



All the lonely people: social isolation and loneliness in County Durham



Report of the Director
of Public Health County Durham 2014



“ Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. ”

Marmot M (2010), Fair Society, Healthy Lives.
The Marmot Review.

Introduction

This year my Director of Public Health annual report is different to previous versions as I have decided to focus on a single issue that impacts on health and wellbeing: social isolation. I hope this report has a wide readership, particularly from local community organisations and front line practitioners working regularly with local people and that it stimulates thought about how we can tackle the issue of social isolation at all levels.

The multi faceted nature of social isolation presents us with a complex challenge. Although acknowledging that social isolation affects many people living in County Durham and has a significant negative effect upon health and wellbeing, this report concentrates on two specific groups - children and young people and the elderly. We hear a lot about social isolation but what does it mean? Who is at risk? What are we doing about it? How does it impact on health and wellbeing? Hopefully some of the answers are in this report and by drawing attention to the scale of the issue, action will follow.

Although academics now identify and define social isolation and loneliness as separate issues, this report is treating them as interchangeable as the root causes and the methods we can use to tackle them are largely the same. Put simply, isolation refers to the involuntary, complete or near complete lack of contact with people and society. It includes many people with different characteristics and it impacts on an individual's quality of life and their wellbeing.

The Marmot Review 'Fair Society, Healthy Lives' (2010) makes the case for tackling social isolation by noting that "individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely". The report also makes it clear that health inequalities result from social inequalities and that action is needed across all the social determinants of health (e.g., poverty, housing, employment and education) taking a 'lifecourse' approach. These social determinants of health have been described as 'the causes of the causes of health inequalities'. They are the 'conditions in which people are born, grow, live, work and age' and are also contributory factors to social isolation.

Much is already being done to address social isolation in County Durham by a wide range of individuals and organisations. The Health and Wellbeing Board recognises the value of communities working together to reduce isolation and increase resilience and the benefits that a well connected society can bring. Social isolation has been identified as a priority in the Joint Health and Wellbeing Strategy and through the Community Wellbeing Partnership (see Appendix 2) and the Wellbeing for Life programme, initiatives are being undertaken in partnership with communities to address isolation.

We are working with communities to undertake asset mapping, improving links to local health services, promoting the role of voluntary and community services and working with them to help create an environment where people can connect with their neighbours, communities or people of the same interest. Social isolation is also one of the seven work streams of County Durham's Better Care Fund programme (Appendix 3), recognising that this impacts on the health and wellbeing of our residents.

However, no one organisation can tackle social isolation. It is everyone's business and we must look at how we can work collectively to tackle this issue. Increasingly, we are seeing that communities and individuals are taking greater responsibility in supporting local people across a range of issues, including social isolation and this report aims to build on this approach and encourage wider awareness and involvement. This is about co-production, about less reliance on formal intervention and about working together irrespective of which organisation or community is involved. Together we can, and must, do more - as our population ages social isolation is likely to become a bigger issue.

I want to bring to the reader's attention that this report may appear to be focused on the consequences of social isolation rather than tackling the causes. Much work is taking place to address the social, political and economic dimensions that impact people's lives and can lead to social isolation. This includes approaches to reducing poverty, tackling stigma and discrimination and supporting groups who feel isolated and outside the 'mainstream' of society.

For those readers who like to explore data sets and detail, I refer you to the County Durham joint strategic needs assessment, a comprehensive collection about the health and care needs of County Durham residents.

I hope this report stimulates thought and discussion and is a call to action - we must work more collaboratively to support those in our community who are at risk of, or already suffering from, social isolation. I look forward to hearing both the progress of current initiatives and new developments underway over the next year.

Ana Lynch





**“ Loneliness - the pain of being alone.
Solitude - the glory of being alone. ”**

Paul Johannes Tillich

**“ Loneliness is the poverty of self;
solitude is the richness of self. ”**

May Sarton

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Key messages

- Social isolation and/or loneliness is a significant and growing public health challenge for County Durham's population. It is associated with poor physical, mental and emotional health including increased rates of cardio-vascular disease, hypertension, cognitive decline and dementia.
- Anyone along the lifecourse can suffer from social isolation, not just older people. It can affect anyone at any point in their lives, though some individuals are at higher risk.
- People with stronger social networks are more likely to be healthier and happier. Those with weaker social networks can become isolated, and as a result, more likely to experience poor physical and mental health and require support and intervention from the local health and care services.
- Earlier interventions could help prevent some of the negative effects of social isolation from accumulating further and impacting on health and wellbeing as people get older.
- Social isolation is an issue that requires all organisations, communities and individuals to become involved and to recognise that all have a key role to play.
- The causes of social isolation are complex and varied. As well as supporting individuals who are, or who are potentially at risk of social isolation, partner organisations must continue to tackle the underlying causes such as stigma and discrimination, education, poverty, skills and employment etc.






Recommendations

- Partner organisations should identify those who are, or who are at potential risk of becoming socially isolated. There is a role for communities and individuals to support isolated people at a local level, and to build resilience and social capital in their communities.
- Organisations should support the building of local connectedness in communities, working across partnerships in order to protect those most at risk of social isolation.
- Organisations, including the voluntary and community sector and Action Area Partnerships (AAPs) should work towards creating an environment where people can connect with their neighbours, communities or people of the same interest.
- Front-line professionals should consider the impact of social isolation on their patients/clients and signpost or support them to sources of help.
- Relevant strategies should identify actions to tackle social isolation wherever appropriate.
- Service developments, new commissions and contract specifications should consider the impact of social isolation on client / patient groups.
- Appropriate training and policies should be in place to support volunteers in County Durham communities.
- Partners should continue to focus on 'upstream' approaches that tackle the underlying causes of social isolation.



What is the issue?

Social isolation has become increasingly recognised as a significant and growing public health issue facing communities today. It has a negative impact on individual health and wellbeing, it is costly to local health and care services and it can increase the chances of premature death.

The links between isolation and loneliness and poor physical and mental health are strong. Effects can include depression, decreased immunity and longer recovery from illness, poor nutrition, increased anxiety, fatigue, social stigma and ultimately increased morbidity and (premature) mortality. Recent studies suggest isolation:

- Has a more negative effect on wellbeing than physical inactivity, obesity or smoking 15 cigarettes a day¹,
- Can increase an older person's chances of premature death by 14%²,
- Increases the likelihood of admission into residential or nursing care², and
- Increases morbidity, depression and suicide as well as health service use³.

In 1995 research suggested a 'substantial body of evidence that indicates that the extent to which social relationships are strong and supportive is related to the health of individuals who live within such social contexts'⁴. 'The Solid Facts'⁵ referred to the harm caused by social isolation and how this might be overcome by improving social connectedness. It suggested that 'friendship, good social relations and strong supportive networks' were key in order to 'improve health at home, at work and in the community'.

People with stronger social networks are more likely to be healthier and happier; those with weaker social networks can become isolated and, as a result, more likely to experience poor physical and mental health and increase the demand on local health and social care systems.



What is the challenge?

Taking action to reduce social isolation and loneliness in our communities can reduce the impact and cost on local health and care services, whilst improving the health and wellbeing of our population.

The Office for National Statistics recently suggested that Britain is the 'loneliness capital of Europe'⁶, finding that residents are less likely to have strong friendships or know neighbours than inhabitants of any other country in Europe. It is these strong friendships or social networks/connections that make people happier, healthier and more resilient. Those with weaker social networks can become isolated and, as a result, are more likely to experience those negative effects on health and wellbeing highlighted previously.

This is where local action can make a difference and everyone has a role to play. Today's economic climate, where resource is scarcer than ever, requires cost effective solutions aimed at reducing demand on local services.

Interventions aimed at reducing isolation through harnessing community based networks are highly effective and at the same time, continued action to address the causes of the causes of health inequalities is needed.

The evidence is very clear that communities with high levels of social capital have better outcomes in health and can enjoy greater levels of social cohesion. For these reasons (among others), reducing social isolation needs to be a key priority for a range of organisations. The challenges are therefore:

- To identify those who are, or who are at risk of, becoming isolated or lonely and may often be hidden in plain sight,
- To give appropriate support that helps to build and improve social connections in communities, working across partnerships, in order to protect those most at risk of isolation and loneliness,
- To create an environment through co-production where people can connect with their neighbours, communities or people of the same interest, and
- To create a fairer environment where stigma and discrimination are challenged.

Only through engaging local communities in co-producing local solutions can the issues relating to social isolation be addressed. Work in partnership with community groups, local faith groups, the voluntary and private sectors is needed to build community cohesion and to offer the personal and integrated approach that supports those suffering from social isolation.



‘Healthy lives, healthy people: the strategy for public health in England’ sets out a range of local approaches to improve physical and mental health, recognising the community and environment in which people live can also strongly influence both population and individual mental health and wellbeing. Approaches of particular importance include:

- Reducing isolation, providing support during times of difficulty and increasing social networks and opportunities for community engagement,
- Providing good access to continued learning,
- Improving support for informal carers,
- Developing warm homes initiatives, and
- Promoting physical activity and physical health.

