



Public Health
England

Protecting and improving the nation's health

Tackling social isolation & loneliness

Kent County Council Select Committee
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Social isolation and loneliness



“A sad soul can kill you quicker, far quicker than a germ”



A recent systematic review found that loneliness can increase the risk of premature death by 30%



Isolation and loneliness

The relationship between social isolation and loneliness is **complex and varies** between individuals.

Isolation

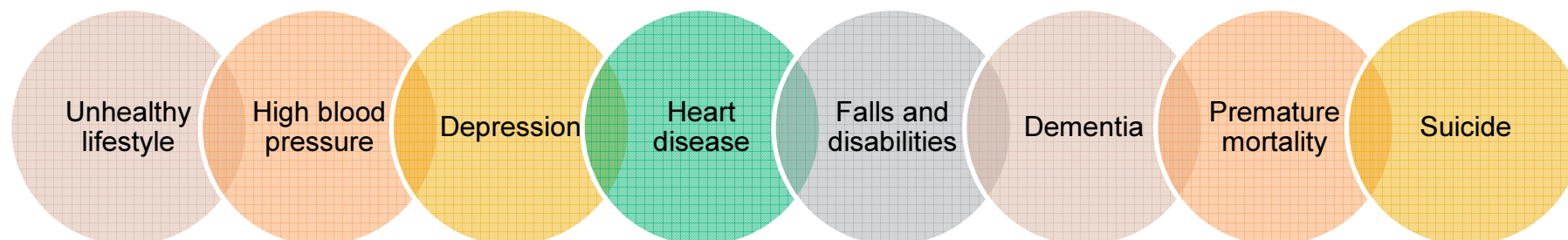
The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).

Loneliness

An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.

Impact on health and wellbeing

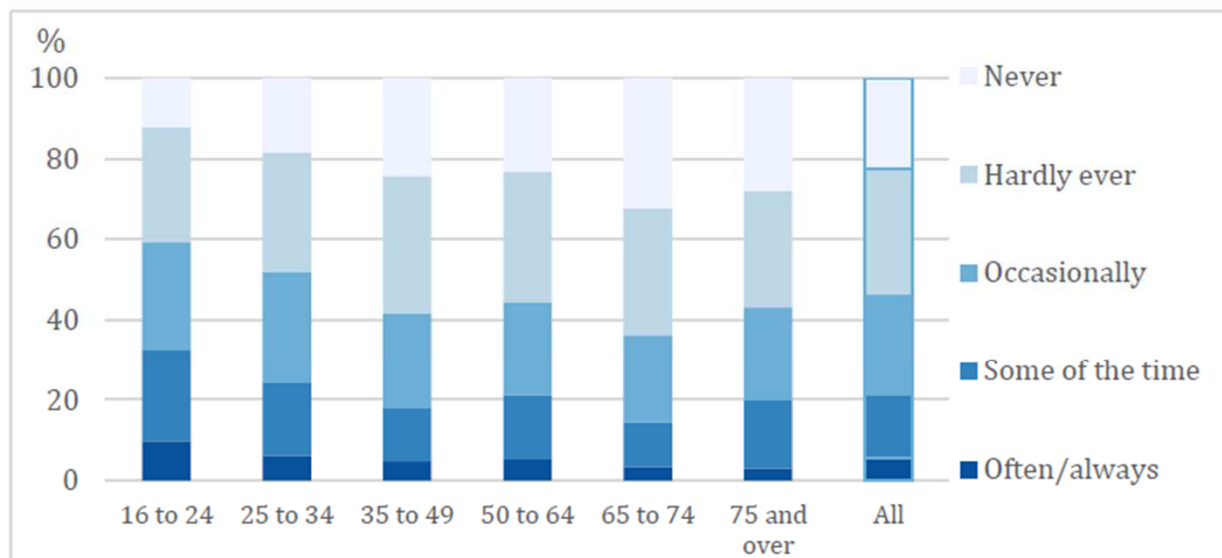
- Social isolation and loneliness are harmful to physical and mental health and increase **risk of morbidity and mortality**.



