



Public Health  
England



UCL Institute of Health Equity

## Local action on health inequalities

# Reducing social isolation across the lifecourse

Practice resource summary: September 2015



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The UCL Institute of Health Equity (IHE) is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health, specifically in four areas: influencing global, national and local policies; advising on and learning from practice; building the evidence base; and capacity building. The Institute builds on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the Commission on Social Determinants of Health, Fair Society Healthy Lives (The Marmot Review) and the Review of Social Determinants of Health and the Health Divide for the WHO European Region.  
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## About this practice resource summary

This resource was commissioned by PHE and produced by IHE. It is a summary of a more detailed practice resource on the same topic and is intended to help local authorities, health and wellbeing boards, and health and social care professionals when devising local programmes and strategies to reduce health inequalities.

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# Reducing social isolation across the life course

## Summary

1. The quality and quantity of social relationships affect health behaviours, physical and mental health, and risk of mortality.
2. Anyone can experience social isolation and loneliness. While social isolation is more commonly considered in later life, it can occur at all stages of the life course. Particular individuals or groups may be more vulnerable than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.
3. There are links between health and social inequality and social isolation; many factors associated with social isolation are unequally distributed in society.
4. Factors that influence social isolation and loneliness operate at the individual level, the level of the community or local area and at the wider societal level.
5. Individual and community level factors that impact on social isolation are nested in the wider social, economic, political and cultural context.
6. A range of services provided by the public sector, private sector, third sector and community and voluntary services may have the potential to impact on social isolation, even if this is not their primary aim. For example, aspects of the built and natural environment and transport infrastructure can help or hinder efforts to enhance social connections.
7. Learning from specific interventions already in place in local areas can be used to inform work in other local areas to reduce social isolation. Although the context of social isolation across local areas may differ, a recurrent theme is the importance of involving communities in the design of interventions and the way they are managed and implemented.
8. Many community based interventions intended to reduce social isolation will not be identified as such within the community they serve. Instead, they will be focused on activities that can be shared; bringing people together naturally in a way that is appropriate to their particular needs.
9. Successful interventions to tackle social isolation reduce the burden on health and social care services. As such they are typically cost-effective.

## Introduction

The issue of social isolation is receiving increasing attention from health and social care professionals, the voluntary sector, community-based organisations and local authorities. One reason for this is the negative impact that social isolation is known to have on individual health and wellbeing at different stages of life. As a result, social isolation brings significant costs to health and social care services. There are links between social and health inequalities and social isolation: this is because many factors associated with social isolation are unequally distributed in society.

Reducing social isolation is a priority for social care and public health as reflected in shared indicators across both the public health outcomes framework<sup>1</sup> and the adult social care outcomes framework.<sup>2</sup> The current measures draw on self-reported levels of social isolation (using social contact as a proxy) for users of social care and carers. These indicators assist local authorities in focusing on some of the more vulnerable people in their community.

The relationship between social isolation, health and inequalities in health is complex and multifactorial. Consequently no single sector can tackle social isolation comprehensively if acting alone. Efforts to reduce social isolation require working across organisations and government departments. This provides opportunities for health and wellbeing boards to encourage partnership work between community and voluntary services, the NHS and local authorities to engage in strategies to reduce social isolation and loneliness in the community.

Learning from local areas and organisations already addressing social isolation shows that much can be done to tackle social isolation using existing community assets – particularly relevant in view of local spending constraints coupled with increasing demands for health and social care.

### Key definitions

**Social 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).<sup>3</sup>

**Loneliness** – An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.<sup>3</sup>

## The links between social isolation and health inequalities across the life course

Factors that influence social isolation and loneliness operate at the individual level, the level of the community or local area and at the wider societal level. Anyone can experience social isolation and loneliness. However, particular individuals or groups may be more vulnerable than others, depending on a number of factors including physical and mental health, migrant status, level of education, employment status, wealth, income, ethnicity, gender and age or life stage.

Social isolation is a health inequality issue because many of the associated risk factors are more prevalent among socially disadvantaged groups than the general population. Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health,<sup>4</sup> teenage pregnancy,<sup>5</sup> unemployment, and illness in later life.<sup>4</sup>