There are numerous examples of initiatives and programmes in County Durham that build and improve social connections in communities. These work across partnerships to support those most at risk of isolation and loneliness and it is impossible to capture them all in this report. Some offer one to one support, some group support and others offer support that is broader and across a community of either interest or geography. The value of this work should not be underestimated and there is a growing evidence base that demonstrates the effectiveness of a range of interventions. For example, a study referenced by the Social Care Institute for Excellence (SCIE) in 2011 estimated that a befriending scheme costing £80 per person resulted in savings of £300 per person per year^{7,8}.



Who is at risk?

Anybody can be affected by social isolation or loneliness. It can 'affect any person, living in any community'⁹. Older people are particularly vulnerable due to factors such as bereavement, reduced mobility, sensory impairment or limited income. The Campaign to End Loneliness suggests that over 700,000 people aged over 65 in the UK report that they are lonely¹⁰. Of course, as this elderly population grows then so does the number at risk of social isolation. Estimates suggest that 20% of the older population are mildly lonely and a further 11% are intensely lonely¹¹.

For County Durham this would mean around 19,000 people aged 65+ being lonely, with over 10,000 experiencing intense loneliness.

However, other groups in the population are at risk including:

- New, young or lone parents,
- Carers (both young and old),
- People experiencing domestic abuse,
- Lesbian, gay, bisexual or transgender,
- Long term unemployed,
- People with autism or a learning disability,
- Those with a physical disability or long term condition,
- Black minority ethnic and recent migrant communities,
- Those experiencing poverty and deprivation,
- The young,
- The homeless, and
- Those with substance misuse problems.

Public Health England estimates that 7% of the 18-64 population are socially isolated¹².

For County Durham this would mean around 22,000 people aged 18-64 being socially isolated.

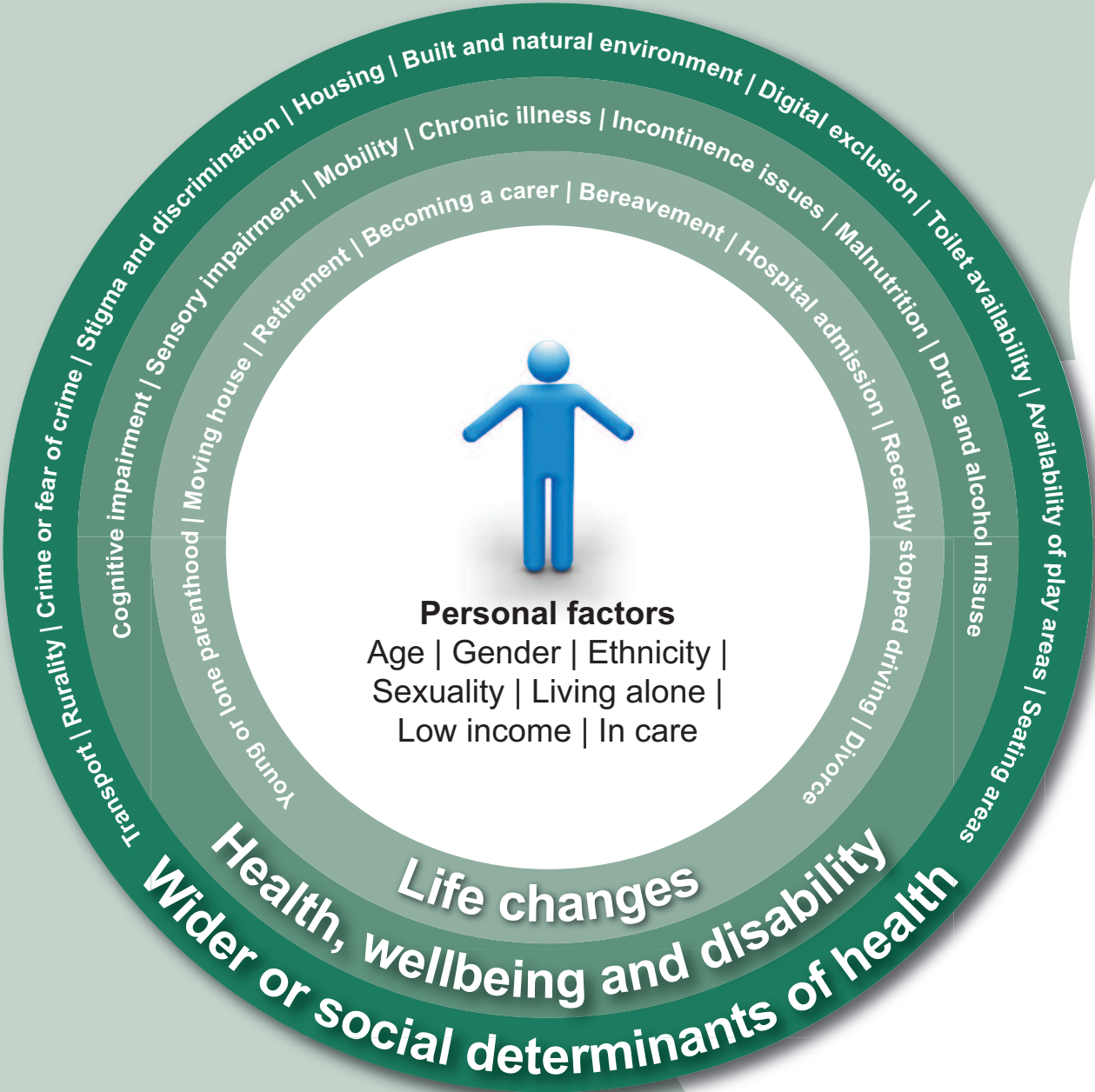
This report explores the issue in relation to children and young people and older people whilst recognising that social isolation also impacts on the wider population and specifically those groups mentioned above.

Risk factors for isolation and loneliness can be categorised into four distinct areas:

- Personal factors
- Life changes
- Health, wellbeing and disability
- Wider or social determinants of health

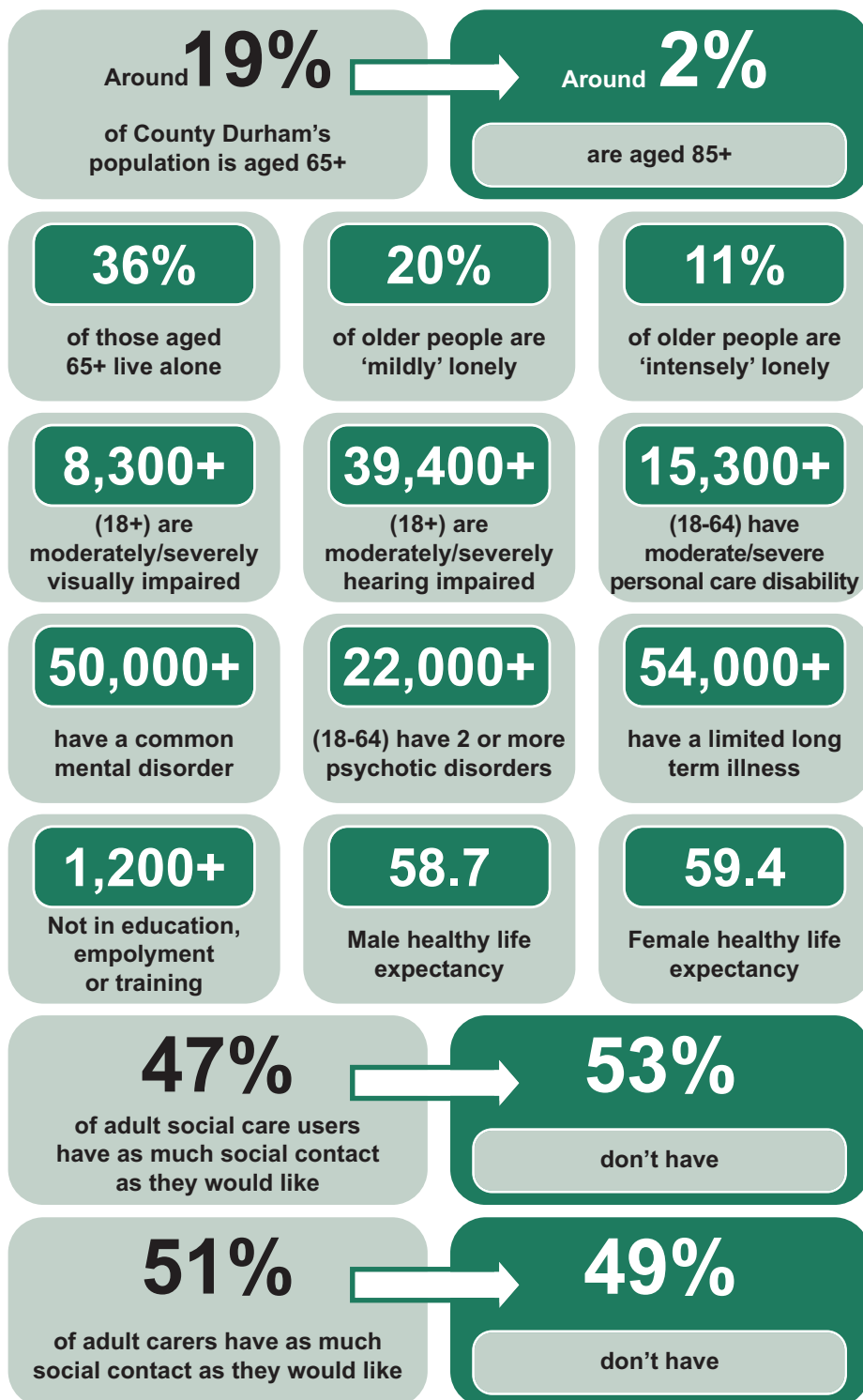
Individual risk factors within these four areas are shown in Figure 1 overleaf.