- Social isolation and feelings of loneliness can also be physical or psychosocial **stressor** resulting in behaviour that is damaging to health.
- Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help **individuals to recover** when they do fall ill (Marmot, 2010).

Loneliness in the UK

Proportion of adults who felt lonely by age group, 2016-2017 (DCMS, 2017)



The proportion of adults reporting they felt lonely often/always has remained unchanged since collection began in 2013-14 at 5%. In 2016-17 over half (54%) stated they felt lonely hardly ever or never.

Those aged 16 to 24 are significantly more likely to feel lonely often/always than the other age groups, at 10% compared to 6% of those aged 25 to 34, 5% of those aged 35 to 64, and 3% of those aged 65 and over.

Measuring high level outcomes

At population level:

Reducing **social isolation is a priority** for social care and public health

- Public Health Outcomes Framework and the Adult Social Care Outcomes Framework.
- The current measure draws on self-reported levels of social isolation (using social contact as a proxy) for both users of social care and carers.
- These indicators assist local authorities in focusing on some of the more vulnerable people in their community

“the percentage of adult carers who have as much social contact as they would like”

Who is at high risk ?



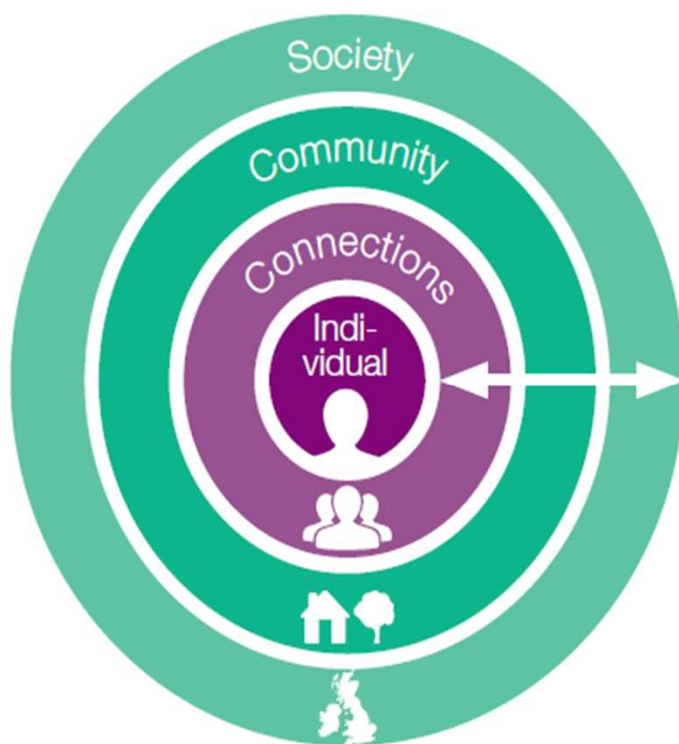
Inequalities and wider determinants

There is evidence to suggest a significant correlation between low socioeconomic status and social isolation. Action on structural determinants including economic disadvantage is important.

Social disadvantage linked to life experiences that increase risk of isolation, e.g. poor maternal health, teenage pregnancy, unemployment, illness in later life.

Wider issues such as access to green/public spaces, transport (to enable social connections) can help or hinder

Drivers to loneliness and barriers to connection



Social and cultural norms, work/life balance, stigma, digital age, insular communities, political landscape, financial hardships



Social activities, funding cuts, statutory services, transport, neighbourhood safety