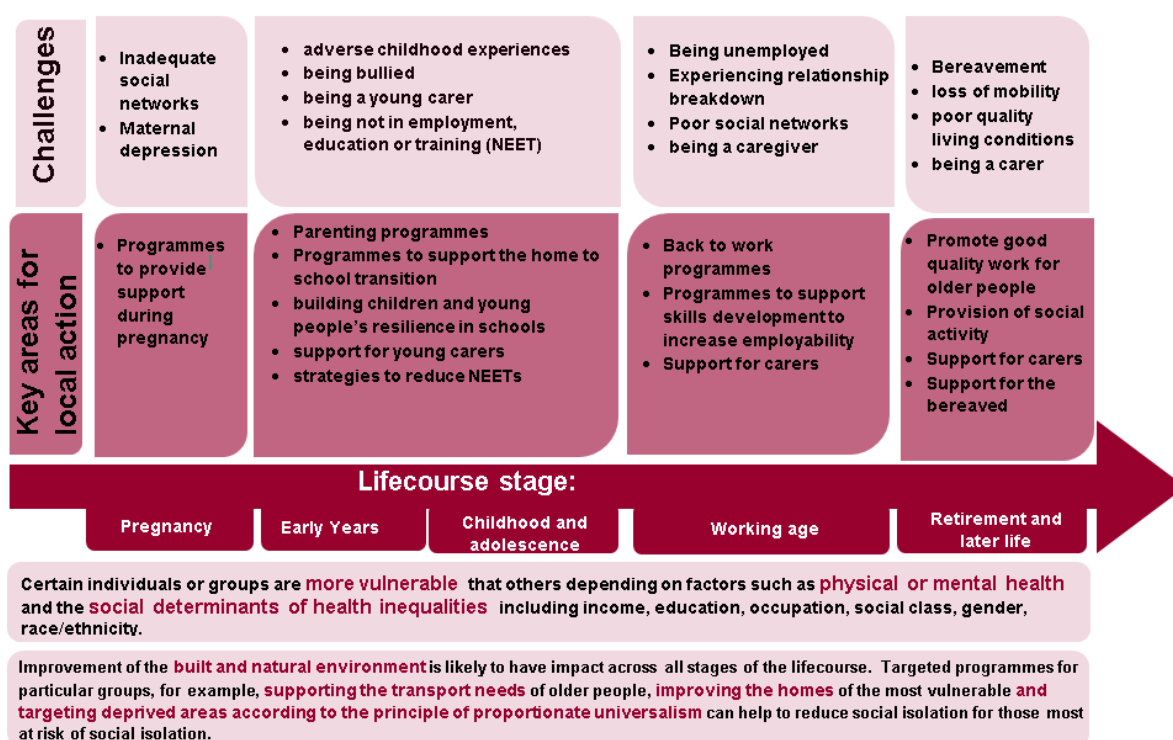
Characteristics of the built environment and transport also impact on social isolation and may do so at all stages of the life course. Deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement. Access to transport is also vitally important in building and maintaining social connections.<sup>6-8</sup>

Influences on social isolation accumulate throughout life.<sup>9</sup> For example, social withdrawal in childhood serves as a risk factor for impairment of adolescent interpersonal interactions, which increases risk of depressive symptoms and diagnoses of depression in young adulthood. Depression in turn increases the risk of social isolation.<sup>10</sup> While social isolation at older ages may have roots in earlier life, current circumstances also play a role. Events including the loss of a loved one, health conditions that precipitate disability and caring responsibilities may contribute to a reduction in social contact. The extent to which these events contribute to social isolation or loneliness depends on individual factors, such as the extent and quality of an individual's previous social connections.

## What works to help reduce social isolation

This briefing is focused on informing action at the local level to tackle social isolation. Figure 1 illustrates when and how social isolation can impact on the individual across key stages of the life course, as well as the key components of an effective intervention for each life course stage.

Figure 1 – the impact of social isolation across the lifecourse



The full practice resource document also looks at a number of interventions and their impact on social isolation, considering action at different stages of the life course. One finding is that some interventions, while not targeted specifically at social isolation, can nevertheless help sustain and create social networks. One example is the Hackney WellFamily Service, which is mainly aimed at working-age adults.

### Example intervention: Hackney WellFamily Service

**Description:** The Hackney WellFamily Service is a primary care service aimed at addressing complex psychosocial needs. The service provides recovery-focused and holistic interventions including a mix of individually targeted and flexible practical and emotional support to promote health and social wellbeing.

**The aim is to improve clients' wellbeing in terms of anxiety and depressive symptoms and improved social adjustment and recovery in terms of mental health, financial status, self-care and physical health, social networks, work, education and training, relationships, independent living and addictive behaviour.**

**Target groups:** Primarily working-age adults: uptake is high among ethnic minority groups and services are delivered in first languages. (White British users only accounts for 15%.)

**Delivery partners/roles:** People are referred to WellFamily from local services including Improving Access to Psychological Therapies Services (IAPT) and GPs.

**Type of intervention:** The service provides advice and information, including in the areas of employment and housing support, counselling and welfare benefits support. It also encourages and helps facilitate activities such as physical activity, advocacy, volunteering, signposting to other services, carer support and peer support.