Figure 1: Individual risk factors
by category (all ages).



General factors linked to social isolation and loneliness

The information below, drawn from a wide variety of sources and estimates, is intended to provide an overview of the possible scale of those potentially at risk of social isolation in County Durham.



General factors linked to social isolation and loneliness

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*Learning disability



Definitions

Social isolation and loneliness aren't the same thing, but are used interchangeably. People can feel lonely without being isolated and isolated without being lonely. Whilst there is a strong and complex relationship between social isolation and loneliness, one does not necessarily follow the other, although many of the risks or triggers are shared and there is a large overlap between the two¹³.

Although the links between isolation and loneliness and poor physical and mental health are strong, only social isolation (and not loneliness) has been shown to be associated with increased mortality¹⁴.

Social isolation

An objective experience and relates to the lack of, or frequency of social contacts, interactions or social support structures, or the lack of input into wider community activities.

Social isolation is commonly an involuntary state and is often brought about by marginalisation, deteriorating mental capacity or discrimination. It is a precursor to loneliness, but can also be a consequence of it. It can manifest over short or prolonged periods of time.

Loneliness

A subjective experience which relates to the evaluation of the quality of social contacts an individual has. It is possible to be lonely in a room full of people if there is nothing to connect them.

Loneliness can be further split into two categories. Emotional loneliness relates to the absence of a 'significant other' such as a partner or close friend and social loneliness, which relates to the lack of social networks, work colleagues, neighbours or a wider group of friends.

Stigma and discrimination

Discrimination can leave people feeling isolated, affecting daily life, health and wellbeing. Its causes are societal and individual prejudice against people viewed as being different (e.g., not white, able-bodied, heterosexual or male). This results in the range of oppressive attitudes such as homophobia, ageism, racism, sexism and disableism that pervade our society; having a negative impact on community and individual health and wellbeing. This is not only felt by those stigmatised individuals but also diminishes the people and organisations that knowingly or unwittingly promote and support such prejudices.

The effect of this upon daily life and mental wellbeing is likely to be profound, not only impacting on mental health and self-worth but also preventing individuals seeking help.

The Marmot Review 'Fair Society, Healthy Lives'¹⁵, championed a social determinants approach to reducing health inequalities, with clear links to participatory decision making, community engagement, social connectedness and building social capital. Social capital and social connectedness are closely linked, strong social connectedness creates strong social capital.

Social connectedness

Refers to the relationships people have with others and the benefits these relationships can bring to the individual as well as to society. It is a measure of how people come together and interact socially and is the opposite of social isolation.

Individual connectedness may refer to the number of social contacts or support structures an individual has. In terms of community, it may refer to the sense of community and social cohesion.

Social capital

Refers to the 'degree of social cohesion within communities' (NICE) and 'social connections and all the benefits they generate' (ONS). The benefits for people having these social connections can occur either at an individual level (e.g., family support) or at a wider collective level (e.g., volunteering). It is also associated with values such as tolerance, solidarity or trust which are beneficial to society and are important for people to be able to co-operate.

Resilience

Refers to the ability of people, places and communities to cope with life's stresses and challenges and to adapt to adversity. Levels of resilience can change over the lifecourse and are closely linked to connectedness. Resilient people, places and communities have robust social networks.

Five ways to wellbeing

The five ways to wellbeing is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population. Developed by NEF (the New Economics Foundation) as the result of a commission by Foresight, the UK government's futures think-tank (part of the Foresight Project on Mental Capital and Wellbeing). More detail on the five ways to wellbeing can be seen later in this report.

Quotes from County Durham residents who are participants in local programmes.



Artwork provided
by group participants
at Waddington
Street Centre.
Images used with
permission.



“...because of CREE* I now have friends to socialise and spend recreational time with, for the first time in months I feel I have a purpose in life ...and feel less isolated.”

“...there’s a lovely atmosphere and I’ve made new friends.
The project has made all the difference to me, getting me out of the house.”

**“...Come Eat Together has helped me to eat healthily,
get away from everyday problems, and socialise.”**

“Thank you all so much, I wouldn’t have got through without you.”

**“Coming to the session, getting out of the flat, meeting people,
mixing socially...moving around the flat, couldn't even do that before!!”**

* For a definition of CREE, see page 32



Older people

Loneliness and isolation are significant issues for older people. Whilst anyone can be lonely or socially isolated, older people are particularly vulnerable. Certain risk factors that increase the risk of social isolation are more numerous in the older population. These include bereavement, generally poorer health and mobility, sensory impairment, absent family members, reduced income, a small social network, inadequate social support, ageism, potentially unsafe or inaccessible neighbourhood or community (built environment) and a reduction in the ability to travel which is particularly relevant in rural areas.

Preventing isolation for older people is essential in order to enable them to maintain their independence. Older people suffering from isolation are more likely to have increased need for long term care, visit their GP more often, have higher use of medication and a higher incidence of falls¹⁶. They are more likely to experience earlier entry into residential or nursing care¹⁷ and use A&E services independent of chronic illness¹⁸.

The Social Care Institute for Excellence reported in 2012 that an 'increasingly ageing population makes the issue of acute loneliness and social isolation...one of the biggest challenges facing our society'¹⁹. As the older population increases, so does the number of older people at risk of isolation and loneliness, as in turn does the demand on local health and care services. The impact of loneliness and social isolation on older people can:

- Increase the pressure on a wide range of council and health services,
- Be responsible for a significant number of GP attendances, and
- Be a tipping point for referral to adult social care.

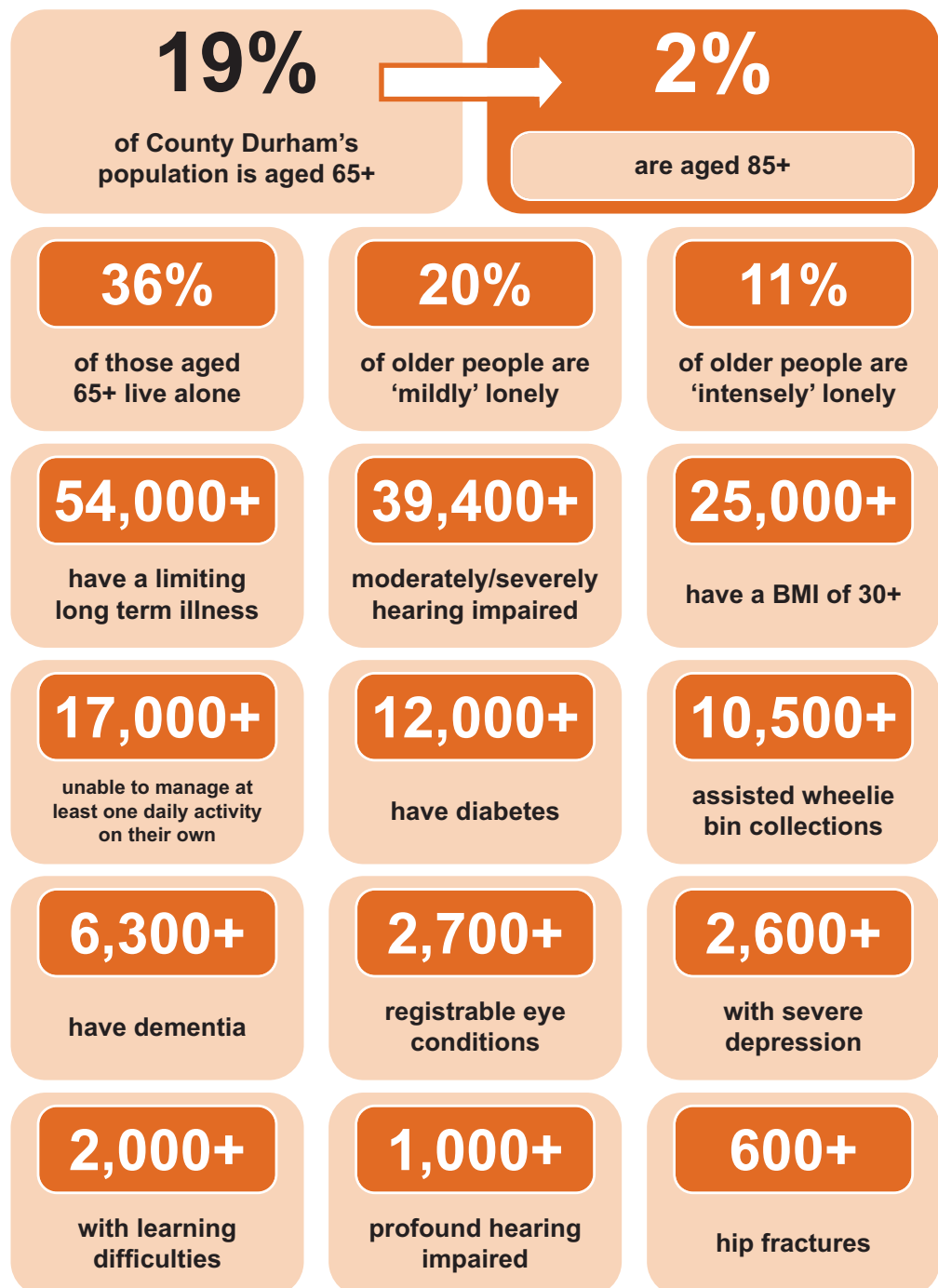
The negative impact of isolation and loneliness upon individual health and wellbeing is well documented elsewhere in this report. The importance of tackling social isolation and loneliness, particularly among older people cannot be underestimated.