Friends and acquaintances, family, colleagues



Sense of self, health, income, energy, confidence, emotions, perceptions

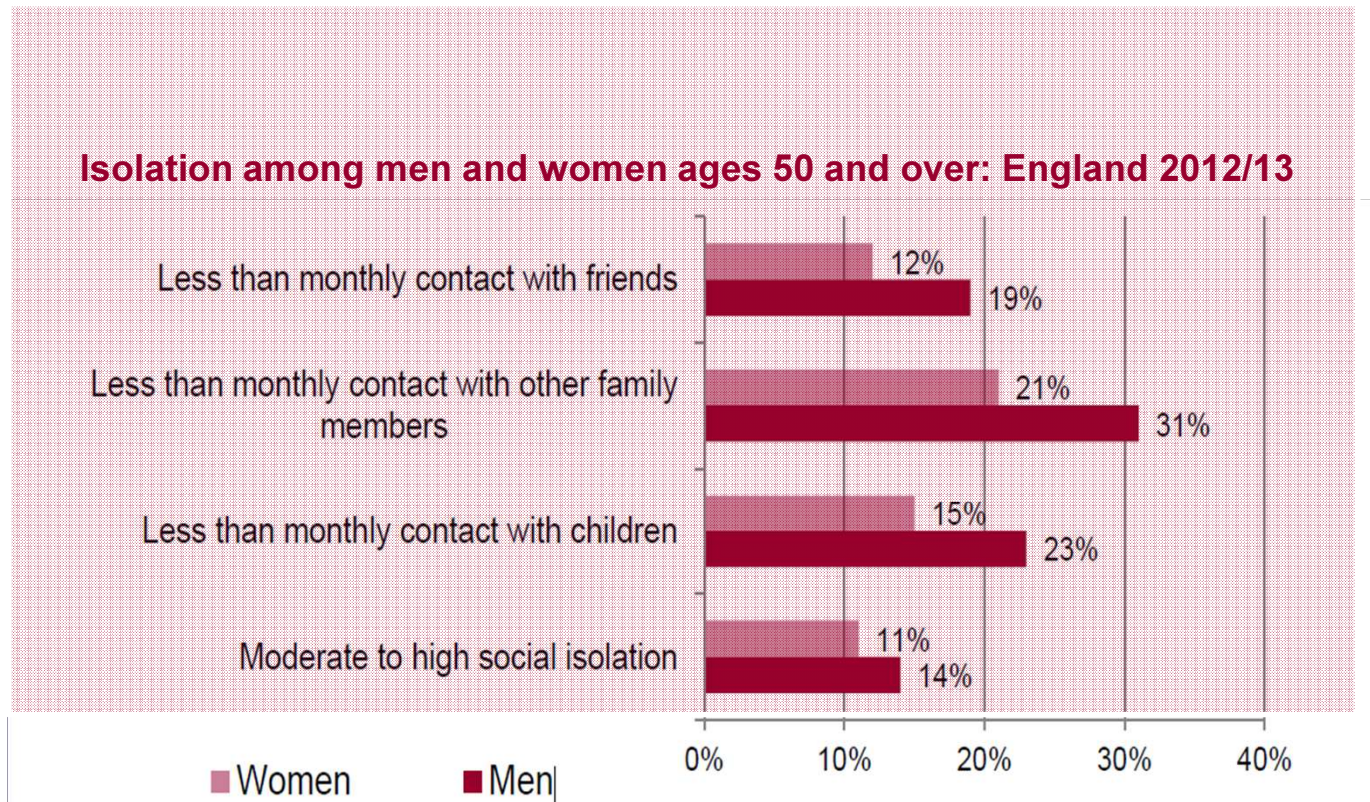
Inequalities – ethnic minority

- Some evidence suggests that levels of loneliness are **higher** among older adults from ethnic minorities (exception of Indian population). (Victor et al, 2012)
- Social isolation among older ethnic minority people is of further concern as people in this group are **less likely** to access services for older people. (Sachragda, 2011)
- Older adults in ethnic minority groups may also experience language barriers and **higher** levels of poverty than the general population. (Khan, 2014)



Inequalities – gender

- Older men are more likely to be **isolated** than older women (Beach et al, 2014)



