, with a greater number of small areas having higher numbers of the aged 56+ population at risk, with a similar picture also being seen in Rugby town.

3.2.3.2 North Warwickshire Borough

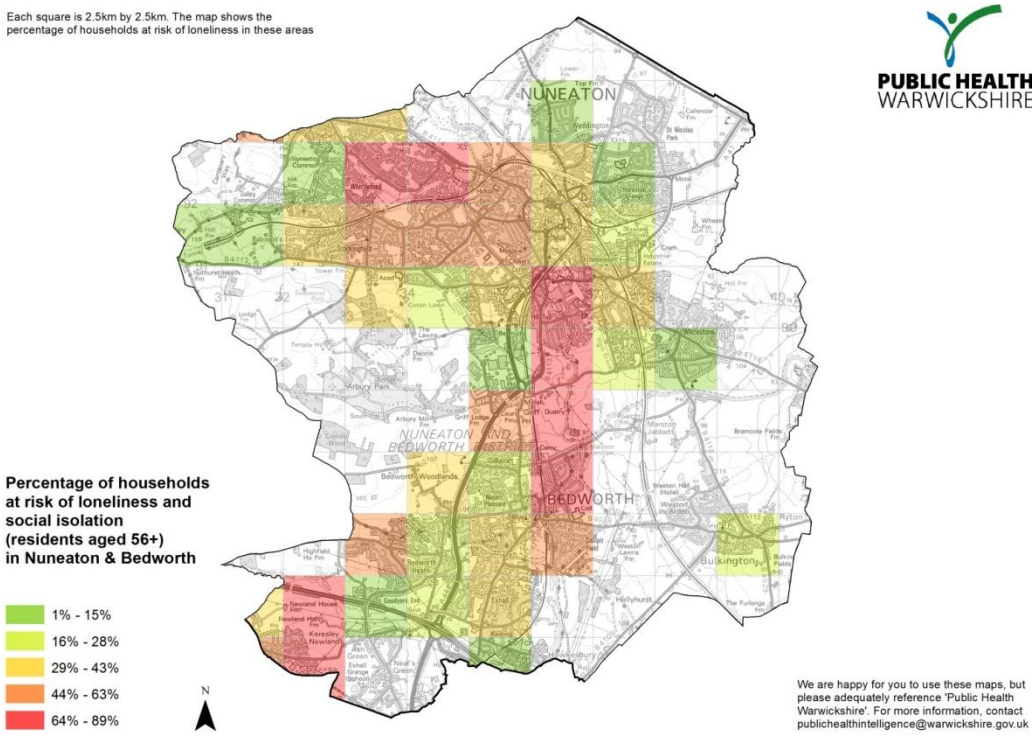


Map 2: Percentage of households at risk of loneliness and social isolation in North Warwickshire Borough, residents aged 56+

For the identified areas in North Warwickshire Borough, a higher percentage of the households are at risk in the aged 65+ group than the population as a whole. As shown in map 2, the area with the highest proportion of households at risk is in the northern area of the Atherstone South Mancetter Ward, where up t 89% of households with residents aged 56+ are at high risk of loneliness and social isolation (this is compared to 56% for the same area for the population as a whole). Other high proportion of high risk areas include within the Dordon, Arley and Whittaker, Hartshill, Atherstone North, Atherstone Central, Kingsbury and Hurley and Wood End Wards.