Age UK recently estimated that 37% of older people in the UK say that the television is their main source of company²⁰. Applying this to the population of County Durham would suggest that almost 36,000 older people have television as their main source of company. Estimates suggest that between 5% and 16% of those aged over 65 report loneliness and 20% feel isolated¹⁹. These figures are likely to increase as the number of people aged more than 80 is expected to treble in the next 20 years while those over 90 will double. This, combined with increasing family dispersal, indicates that the issue of loneliness and social isolation in old age is likely to escalate.

Vulnerable or 'at risk' older people are those who have low resilience (at individual, family, or community level). Risk factors for isolation and loneliness specific to older people can be categorised into four distinct areas (figure 2 overleaf) but can also include those with physical disabilities, learning difficulties or poor mental health.

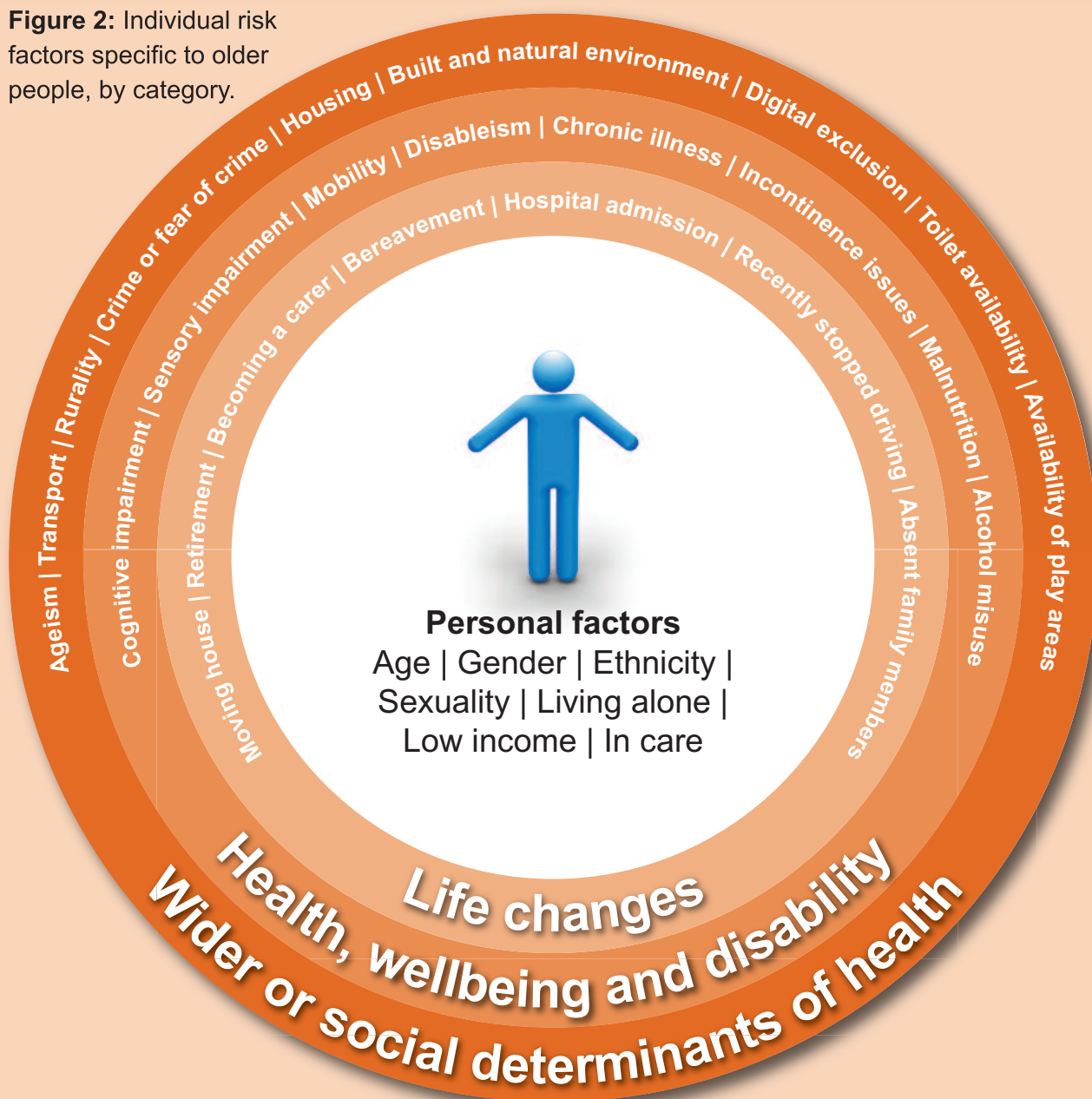
Key figures for older people

The information below, drawn from a wide variety of sources and estimates, is intended to provide an overview of the possible scale of those potentially at risk of social isolation in County Durham.



Who is at risk and why?

Figure 2: Individual risk factors specific to older people, by category.



Those aged 65+ living alone

POPPI (Projecting Older Peoples Population Information System) estimates around 19% of County Durham's population is aged 65 or over and 36% of these live alone (2014).

Those with limiting long term illness or sensory impairment

Older people with a limiting health condition, the onset of a disability or impairment are particularly vulnerable to loneliness. Declining physical mobility can impede the ability to get out and about and therefore interact socially. Similarly, increasing sensory impairment can affect the ability to communicate which can have an isolating impact. Illness, disease or impairment, combined with disability in later life has a significant impact on social engagement.

Lesbian Gay Bisexual Transgender (LGBT)

There is anecdotal evidence which suggested that LGBT elders are often isolated. LGBT older people are twice as likely to live alone, twice as likely to be single and 3 to 4 times less likely to have children and some are estranged from their biological families²¹.

Black and minority ethnic (BME) including Gypsy, Roma Travellers (GRT)

BME populations may experience disproportionately high levels of deprivation, coupled with insufficient services and facilities to support them and may face negative attitudes. In some cases English may not be their first language. Evidence suggests that older BME groups face more barriers to service access, alongside overcoming stereotype assumptions and the challenge of mainstream services²² not tailored to their specific needs.

Those with a continence issue

Continence issues can have a profound impact on the quality of life for older people and can lead them to withdraw from social contact in an effort to manage their incontinence²³. Lack of public awareness of incontinence and a lack of access to toilet facilities can leave some older people feeling isolated as they choose to stay at home rather than going out into their communities to meet friends and family. Ironically this may also limit their ability to access the services and community support networks designed to help them.

Transport

Poor transport can contribute significantly to isolation, particularly in rural areas. In older age driving skills and income levels decline, resulting in accessible transport being identified as a risk factor for social isolation. For those with mobility problems, a physical disability or with poor mental health use of public transport may prove problematic. Poor transport links may also restrict access to ongoing education, training, employment and to shops and amenities. Transport, it can be argued, is one of the single biggest barriers to tackling social isolation.

Housing, planning and the wider built environment

The environment in which people live can have a significant impact upon their health and wellbeing. It can both enhance community involvement or increase isolation. Good amenities, such as seating, lighting and open spaces can encourage use by the public and increase feelings of safety and security.

Fear and perception of crime

Fear of crime and the perception of rising levels of crime can have a significant effect on mental health and wellbeing, particularly for older people. Local data²⁴ for County Durham shows the following percentage of residents perceiving the following to be a problem:

- 69% - speeding vehicles,
- 47% - underage drinking and sale of alcohol to youths,
- 40% - drug dealing and misuse,
- 40% - burglary, including sheds, farm buildings etc.,
- 41% - groups of people hanging around in public spaces, causing a nuisance,
- 38% - drinking and causing nuisance in public spaces.

Older Men

A recent report by Independent Age²⁵ identifies that older men experience greater levels of social isolation than older women and that the interventions to address the issue need to be tailored and innovative in their reach. In their words, they need to be 'blokey' and need to reach places 'where they hide'.



Children and young people

Although social isolation is most common in the elderly, it is not limited to that age-group and children and young people may also be affected. Emotional and social wellbeing creates the foundations for healthy behaviours, educational achievement, helps prevent emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol.

Marmot¹⁶ reinforced the need for a life course approach to tackling inequalities, arguing that support should be in place prior to birth and followed through the lifecourse in order to ensure positive outcomes for children and young people across the social gradient thus giving children the best possible start in life. Evidence shows that children who suffer social isolation and loneliness may have cognitive and social impairments as adults, with the effects accumulating throughout the lifecourse.