- ONS found that more women reported feeling **lonely** than men (ONS, 2013)

Inequalities – carers



- There are approx. **1.3 million carers** aged 65 and over in England, and the rate is **increasing**.
- The older carers get the **more likely** they are to provide increased hours of care.
- High levels of care correlates with **less time** out of the house, to self and socialising with friends, as well as negative health impacts, which **increases** risk of social isolation.
- A 2009 study found that male care-givers were **four times** more likely to be socially isolated than their female counterparts. (Robinson et al, 2009)
- A survey in 2014 found 43% of older male carers (65+) think **local support do not fits their needs** (Slack, K and Fraser, M, 2014)

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new data

PoYee Tang, 20/03/18



Loneliness and the oldest old

- Lack of research on the oldest old (85+)
- Newcastle 85+ study show over half (57%) of 85 year olds reported 'never' feeling lonely
- Oldest old & loneliness : widowhood, living alone, depression, being female
- Not a static experience
- Length of widowhood a key factor, most recently widowed having 2 x risk of feeling lonely compared to those widowed for 5 years
- Loneliness can be more prevalent in institutional settings



Ref: Brittain et al, An investigation into the patterns of loneliness and loss in the oldest old – Newcastle 95+ study, Ageing and Society



Inequalities – poverty

- Poverty represents not only lack of financial wealth but of resources
- Social isolation is both a **cause and result** of poverty
- Not only lower income but also **income inequality**, which **undermines trust and social capital** in community.
- **Social exclusion** is a new term Govt. is using



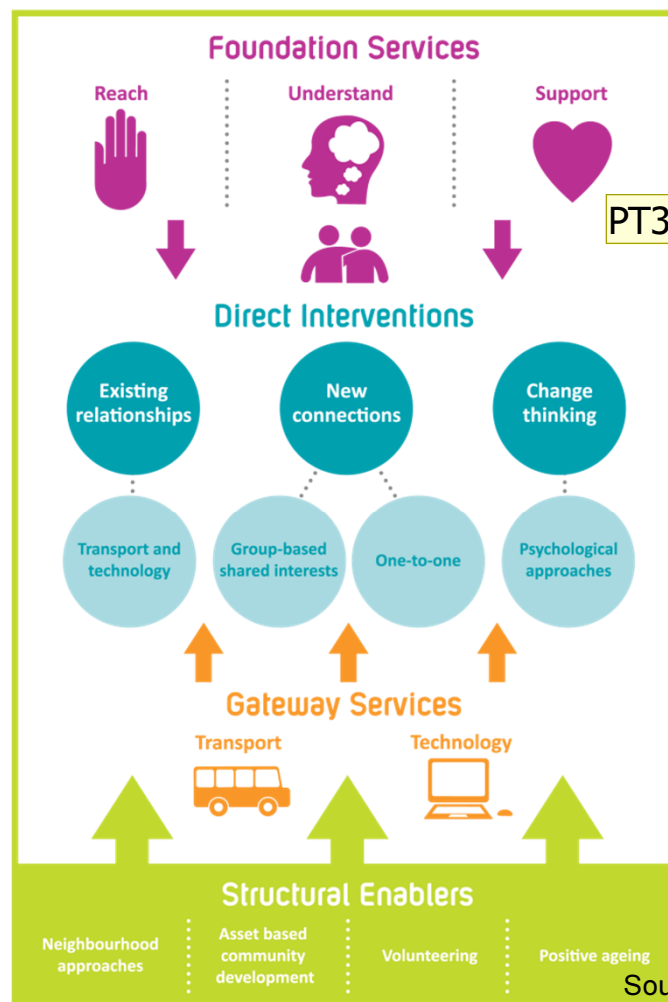
What does the evidence tell us to do ?