**Impact:** The service has been well received by both service users and other providers. Among GPs, 99% of those surveyed in the evaluation said they would recommend the service to another practice. Furthermore, GPs reported a 70% reduction in inappropriate visits to primary care demonstrating financial savings. Among service users, 81% felt the service had mostly or definitely helped to achieve their goals in relation to the issues they presented and 99% of respondents rated the service quality as either excellent (81%), or good (18%).

**Evidence on costs:** The social return on investment (SROI) for the scheme was £5.96 per £1, making it a very cost-effective service. The reason for the high return was because the burden has been shifted from a more to less expensive service. The WellFamily service typically costs £55 per hour, compared to GP costs of up to £300 per hour. Costs incurred include staffing and staff training.

Source: Family Action Impact Report<sup>11</sup>

This intervention focused on improving mental health and had a range of positive benefits. The impact evaluation reported that the service was effective and well received, as well as cost effective through a reduced burden on GPs.<sup>11</sup>

An example of improving social connectedness among older people is the LinkAge programme in Bristol.

### Example intervention: LinkAge, Bristol

**Description:** The LinkAge programme aims to promote and enhance the lives of older people (aged 55-plus) through the facilitation and the development of a range of activities. Its approach includes fostering social awareness and encouraging older people to share their skills with volunteers, young people and others within their community. LinkAge aims to inspire older people and others to share their time and experiences with other older people who for one reason or another have become isolated.

The goal of LinkAge is for older people to have improved physical health through activities, and improved social connectedness through befriending.

**Target groups:** People aged 55 and over, with a particular focus on older people from ethnic minority groups.

**Delivery partners/roles:** LinkAge works with a number of organisations in fundraising and reaching a diverse range of communities. To encourage ethnic minority participation, LinkAge works with a number of local community and voluntary sector organisations: Bristol Indian Association, Golden Agers, Dhek Bhal, Malcolm X Elders, Evergreens, Somali Elders and Bristol Chinese Women's

Association.

**Type of intervention:** The intervention provides a range of services focused on befriending and encouraging physical activity.

**Impact:** The Centre for Social Justice and the University of the West of England conducted an analysis of the service which found that it was beneficial to participants. The Centre for Social Justice described it as, “an excellent example of such an approach from which many other local authorities could learn”.

Surveys of service receipts found both increased physical activity and social connectedness. When asked about frequency of exercise upon joining the service, 26.7% of respondents said they exercised seven days a week. In the follow-up survey this had increased to 40%.

When asked about social connectedness on joining the service, the average score was 14.5 (on a scale where 0 = very socially isolated and 24 = very or highly socially connected). In the follow-up survey six months later, the average was 22.8 – a considerable improvement.

Service users’ comments included:

“LinkAge is a saviour. I gave up work six months ago and it was incredibly important in helping me make the transition” – participant in Tai Chi class.

“LinkAge was a godsend – I could be not only active, I could be doing and helping” – advisory group member and volunteer.

**Evidence on costs:** An evaluation in the Whitehall and St George area found that for every £1 invested there was a social return on investment (SROI) of £1.20. Cost saving benefits for the NHS come through early intervention, saving money from avoiding later stage (and more expensive) interventions. By far the biggest added value that the project brings into the hub is the large amount of unpaid volunteer time provided by individuals to help support its activities. Costs incurred included staffing and renting spaces for activities.

This SROI was deemed to be both considerable and an underestimate, the rationale being that the hub was only in its first year of existence at the time of evaluation. A considerable amount of time was spent bedding down activities and developing beneficiary confidence in the activities and the approach. Therefore a lot of volunteer and community development worker time was spent in start-up rather than delivery.

Source: Centre for Social Justice Evaluation<sup>12</sup>

The examples of interventions outlined in the full practice resource provide insights into how to tackle social isolation in an integrated way that will support individuals in many aspects of their lives, including those managing long-term health conditions. Interventions such as these should form part of a comprehensive strategy to improve health and reduce health inequalities by taking action across the whole of society,



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with more intense and targeted action for those at greater risk – proportionate universalism.<sup>4</sup>

## Conclusion

Social isolation is a complex social issue with roots at the societal, community and individual level. While social isolation is more commonly considered to occur in later life, people can be affected by social isolation at any age or stage of life.

Reducing social isolation across society will contribute to improving overall health and wellbeing, and to reducing health inequalities. More research is needed to quantify the contribution of social isolation to poor health and to health inequalities.

Organisations in local areas are well placed to work with individuals and communities to identify who is at risk and to engage them in finding solutions. Broader interventions in areas such as transport, housing and the built and natural environment will support the creation of conditions that forge and foster good relationships within society. More research is needed to evaluate the effect of interventions on social isolation, and on health, and to better estimate the net benefits of such initiatives, taking into account the wide range of impacts they may have.

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