A Mental Health Foundation survey²⁶ found loneliness to be a greater problem for younger people than the elderly. Almost 60% aged 18 and 34 spoke of feeling lonely often or sometimes, compared with 35% of those aged over 55. 18 to 34 year olds surveyed were also more likely to worry about feeling alone and to feel depressed due to loneliness than the over 55s.

Some children and young people have both emotional and behavioural conditions and poor mental and physical wellbeing. Durham County Council's Public Mental Health Strategy (2013) reports that children and young people with emotional disorders are:

- Almost five times more likely to report self-harm or suicide attempts,
- Four and half times more likely to rate themselves or be rated by their parents as having 'fair/bad health', and
- Over four times more likely to have long periods absent from school.

Durham County Council's Children and Young People's Survey (2014) reports that:

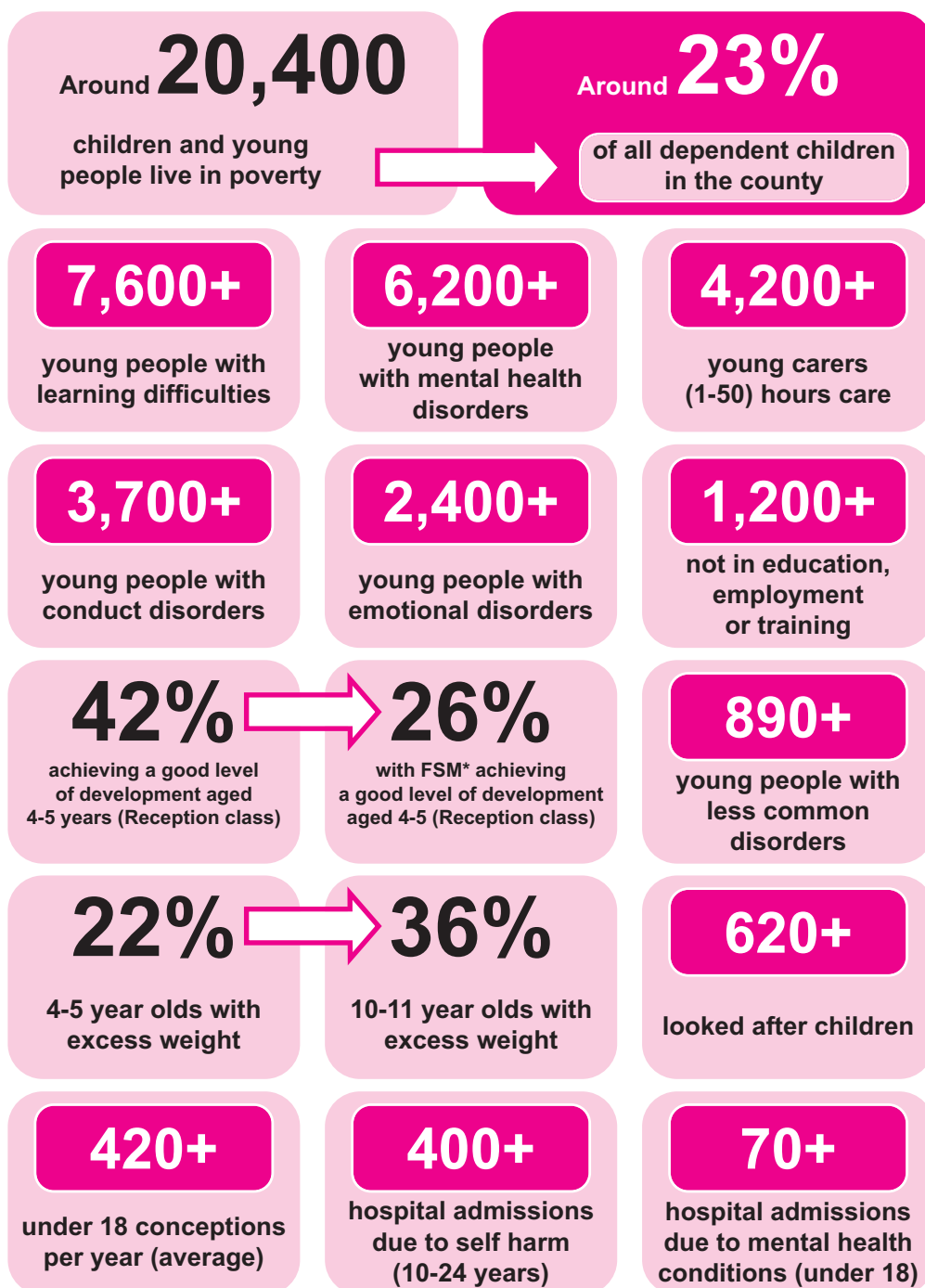
- Girls are more likely to feel lonely than boys,
- 20% of primary school children report they feel lonely,
- 25% of primary school children report they feel awkward or out of place, and
- 27% of secondary school children report they feel lonely.

Who is at risk and why?

Vulnerable or 'at risk' young people are those who have low resilience (at individual, family, or community level). Risk factors for isolation and loneliness specific to children and young people can be categorised into four distinct areas (figure 3 overleaf) but can also include communities such as BME, lesbian, gay, transsexual and transgender (LGBT).

Key figures for children and young people

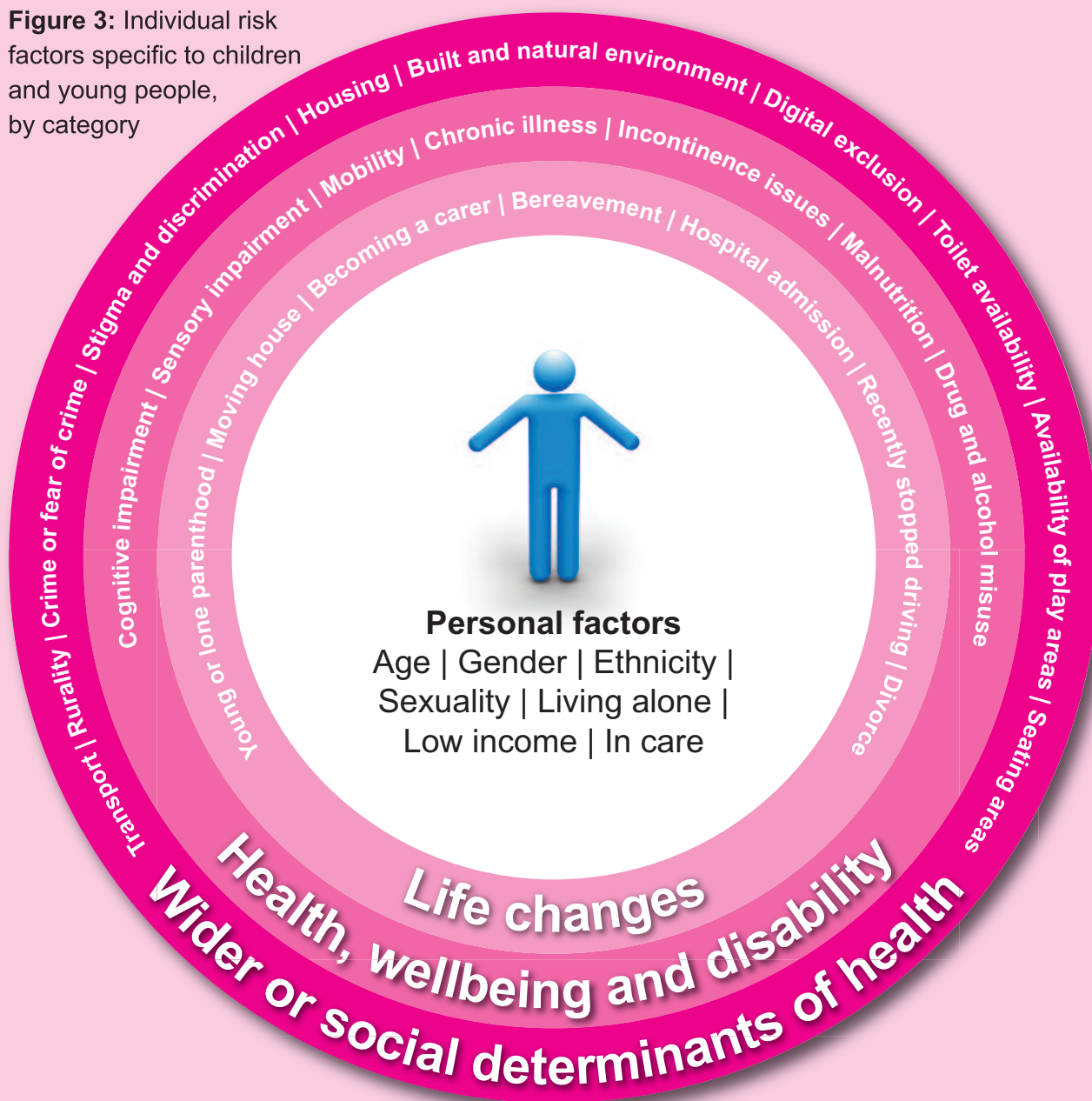
The information below, drawn from a wide variety of sources and estimates, is intended to provide an overview of the possible scale of those potentially at risk of social isolation in County Durham.



* Free School Meals

Who is at risk and why?

Figure 3: Individual risk factors specific to children and young people, by category



Young people living in poverty

Over 20,000 young people in County Durham are classified as income deprived (23%). The relationship between poverty and social isolation can be described as cyclical as each is driven by, and drives, the other.