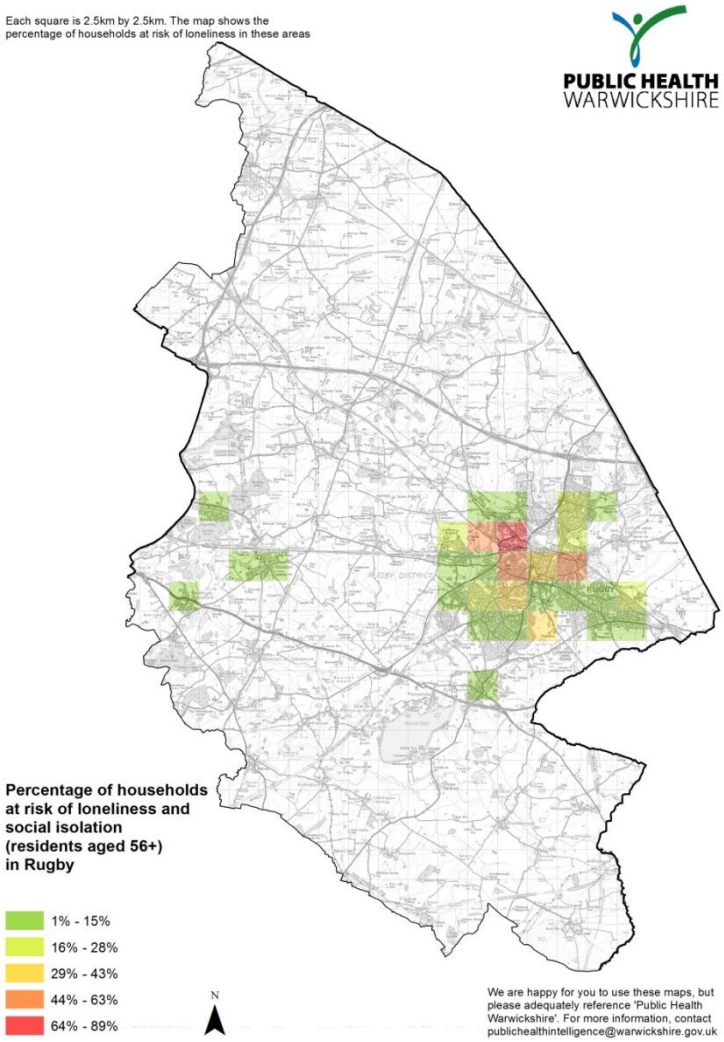
3.2.3.3 Nuneaton and Bedworth Borough

The distribution of areas at high risk of loneliness and social isolation in Nuneaton and Bedworth Borough is similar for those aged 56+ and for the population as a whole. However, as shown in map 3, of the high risk areas, higher proportions of households are at risk for those aged 56+ than the population as a whole, with eight small areas having between 64% and 89% of households at risk. The areas with the highest proportions are located in the centre, south west and north east of the Borough, covering the Poplar, Wem Brook, Exhall, Camp Hill, Bede, Bar Pool and Attleborough Wards.



Map 3: Percentage of households at risk of loneliness and social isolation in Nuneaton and Bedworth Borough, residents aged 56+