- **Targeting** has the greatest impact
- Reduce '**stigma**' attached to being lonely – *avoid the 'L'* word
- Base interventions on effective evidence - positive **mental health promotion** showed good outcomes
- **Group activities** achieve good outcomes especially those with an arts, educational learning or social focus
- **Participatory** initiatives are most beneficial
- One-to-one initiatives (e.g. befriending) only appear to be effective in certain circumstances



What does the evidence tell us to do ?

- The impact of technologies works for specific groups
- Real and practical barriers should be the focus of **joint efforts by all agencies** concerned with the wellbeing of
- **Earlier interventions across the life course** could help prevent some of the negative effects of social isolation from accumulating in later life.



Source:
Campaign to
End Loneliness

Designing Solutions:

Identifying

What works

How

Why

**Place based/
population based
approaches**

Drawing on local knowledge, networks and community organisations

Understanding of local needs and provision gaps, trusted by beneficiaries

Engaging

**Proactive
approaches**

Letters, phone calls, door knocking, home visits

Reaches hidden populations including isolated people, those not accessing support and those initially reluctant to engage

Impacting

**Broad based
approaches**

Public spaces, radio, advertising, leaflets, referral from Health and Social Care, Voluntary and Community sector

Moves beyond traditional organisational reach, receives referrals from public, creates project buzz

Sustaining

Wider public health interventions

- **Design of cities and towns** : provision of public seating and toilets, and good public transport can encourage older people to get out and about, increase their mobility, and socialise. Age Friendly Communities, Compassionate Cities.....
- **Physical activity**: promotion of physical activity to meet new guidelines for activity among the over 50s also create opportunities to increase social interactions and build social networks.
- **Drugs and Alcohol**: efforts to tackle drug and alcohol misuse can be more effectively targeted if loneliness is recognised as a potential contributing factor
- **Health screening and preventative interventions** (e.g. NHS Health Checks) can be capitalised upon to also identify, and address, or build resilience to, loneliness and isolation
- **Falls prevention programmes**: fear for falls can lead to people becoming socially isolated. These programmes are not just a means of reducing costly hospital admissions, but also an opportunity to maintain mobility and independence.