Young mothers

Young mothers may find it difficult to adjust to becoming a parent, particularly if they live alone or have no, or poor, support networks. Related factors can include a higher risk of living in poverty, worklessness, lower uptake of education, training or employment opportunities and post-natal depression.

Looked after children and care leavers

Young people in or leaving care are more likely to experience difficulties regarding social integration if established support networks are not in place. They are more likely to have faced multiple disadvantages such as poverty, poor family relationships, rejection, disruption and loss in their lives. Subsequent life-chances, including outcomes closely related to social isolation such as mental health problems, low educational attainment and worklessness are significantly influenced by these experiences.

Young carers

A Durham County Council needs assessment of carers (2010) aged between 18 and 25 found young adult carers to be a hidden group as individuals often do not present themselves to services, commonly suffer from social isolation, an absence of friends and feel that they have no independence.

Young people with physical disabilities

Young people with physical disabilities, and their families, face an often overwhelming combination of financial, emotional and practical pressures. Siblings of disabled children often receive less time and attention and many parents feel that their own needs as carers are often forgotten. Outcomes for many disabled young people are poor, they are more likely to live in poverty, have poor physical and mental health, be socially isolated and economically inactive.

Young people with mental health needs

Good mental health is important in helping to improve young people's resilience, strengthen families, improve educational achievement and enable social engagement and participation. Half of those with lifetime mental health problems experience their first symptoms before age 14 and early intervention can make a significant difference in helping them to fulfil their potential.

Young people with learning difficulties

People with learning disabilities generally have poorer health than their non-disabled peers. Young people with learning difficulties may experience problems with communication, have less well developed social and interpersonal skills and low self esteem thus making connecting with others difficult and hampering social interaction.

Young people in transition

Transitions are the movements, passages or changes from one position, state, stage, subject or concept to another. These changes can be gradual or sudden and last for differing periods of time. Young people may be vulnerable due to a lack of solid social and emotional wellbeing in their early years. Being vulnerable is not just about circumstances but about having the emotional resilience to cope with the transitional stages of life. These transitional stages could include moving into the education system, moving from primary to secondary school, moving from children to adult services within the social care or mental health system.

Children who are bullied

Bullying often involves a person or group exploiting the fact that they feel more powerful than another. This can lead to children and young people being excluded from a social circle and being singled out as different. Bullying takes on many forms and can cause both physical and mental harm.



Interventions that tackle social isolation

The Campaign to End Loneliness suggests that strategies to address social isolation and loneliness should be undertaken in partnership and as part of a wider strategic approach to issues facing older people²⁷. It notes that services will include, but will not be limited to, interventions delivered by both the voluntary and the public sector which fall into the categories detailed in the figure on the next page.

Neighbourhood action can reduce the impact of loneliness and build more resilient communities. The evidence suggests that a community development approach alongside professional support will have the greatest impact. This approach offers value for money as relatively small investments can realise significant citizen action. To prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability, and delay the need for more costly and intensive services, action to address social isolation should:

- Part of a wider strategic approach,
- Be targeted to identify those in, or at risk of, social isolation,
- Aim to promote resilience and build capacity within communities,
- Promote independence, and
- Combat stigma and discrimination.

Evidence²⁷ suggests that effective interventions to prevent loneliness include:

- Group interventions with an educational focus,
- Targeted support activities either place based i.e., live in a certain area, community of interest based i.e., sharing the same interests or groups that share the same characteristics, such as young carers, and
- Befriending, mentoring, gatekeeping.

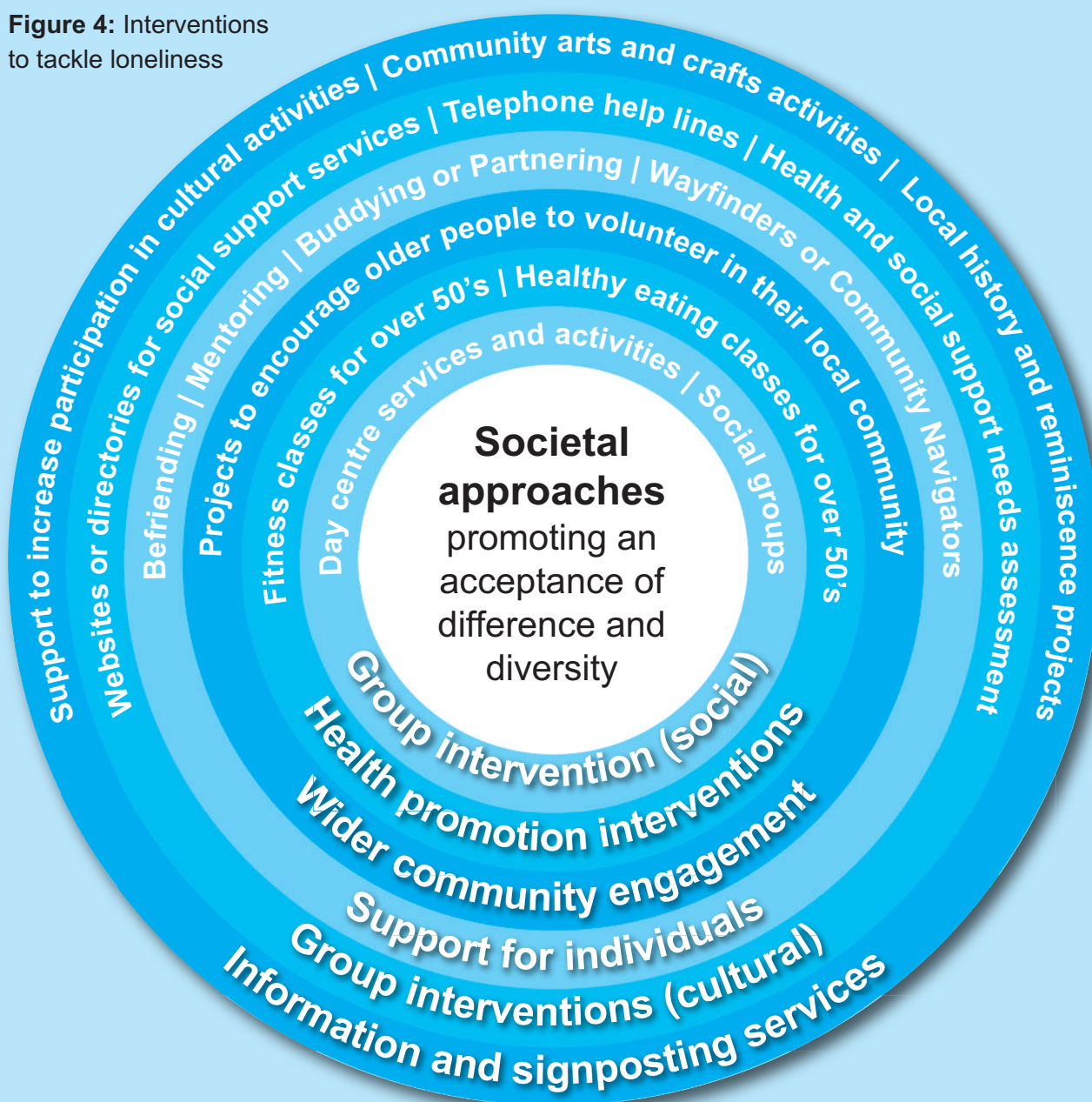
Befriending is an intervention that introduces the client to one or more individuals whose main aim is to provide additional social support through the development of an affirming, emotion-focused relationship over time. Programmes cover many varied initiatives, involving volunteers or paid workers visiting an individual in their own home on a regular, time-limited basis and may include telephone or group befriending.

Mentoring is a relationship between a volunteer and an individual based on meeting agreed objectives set at the onset and where a social relationship, if achieved, is incidental. Mentors work with the individual on a short-term basis and one goal is to develop the necessary skills and abilities that help to continue any achieved changes after the end of the mentoring period.

Gatekeeping uses volunteers as an interface between vulnerable or 'hard-to-reach' people and community and public services, providing them with emotional, practical and social support and helping them access appropriate interventions.

Further detail on effective interventions to tackle loneliness can be seen in Appendix 4.

Figure 4: Interventions to tackle loneliness



'Fair Society, Healthy Lives'²⁹ made clear that the communities in which people live influence health and wellbeing. Communities facing multiple deprivation often have high levels of stress, isolation and depression. The report suggested interventions and policies that could reduce social isolation fall into the categories below:

- Better quality information from communities, leading to health improvements and reduced health inequalities through an increased uptake of more effective services, particularly preventative services, and/or more effective interventions,
- Improving governance and guardianship and promoting and supporting communities to participate in directing and controlling local services and/or interventions,
- Develop social capital by enhancing community empowerment, and
- Increasing control and community empowerment may result in communities acting to change their social, material and political environments.

Five ways to wellbeing

The five ways to wellbeing, developed by NEF from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing, is a set of evidence based actions which promote wellbeing. These activities are simple things individuals can do in their everyday lives for themselves and others.



Connect

Talk with family, friends, colleagues and neighbours. With those around you at home, work, school or in your community.



Be Active

Step outside. Go for a walk, run or ride. Play a game. Garden. Dance. Take the stairs.