3.2.3.4 Rugby Borough



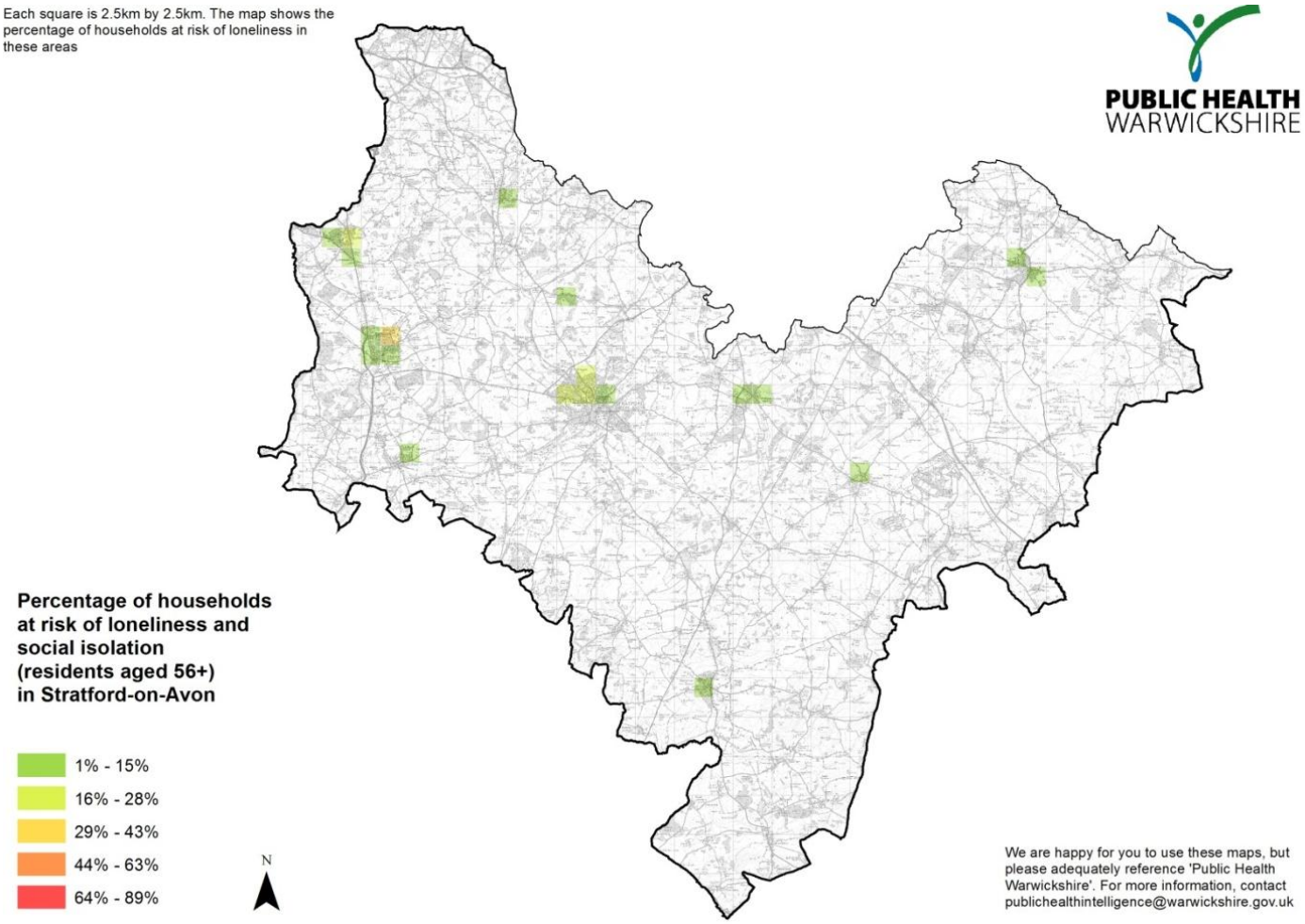
Map 4: Percentage of households at risk of loneliness and social isolation in Rugby Borough, residents aged 56+

Map 4 shows the distribution of households with residents aged 56+ who are at risk of loneliness and social isolation, as a proportion of all households. The distribution is similar to that of the population as a whole, although some additional small areas have been identified (in the Wolston and the Lawfords Ward), and of the identified areas, a higher proportion is at risk when considering the aged 56+ population, when compared to the population as a whole. The Newbold on Avon area has the highest proportion of households at risk for the 56+ population, at between 64% and 89% of all 56+ households. The northern area of the New Bilton Ward, as well as and an area straddling Benn and the north of the Eastlands Wards are the areas in Rugby Borough with the highest proportion of residents aged 56+ who are at risk of loneliness and social isolation.

