EQUAL OPPORTUNITIES COMMITTEE
AGE AND SOCIAL ISOLATION
SUBMISSION FROM AGE SCOTLAND

Introduction

Age Scotland welcomes the Equal Opportunities Committee’s inquiry into age and social isolation. Our understanding of loneliness and social isolation and their impacts has greatly increased in recent years, and tackling them is one of Age Scotland’s strategic objectives, although policy responses to it have been limited, so this inquiry is both pertinent and timely. It may be the first parliamentary inquiry into this subject worldwide.

Isolation and loneliness

Although isolation and loneliness are clearly related concepts, loneliness is not synonymous with being alone. There is an important distinction which we believe should inform the Committee’s deliberations.

- **Isolation** describes a physical situation of not having other people in your immediate surroundings.

- **Loneliness** is a distressed emotional response to the difference between the social relationships you desire and those you experience.

Although there is often a cause-and-effect relationship between these concepts, it is not necessarily so. Being with others is no guarantee against feeling lonely; it is quite possible to be in a place where there are many people, but to be dissatisfied with the relationships one experiences. On the other hand, isolation can sometimes be a positive choice – sometimes for work, leisure or the spirit – to avoid distraction and enable focus.

So loneliness is the experience which causes harm to wellbeing, but it remains difficult to identify and quantify. Our sister charity Age UK has estimated that **around 10% of older people (65+) feel lonely some or all of the time.**¹ The difficulties are partly because loneliness is subjective and emotional, partly because our expectations of companionship change over time and can be influenced by cultural factors, but also because there many older people perceive loneliness to have a stigma of neediness and are reluctant to admit to others – especially strangers – that they feel lonely.

Isolation therefore tends to be used as a proxy for loneliness, especially by public institutions, because it is more easily measured. For example, we know that:

- Half of all people aged 75 and over live alone;
- 6% of older people leave their house once a week or less;
- 17% are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month; and
- Two in five older people in Scotland regard the television as their main form of company.
The impact of isolation and loneliness

Human contact is an innate need. A leading expert on loneliness, Professor John Cacioppo, has described it as an involuntary response – like hunger or thirst, tiredness or pain – which derives from our biological sense that we need to form communities for our own survival. Unsurprisingly, a deficiency of contact therefore has profound effects on mental and physical wellbeing. It also suggests that the stigma about loneliness is as nonsensical as a reluctance to feel hungry or tired, and that services should be supportive rather than dismissive of loneliness and its effects.

Loneliness has been shown to increase blood pressure and risk of cardiovascular disease, impair sleep quality and memory, and heighten feelings of depression, anxiety, increased vulnerability, pessimism, emptiness, resentment and worthlessness. It also doubles the risk of developing Alzheimer’s disease and increases other forms of cognitive decline. Its impact on health is akin to a fifteen-a-day smoking habit, more harmful than alcohol misuse, and twice as harmful as obesity.

Loneliness can also influence lifestyle factors which damage health. Lonely people are more likely to be overweight and to smoke, less likely to exercise, and more likely to seek to alleviate the negative feelings through alcohol misuse. There are also recorded links with eating disorders such as bulimia, drug abuse and suicide.

Because of “maladaptive social conditioning”, loneliness can become a vicious circle. Lonely people are more likely to view social encounters with cynicism and mistrust, expect others to reject them, and adopt behaviours that reinforce their isolation. Being isolated – in the sense of having no relationships with anyone they can trust who has no power over them – may also increase the risk of abuse of older people.

By contrast, people with strong social connections have reduced risk of age-related disorders such as dementia, osteoporosis, rheumatoid arthritis, cardiovascular disease, and some cancers. NHS Health Scotland’s Outcomes Framework for Older People has identified “keeping more socially connected” as a key outcome leading to increased sense of self-worth, reduced anxiety and optimised mental health and wellbeing, as well as better quality of life overall. Good social connections lead to a higher level of trust in the community and life satisfaction. High perceived levels of social support are associated with less depression, lower suicide rates and improved recovery from mental health problems. Attachment with family members has been identified as a protective factor for good mental health at all ages by the World Health Organisation.