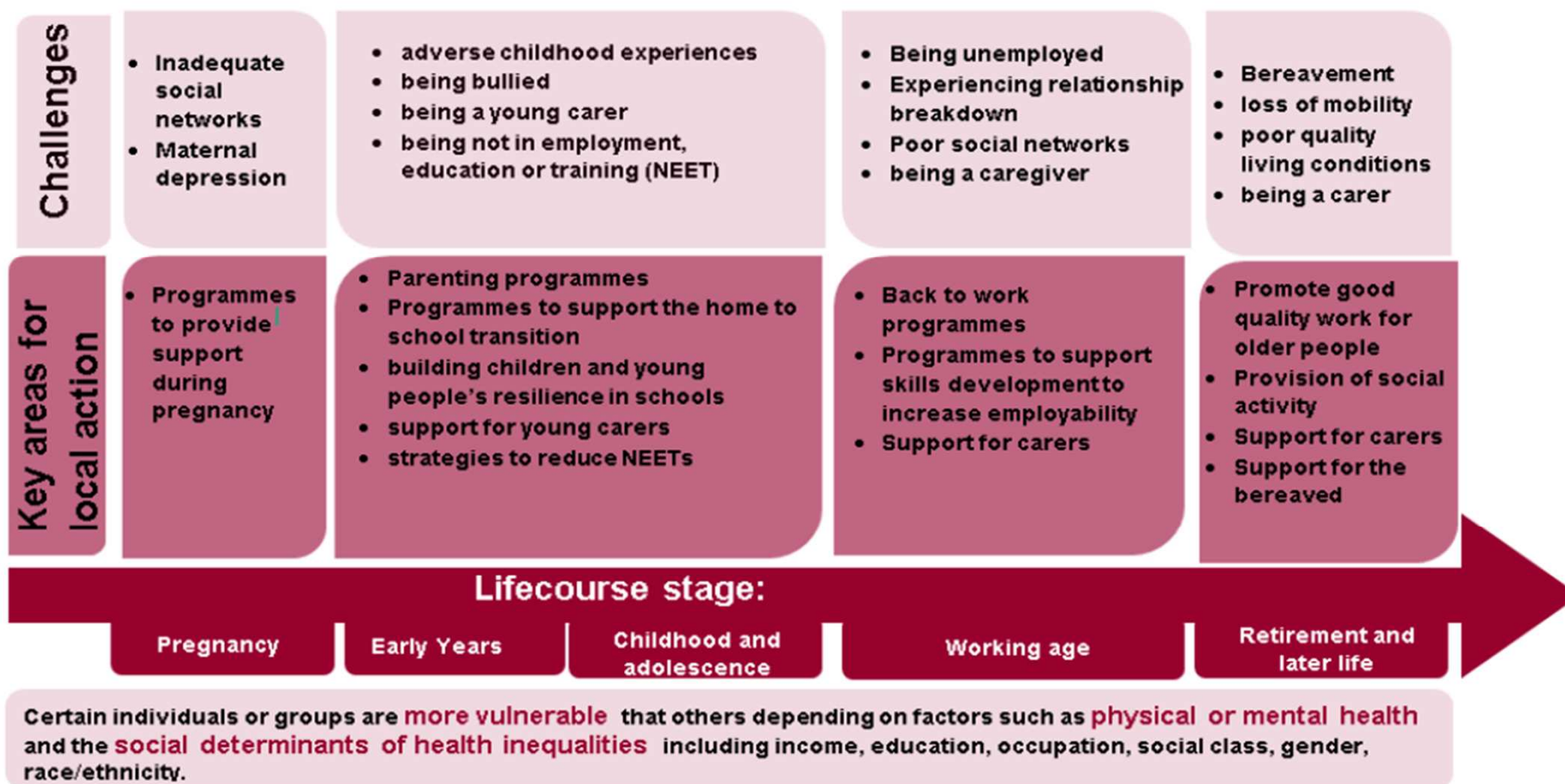
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additional finding

PoYee Tang, 20/03/18

Social isolation across the life course – opportunities



PHE's approach : examples

Cross-organisation approach:

- Evidence review of 'what works' for using **a community assets based approach** for reducing social isolation
- **Collaboration with Fire and Rescue services** to identify lonely older adults and signpost to relevant services.
- Work with Alzheimer's Society to promote **Dementia Friendly Communities** to address loneliness in people living with dementia
- **ROI Evidence Tool** - Mental health Promotion
- **Evidence resources for Professionals:** Prevention Concordat for better mental health, a suite of resources (30.08.2017), Human Trafficking, Helping older people maintain a healthy diet: A review of what works.
- Mental Health Employer Toolkit and Wellbeing in Mental Health
- **Suicide prevention Toolkit** developed in partnership with Business

Conclusion

- Loneliness and social isolation are **important, cross cutting, public health issues**
- **Complex and multi-factorial** issues that require partnership working
- There are **opportunities** for health and wellbeing boards **to encourage partnership** working between community and voluntary services, the NHS and local authorities to engage in strategies to reduce social isolation
- A **life course approach** offers opportunities to intervene at different time points, tailoring interventions to 'at risk' individuals/groups.
- Research identifies promising practice, but the **evidence base needs to be more robust for some groups and the cost effectiveness.**

Understanding what's happening locally & implications for action locally – questions for reflection & discussion

- What's already happening locally?
- Given the complexity & breadth of potential action, how are you focusing your energies?
- Is SI&L being included in JSNAs, both in terms of needs & assets?
- How are STPs and emerging ACOs and ICSs engaging with this area of work?
- Are there opportunities that could be developed through volunteering?
- How are initiatives and/or approaches to embedding this in local system thinking?
- Are there opportunities for collaboration?
- What support do you want/need from PHE?