3.2.3.5 Stratford-on-Avon District

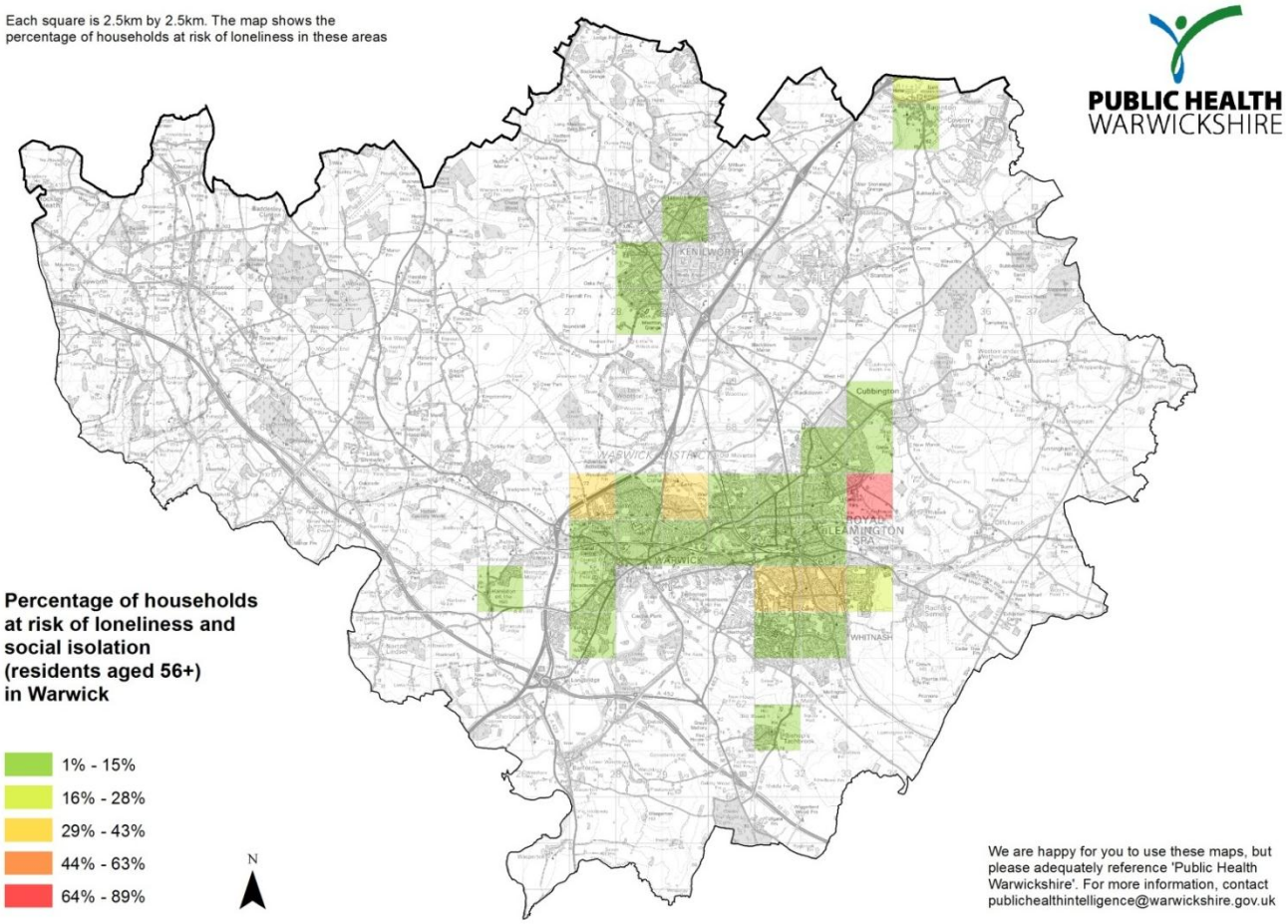
Map 5 illustrates 20 small areas in Stratford on Avon District where a high proportion of the population aged 56+ are at higher than average risk of loneliness and social isolation. This represents a slightly higher number of small areas than for the proportion of population as a whole, of which there are 18.

An area of north-east Alcester has the highest proportion of residents aged 56+ at risk of loneliness and social isolation, although when compared to other areas in Warwickshire, the proportion of houses at risk within the high risk areas is relatively lower. Within the high risk areas in Stratford on Avon District, other areas with relatively high proportions of the population at high risk include north-eastern Studley, as well as the Bishopton, Drayton and Stratford Town areas of the main town of Stratford upon Avon.



Map 5: Percentage of households at risk of loneliness and social isolation in Stratford on Avon District, residents aged 56+

3.2.3.6 Warwick District



Map 6: Percentage of households at risk of loneliness and social isolation in Warwick District, residents aged 56+

Map 6 shows that the number of small areas at with higher proportions of residents at a higher risk of loneliness and social isolation is greater for those with residents aged 56+ than for the population as a whole. The area with the highest proportion of residents aged 56+ at risk covers south-east Lillington. The other areas with high proportions of high risk households aged 56+ in the district are around the Spinney Hill and west Woodloes/Cape areas of Warwick Town, as well as in the Brunswick Ward area in Leamington Spa.