Causes of isolation and loneliness, and the effect of age

There are a wide variety of causes of loneliness over the course of life, especially since our expectations change over time too. The most common triggers of loneliness are life transitions, with the most significant being the loss of a spouse or partner, either through bereavement, divorce or separation. In the latter cases, the risk of loneliness appears to be greater for the party to the relationship which did not initiate the split (who, by contrast, tend to feel that their action represents taking greater control over their life).

Similarly profound is when older children grow up and move out of the domestic home (so-called “empty nest syndrome”). Economic and social changes have had an impact:
family units were more multi-generational than now, and it used to be much more common for older relatives and their children and grandchildren to live together. Economic mobility also matters: if an extended family moves away for reasons of work, contact between them can become much more problematic and less rewarding.

As well as increasing the risk of loneliness, these changes may involve the loss of informal care and support, and thus increase demands upon the State for social care.

Retirement can involve the loss of status, identity and regular interaction with a professional social network, all of which can be hard to replace. Age Scotland runs pre-retirement training courses, and these deal with managing transitions effectively for health and wellbeing, including social connection, as well as financial and legal guidance.

Growing older has become one of the chief reasons for moving home into more suitable accommodation which is either smaller, and so easier for an older person to manage (such as smaller flats, bedsits or bungalows), or supported (such as sheltered housing or care homes). As well as the physical upheaval of moving home, moving and downsizing may involve losing neighbourhood connections and possibly also having to dispose of valued and memory-laden possessions. Care homes in particular can be distressing places to move to, since a move may be prompted by a traumatic medical incident such as a fall, which may also be associated with lower confidence, a sense of lesser capability and increased vulnerability, and often the sense that these changes are being imposed upon an older person against their instinct for self-reliance.

The effect of such transitions may be cumulative: the impact on a person who retires, loses their spouse, and whose children move away all within a short space of time could be shattering. Yet there is no systematic support system for recognising what the psychological costs might be of these very typical trigger points, and which supports people going through them to recognise them and take steps to minimise or cope with them.

Other factors which accentuate feelings of loneliness include a loss of mobility and/or sensory or cognitive impairment. If an older person’s mobility suffers, typically following an accident or a stroke, they can feel more vulnerable and more reliant on others making an effort to visit them. Loss of sense functioning can have a profound impact on people’s self-confidence, sense of self-worth and the quality of their interactions. Similarly, where anyone finds it more difficult to understand what is happening to them or to communicate with others, their sense of isolation can become overwhelming.

### Preventing loneliness and isolation – gateways and enablers

Our sister charity, Age UK, recently published a report with the Campaign to End Loneliness called “Promising Approaches”. This identified a range of successful interventions, but also some key gateway services and enablers which allow older people to maintain social connections and avoid loneliness and isolation.

Transport is a key gateway service. Many older people suffer a loss of mobility; others either find it uneconomic to continue to keep and use a car or may have to surrender their driving licence because of difficulties in maintaining driving ability in advanced years. Some activities designed to promote connection can themselves become inaccessible
without effective transport links; some local services also provide community transport but for others the cost is prohibitive. There is also some evidence that transport services can themselves promote positive interactions.

Technology can be an enabler. Many older people with limited or no previous experience with digital technology, and/or with low levels of confidence and without basic online skills, are motivated to try it because of the opportunity for contact with family members. However, the evidence about social media’s impact on loneliness is mixed. Face-to-face interaction remains hugely important; technology is most effective where it supplements rather than replaces this. If online interaction replaces the direct and personal it can leave people feeling more, not less, alienated.

Enablers include activities at neighbourhood level. Large numbers of people aged over 75 do not know their nearest neighbours, yet older people who spend more time in their immediate neighbourhood experience very positive impacts. Asset-based approaches, as advocated by the Christie Commission, also underpin good results, such as intergenerational activity. Similarly, volunteering makes a great difference for the volunteer as well as the service benefitting from their input. The development of age-friendly communities helps to tackle negative stereotypes of later life and foster greater proactivity and creativity in devising approaches to tackling loneliness and isolation.