Take Notice

Be curious. Ask questions, listen to answers. Remark on the unusual. Notice the weather. Savour the moment.



Keep Learning

Try something new. Rediscover an old interest. Sign up for that course. Challenge yourself.



Give

Give time to a friend, or a stranger. Thank someone. Smile. Volunteer. Join a club. Look out, as well as in.

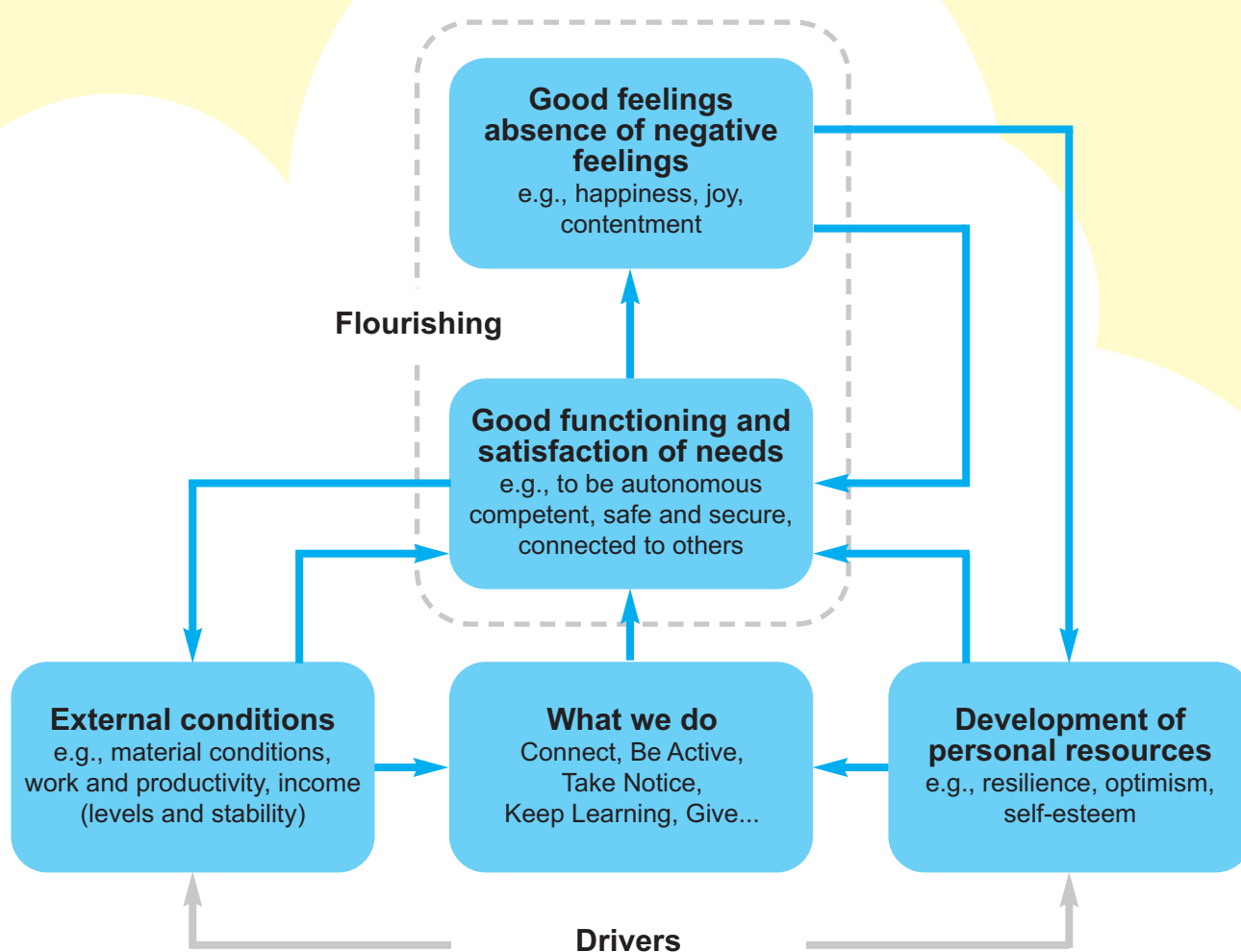
Challenge - what can we do as citizens, communities, providers, commissioners, stakeholders to enable these five activities to occur?

No wellbeing without connectedness

People's lifestyles and the conditions in which they live and work act together to influence their health and wellbeing. Poor socio-economic circumstances can affect health and wellbeing throughout life, resulting in health inequalities. The NEF's 'dynamic model of wellbeing' describes a model of wellbeing and its drivers and how they impact on wellbeing.

Figure 5 below describes how the two main elements of wellbeing, feeling good and functioning well (the top two boxes) are affected by the key drivers of 'personal resources' (i.e., who you are), 'what you do' and 'external conditions' (income, employment status and social networks etc.). When these come together, people function well and experience good feelings (flourishing). It's important to note when viewing this model that people are not made happy by things, but by doing things. This explains the lack of a direct arrow from 'external conditions' to 'good feelings'.

Figure 5: NEF's dynamic model of wellbeing (2012).



Case studies

These case studies have been shared by individuals living in County Durham and demonstrate how some residents living in social isolation are being supported by our voluntary and community sector. This is not of course, in any way a comprehensive picture of the extensive work taking place across the county and is a small snapshot that hopefully allows the reader to appreciate the value and impact interventions can make to the lives of individuals.

Case studies are based on the actual health and wellbeing journeys of our citizens but names have been changed.

Case study 1: Jack. Waddington Street Centre Mens CREE*	
Profile	Jack is 50, living on his own in one of the former pit villages near Durham City. He was known to social services community based teams as being someone who was isolated, had limited social skills and kept himself to himself.
Making the change	Jack had heard about the weekly 2 hour CREE from a support worker and came for the first time on his own. After a period of attending the CREE staff started to be able to engage more with the man, although he continued to be very reserved.
Impact	Over time support workers noticed that Jack enjoyed reading magazines about trains, and had joined a walking group. After a ten pin bowling session it became apparent that this was something that he also enjoyed which has been proven by his enjoyment at participating in subsequent bowling sessions.
Outcome	Jack remains on fringes of the Men's group, never becoming fully involved in discussions but always attending the weekly CREE. He is accepted for this by the other participants, never pushed to do more, is always acknowledged and included. Attending the Mens CREE has allowed Jack to have a feeling of belonging, to be able to control his extent of participation and even though his integration into the group has been slow it has been at his pace. Jack's confidence levels have grown due to him attending this supportive group of men that he now feels comfortable within and that his social isolation levels have been greatly reduced as a result.

* A Cree or Men's Shed is a larger version of the typical man's shed in the garden. A place where he feels at home and pursues practical interests with a high degree of autonomy. They are places of skill-sharing and informal learning, of individual pursuits and community projects, of purpose, achievement and social interaction. A place of leisure where men come together to work. Although Crees were originally aimed at men, some have developed for women and young people. Whichever activities are pursued the essence of a Cree is not a building, which some don't have, but the network of relationships between the members.

Case study 2: Claire. Chit Chat, East Durham Trust	
Profile	Claire had been feeling very low following the death of a family member.
Making the change	Claire was referred to Chit Chat by her GP surgery due to her low mood.
Impact	Claire received her first Chit Chat call from East Durham Trust in January 2014. She had been receiving regular weekly calls where the Chit Chat volunteer established a good relationship with her and was able to encourage her to start to get out and about a little more and get back in contact with her friends.
Outcome	In July the volunteer had noticed that Claire had not answered her phone in a while. A letter was sent to ask if she would still like to receive calls. Claire got back in touch to say that due to the encouragement she had found herself a new job and was starting to go out a lot more therefore no longer needed the Chat Chit calls.

Case study 3: Victoria. Connected Communities, Murton Mams Project	
Profile	Victoria is 43 years old and lives in Murton. Prior to attending the Murton Mams Project she had been experiencing poor mental health, including anxiety and depression. Her daughter had also been experiencing poor mental health, which in turn contributed to Victoria's stress levels.
Making the change	Victoria has attended Murton Mams since the start of the project, with her cousin for support. Initially she was interested in a craft session.
Impact	Initially Victoria was shy and didn't verbally contribute to the group often, simply choosing to take part in sessions. This taking part has made Victoria feel better, it has given her a chance to forget about her own worries for a few hours, relax and have a chat with other women.
Outcome	Since joining the group Victoria has come forward with an interest in becoming a Welfare Champion and has attended training.

Case study 4: Keith. Good Companions

Profile	Keith suffered from a stroke three years ago, following which he lost the use of his left arm. Being entirely left-handed, this was particularly difficult to cope with.
Making the change	A formerly physically active man, Keith was unable to go out on his own. As his wife doesn't drive he became almost housebound and isolated from his community, "getting fat in a chair". He decided to teach himself to paint (right-handed).
Impact	On learning of Good Companions from a volunteer Keith began being taken to photography sessions, which he thoroughly enjoyed. Then the volunteer who drove him there mentioned the New Age Kurling, so he joined that group and has been going ever since. He is thinking also of going to an art group. Some of his paintings are now displayed on the walls of local hospitals.
Outcome	Keith believes the Good Companions scheme has given him a reason for going out again. He feels healthier, is more active and loves being able to meet people.