For those aged 56+, the distribution of areas at high risk of loneliness and social isolation is similar around the Warwick and Leamington Spa urban areas, as for the population as a whole, but with more small areas identified, and amongst those areas higher proportions are at higher risk. Furthermore, a number of additional areas have been identified as higher risk for those aged 56+ than for the population as a whole, including Hampton on the Hill, South West Kenilworth and an additional area in northern Cubbington.

3.3 Trends over time

Over the next 10 years, the number of people aged over 65 in England is expected to increase by 18%. This is reflective of the situation in Warwickshire, where the number of residents aged over 65 is projected to rise by 18% or approximately 25,400 people between 2015 to 2025[18]. This therefore suggests that the number of people experiencing loneliness and social isolation both locally and nationally will increase.

However, a 2005 study[19] found that the proportion of people in the population who experience loneliness and social isolation has remained relatively unchanged over the last 60 years. The study examined the prevalence of self-reported loneliness amongst older people in Great Britain, and made comparisons with the findings of studies undertaken during the last five decades. Table 6 shows the variation in self-reported loneliness over time; the proportion experiencing loneliness ‘always/often’ showing little change.

	Sheldon 1948	Townsend 1954	Victor 2005
Always/often	8%	9%	9%
Sometimes	13%	25%	32%
Never	79%	66%	61%

Table 6: Self-reported loneliness over time. Source: Victor et al, 2009

3.4 Interventions

Historically, the evidence base around interventions designed to tackle and/or prevent loneliness and social isolation has been relatively limited. This has meant that the effectiveness of many interventions has been questioned due to a lack of supporting evidence. However, over the past few years a number of reports and systematic reviews have been published which is helping to establish a bank of knowledge around what works in tackling loneliness and social isolation.

Preventive services represent a continuum of support ranging from the most intensive, 'tertiary services' such as intermediate care or reablement, down to 'secondary' or early intervention, and finally, 'primary prevention' aimed at promoting wellbeing. Primary prevention is generally designed for people with few social care needs or symptoms of illness. The focus therefore is on maintaining independence and good health and promoting wellbeing. The range of these 'wellbeing' interventions includes activities to reduce social isolation, practical help with tasks like shopping or gardening, healthy living advice, intergenerational activities and transport, and other ways of helping people get out and about. All of these interventions can help alleviate loneliness and social isolation.

Loneliness and social isolation are complex issues and practical steps to tackle the problem need to be taken at different levels: s**trategic** level across the authority; n**eighbourhood** action; and **individual** intervention.

3.4.1 Effectiveness of Interventions

A variety of interventions can be used to tackle loneliness and social isolation:

- befriending
- volunteering
- mentoring
- navigators
- group schemes
- wider community engagement
- internet access
- informal interventions
- social prescribing

The full version of this report includes an evidence review assessing the interventions above on to their effectiveness in reducing loneliness, improving mental and physical health and wellbeing and reducing usage or demand on health services.

3.4.1.1 Summary of research

The evidence around interventions aimed at tackling loneliness and social isolation is mixed, even at specific intervention level.

- The evidence around **befriending** is particularly mixed; whilst some users reported feeling less lonely and socially isolated following usage of the service, one systematic review concluded that effectiveness in terms of impact on wellbeing was unclear;

- People who use **Community Navigator** services reported that they were less lonely and socially isolated following the intervention;
- The outcomes from evaluating **mentoring** services is less clear; one study reported improvements in mental and physical health, another that no difference was found;
- Where longitudinal studies recorded survival rates, older people who were part of a **social group intervention** had a greater chance of survival than those who had not received such a service; the evidence also suggests that usage of social group interventions also yields positive results in terms of lessening demand on services. Furthermore, increase social interaction and community involvement.
- Limited evidence to support that increasing **internet** access can reduce loneliness and social isolation, although some small scale studies have suggested that it can.
- **Volunteering** is shown to positively impact on loneliness and social isolation.
- There is very limited evidence around **informal interventions**; however this does not mean that they are not effective;
- **Social prescribing** has been found to result in reduced loneliness and social isolation – although the socially prescribed services must be tailored to this purpose.

3.4.1.3 Implications from the evidence

Having a range of interventions available is useful, as it means that they can be targeted to the characteristics of an individual. However, the wide variety of interventions and their different outcome measures make it difficult to be certain what will work for each individual.

Effective and favourable interventions tend to be:

- Either group interventions with an education focus or provide targeted support activities;
- Targeted towards specific groups e.g., lonely men are best engaged through specific activities related to long-standing interests and respond less well to loosely-defined social gatherings, which are of more interest to women.
- Flexible and adaptable.
- Involving partners: strong partnership arrangements need to be in place to ensure developed services can be sustained. Key facilitatory actions could include appropriate tendering and longer-term funding;
- Loneliness and isolation may also require different responses. Older people experiencing isolation may require practical support such as the provision of transport. Older people experiencing loneliness may require social support;
- Involving users in the planning, implementation and evaluation of programmes improves outcomes and ensures that services are matched with needs;
- In the planning stage of any service or intervention, there should be an awareness of the existing community resources in order to build on community capacity.
- Ineffective interventions tended to be those offered on a one-to-one basis, conducted in people's own homes.

3.4.1.4 Evaluation

Evaluating the impact of services is important to:

- demonstrate impact on target areas
- help identify and disseminate good practice
- justify any additional investment needed[20]

A measurement strategy should put in place for any activity, to ensure that relevant data are captured from the outset. However, it's also important to consider wider implications and unintended outcomes. Public Health Warwickshire have two preferred methods of evaluation:

- Companionship Scale[21]: developed by Health Psychologists from Coventry University and Public Health Warwickshire, designed to measure the level of loneliness and social isolation that a person feels. It can be used by anyone of any age. It is a short scale designed to be quick and easy to use.
- Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[22]: developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

3.4.1.5 Issues to consider

- Different studies use different measures; some measure self-esteem, depression and social networks known to affect loneliness rather than loneliness per se.
- Self-selection may lead recruitment of 'socially active lonely', rather than the 'socially isolated lonely'.
- People may be reluctant to report feelings of loneliness due to the attached stigma. Therefore there may be a significant under reporting at play.
- Lack of evidence in considerating of different types of loneliness across the lifespan – e.g adolescence, when children leave home, chronic illness and following bereavement.

3.5 Value for money assessment

There is limited evaluation or research that includes an analysis of cost-effectiveness of interventions designed to tackle loneliness and social isolation. However, some smaller studies have investigated the financial aspects of interventions designed to tackle loneliness and social isolation[23],[24],[25].

- £80 investment in befriending could provide a recurrent £35 in savings. When factoring in quality of life improvements through reductions in wellbeing aspects such as depression, the savings could reach £300 per year in terms of reduced need for treatment and quality of life improvements.
- For Community Navigators, the intervention cost per person is £300. With additional costs e.g. a visit to a Citizen's Advice Bureau or Job Centre, the total cost would be £480 per person per year. However, it is estimated that the economic benefits (e.g. move into employment, fewer services used) would amount to approximately £900 in the first year for employment and reduced demand on services.
- For community engagement interventions, evidence suggests that cost benefits can be yielded. For example, volunteer and peer health programmes may see a proportion of volunteers gain paid employment, which generates savings but may not be picked up in an evaluation about health behaviours. The Cabinet Office calculates the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year**Error! Bookmark not defined.**.
- Economic analysis of community capacity building using time banking, community navigators and befriending. found that all delivered a net economic benefit when costs and value were calculated. Time banking had a net value of £667 per person per year, extending to £1,312 if improvements in quality of life were included in the analysis.

4.0 Supply: the services available

4.1 What services are there?

4.1.1 Warwickshire County Council Commissioned Services

A number of services are commissioned by Warwickshire County Council which seek to address loneliness and social isolation:

- Befriending and Community Support Service: for individuals with a mental health diagnosis, aged 55+.
- Dementia Befriending Pilot: For individuals who have a diagnosis of dementia or who are seeking a diagnosis, any age, living in Rugby. A pilot project until September 2015.

4.1.2 Services provided across the county

There are many services and initiatives across Warwickshire that address (either directly or indirectly) loneliness and social isolation. These are specific e.g. befriending services or indirect e.g. book clubs. The identification and mapping all of these services will be considerably time and resource intensive and is therefore being addressed as part of an organisation-wide workstream around information and advice.

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