Case study 5: Charles. Silver Talk

Profile	Charles is 50, and was struggling with mobility issues and poor self confidence. In effect he had become a recluse.
Making the change	Charles heard about Silver Talk through a care worker and was persuaded to give it a go.
Impact	After a few months as a client of Silver Talk Charles felt his confidence begin to grow and decided to ask about training as a volunteer for Silver Talk.
Outcome	Charles is now a volunteer with Silver Talk, making regular calls to clients who were in a similar situation to him not too long ago. He also now regularly attends volunteer coffee mornings.

Case study 6: Danny. The Hut, Stanley Men's CREE, East Durham Trust

Profile	Danny was a homeless young man, very quiet with little self confidence and low mood. He had very little social interaction with anyone.
Making the change	Danny was referred to the Stanley Hut via Single Homeless Action Initiative Durham (SHAID).
Impact	Over time Danny has taken part in many group activities such as mindfulness, cooking, and dog training. He now interacts really well with the other CREE members, volunteers, visitors and staff. His self confidence/esteem has shown a massive increase since he first joined the group.
Outcome	Danny has now started volunteering 3 mornings per week at SHAID's main office, gaining valuable work experience. Danny now volunteers at the HUT covering general administrative duties including answering the telephone and IT, including maintaining databases of CREE activities and attendance.

Case study 7: Colin. Colour your life, Pioneering Care Partnership

Profile	Colin is a 77 year old gentleman who lives alone with his dog 'Tilly', having expressed that he was feeling 'quite down' with a poor sense of self worth. Colin had a bad fall in January this year and ended up in hospital for three weeks, which left him with a lack of confidence and a feeling of only wanting to carry on for the sake of looking after his dog.
Making the change	As an experienced artist Colin felt he had a lot of knowledge to give to others. He came to the group for social contact and to help people with their drawing skills.
Impact	Since joining CYL Colin has since been diagnosed with Post Traumatic Stress Disorder, however, he has made new friends and has gained confidence enough to have joined an art group at The Spennymoor Settlement, which he has wanted to join for many years. This group is for experienced artists to meet up, swap painting techniques and methods, and for social activities.
Outcome	Joining this group has led to Colin attending coffee mornings every Saturday morning, where he has asked if he can sell his artwork to help raise funds. This has helped build his resilience and his social connections in the community.

And finally....

Of course, after reading this report the reader will legitimately ask “so what happens next?”. As Director of Public Health, I hope to influence the planning and commissioning of services that will impact on health and wellbeing and improve outcomes for County Durham residents. I will ensure that the issue of social isolation remains a focus of the Community Wellbeing Partnership and that collectively partners consider how they can address this through either their commissioning or delivery of services.

Social isolation is now being identified as a public health issue and is clearly going to be a priority for future years as our population profile changes and we have a larger proportion of over 65s and over 85s. However, we can only address social isolation by working collaboratively and involving a wide range of partner organisations.

It is everyone's business!

Many thanks to Michael Fleming, Public Health Epidemiologist and Chris Woodcock, Social Marketing lead for their support in pulling this report together.

Thanks also to those who have shared their stories - they are understandably the most powerful element of this report.

As this is a new format for the Director of Public Health Annual Report comments and feedback are very welcome. Please send comments to Anna Lynch, Director of Public Health, County Hall or publichealth@durham.gov.uk

Appendix 1

References

1. Holt-Lunstad et al. 2010. Social relationships and mortality risk: a meta-analytic review.
2. Prof John Cacioppo, Presentation: 'Rewarding Social Connections Promotes Successful Aging', American Association for the Advancement of Science, 16 Feb 2014.
3. Victor C et al, 2006. Older people's experiences of loneliness in the UK: Does gender matter?
4. Berkman, LF, 1995. The role of social relations in health promotion.
5. The Solid Facts, World Health Organisation, 2003.
6. Measuring National Well-being: Life in the UK, ONS, 2014.
7. Healthy lives, Healthy People: Our strategy for public health in England. HM Government, 2012.
8. Windle, et al, 2011. Preventing loneliness and social isolation: interventions and outcomes, Social Care Institute for Excellence.
9. Can a neighbourhood approach to loneliness contribute to people's wellbeing? Joseph Rowntree Foundation, 2014.
10. Loneliness and isolation: a toolkit for health and wellbeing boards. Campaign to End Loneliness: statistics, 2014.
11. Public Health Approaches to Social isolation and Loneliness: Public Health England, 2013.
12. Estimates of social isolation in England and Wales, Public Health Approaches to Social isolation and Loneliness: Public Health England, 2013.
13. Golden J, Conroy RM, Bruce I, et al (2009) Loneliness, social supports, mood and wellbeing in community-dwelling elderly.
14. Steptoe A, Shankar A, Demakakos P et al, Social isolation, loneliness and all-cause mortality in older men and woman, 2013.
15. Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post 2010. 2012.
16. de Jong et al, 2011. Alleviating loneliness among older adults: possibilities and constraints of interventions.
17. Russell et al, 1997. Loneliness and nursing home admission among rural older adults.
18. Geller et al, Loneliness as a predictor of hospital emergency department use, 1999.
19. At a glance 60: Preventing loneliness and social isolation among older people. Social Care Institute of Excellence, 2012.
20. TNS Loneliness Omnibus Survey for Age UK, 2014.
21. Moriarty, J, 2008. The health and social care experience of black and ethnic minority older people: A Race Inequality Foundation briefing paper, Better Health Briefing 9.
22. Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders(SAGE).
23. Incontinence and Older People. Is there a link to social isolation? Help the aged, 2007.
24. Durham Constabulary Police Confidence Survey (2014/15 quarter 2).
25. Isolation: the Emerging Crisis for Older Men. Independent Age, 2014.
26. Griffin, J. 2010. The Lonely Society, The Mental Health Foundation.
27. The Campaign to End Loneliness (2012) Loneliness and isolation, a toolkit for health and wellbeing boards. Available at, <http://www.campaigntoendloneliness.org.uk/>
28. Windle K, et al, 2011. Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence. Research Briefing 39.
29. Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post 2010, Policy Objective E. Create and develop healthy and sustainable places and communities. 2012.

Appendix 2

Community Wellbeing Partnership

The Community Wellbeing Partnership (CWP) is a multidisciplinary group whose aim is to support transformational change in order to improve the health and wellbeing of the residents of County Durham, and reduce inequalities and social isolation.

The Partnership aims to:

- Progress the development of an integrated and holistic community wellbeing for life approach,
- Develop approaches that support people to live well, by addressing the factors that influence their health and wellbeing, and building their capacity to be independent, resilient and maintain good health for themselves and those around them,
- Adopt a holistic approach to health i.e., a model of health that considers not only the body-focused biological components of health but also the individual and societal contexts of the individual's experience of health,
- Go beyond looking at single-issue, healthy lifestyle services and a focus on illness, and instead take a whole-person and community approach to improving health, and
- Harness the power of the community to sustain health change and recognise people as contributing to their own health and wellbeing and not purely as receivers of costly services/interventions.

Appendix 3

Better Care Fund

The Better Care Fund (BCF) was introduced to develop integrated health and social care and support for local people. The BCF aims to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services.

The vision for the BCF in County Durham is to 'Improve the health and wellbeing of the people of County Durham and reduce health inequalities'. The following seven work programmes underpin the Better Care Fund plan in County Durham:

- Short term intervention services which includes intermediate care community services, re-ablement, falls and occupational therapy services,
- Equipment and adaptations for independence which includes telecare, disability adaptations and the Home Equipment Loans Service,
- Supporting independent living which includes mental health prevention services, floating support and supported living and community alarms and wardens,
- Supporting Carers which includes carers breaks, carer's emergency support and support for young carers,
- Social inclusion which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services,
- Care home support which includes care home and acute and dementia liaison services, and
- Transforming care which includes the development of IT systems to support joint working and implementing the Care Act.

Appendix 4

Societal approaches

- Celebrate diversity,
- Cultural awareness, and
- Promote the challenge of discrimination and stigma.

Group intervention (social)

- Day centre services such as lunch clubs for older people, and
- Social groups which aim to help older people broaden their social circle, these may focus on particular interests e.g., reading, knitting.

Health promoting activities

- Fitness classes for people over 50, and
- Healthy eating classes for people over 50.

Wider community engagement activities

- Projects that encourage older people to volunteer in their local community (e.g., local volunteer centres and time banks).

Support for individuals

- Befriending: visits or phone contact, it may include assistance with small tasks such as shopping,
- Mentoring: usually focused on helping an individual achieve a particular goal, generally short term,
- Buddying/partnering: helping people re-engage with their social networks, often following a major life change such as bereavement, and
- Wayfinders/Community Navigator initiatives: helping individuals, often those who are frail or vulnerable, to find appropriate services and support.

Group intervention (cultural)

- Initiatives that support older people to increase their participation in cultural activities (e.g., use of libraries or museums),
- Community arts and crafts activities (e.g., Craft Café), and
- Local history and reminiscence projects.

Information and signposting services

- Websites or directories including information about social support services,
- Telephone help-lines providing information about social support services, and
- Health and social support needs assessment services (postal or web based questionnaires/visits).

Please ask us if you would like this document summarised in another language or format.

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