**Tackling loneliness and isolation – effective interventions**

The evidence suggests that there should be no “one size fits all” solution. Loneliness can be caused by a range of different individual circumstances (or combinations of them); so an intervention will be most effective where it addresses the specific cause(s).

The *Promising Approaches* report identified a range of foundation services and direct approaches which are necessary in tackling loneliness effectively, including:

- Using inter-agency data (e.g. from health and fire services) about known risk factors to identify households where there may be residents at risk of loneliness and isolation, and targeting support and services at these areas.

- On the basis that most lonely people still have some contact with the outside world, using human networks to serve as “eyes and ears on the ground” to be conscious of indicators of loneliness and isolation and engaging with or referring those people whom they identify.

- Linking loneliness interventions with formal health services, through a range of different approaches such as voluntary-led “Home from Hospital” schemes which provide practical and emotional support during these transitions; formal community wellbeing practices schemes; social prescribing by GPs and hospitals; and integrated care pathways that involve social activity in the community.

- Personalised approaches to tackling loneliness by supported “guided conversations” using tools and checklists – these can help older people to explore their circumstances, needs and wishes which they feel are important to their wellbeing.

- Supported access through “buddying” or “mentoring” schemes which can provide short-term emotional and practical support towards the achievement of specific goals.
• Group-based activities which are focused on something else desirable (e.g. learning, health promotion, overcoming difficult circumstances). The evidence suggests that these are far more effective in tackling loneliness where this is never expressed as a specific goal. Professor Mima Cattan's systematic review showed that these also work best where they focus on a shared interest and where older people themselves are involved in running the group. The vast majority of Age Scotland’s 900 member groups around Scotland meet these criteria. Many of these focus on artistic or creative opportunities, as highlighted by Luminate: Scotland’s creative ageing festival.

• Specific interventions for men tend to be more problematic because of a general reluctance among men to join groups. Those that have been most successful include walking football initiatives and Mens’ Sheds.

• One-to-one approaches, such as befriending schemes. These have the most beneficial effect where an older person has difficulty getting around, such as limited mobility or a disability. They also function well where contact is combined with another service, such as information and advice (as by Silver Line Scotland).

• Psychological interventions can help older people to change their thinking and expectations about the relationships they need during their later lives.

The impact on policy

The process of integrating health and social care may afford an opportunity for a more systematic approach. The contribution that loneliness and isolation make towards negative health and wellbeing outcomes should be formally recognised by all health boards and, especially importantly now, by Health and Social Care Partnerships (HSCPs) in their strategic planning. Age Scotland believes that the case for this has been made, despite an obvious need for further research. Doing so would lead to a range of positive steps. It would oblige HSCPs to do more to understand what impact “social prescribing” can have and how to do it effectively. And it would encourage HSCPs to work with Government to develop an accepted measure of social connectedness, which would be important for an outcomes-based approach.

Because social isolation is often prevented or tackled most effectively by services offered or organised by third sector organisations, the long-term capacity and security of those bodies is a crucial factor in effectively addressing it. Public resources may be scarce in austere times, but we should not be surprised that divesting from effective preventive services causes problems down the line. It also conflicts with the Scottish Government’s stated ambition of a “decisive shift” to prevention following the Christie Commission. Third sector bodies should be supported to be able to indicate their contribution to prevention but commissioners must also be willing to consider different forms of evidence for effective prevention. If we keep looking for certainty around prevention we will never find it, and we will continue to invest in tackling symptoms rather than causes.

Similarly, community-based amenities are often the backbone of community life. Services such as libraries, community centres, leisure facilities, post offices and local public transport are hugely important for older people not only as citizens and users of the services themselves but for the opportunities for interaction and connection they afford.
Yet decisions to prioritise or reallocate resources are often made without any consideration of that factor and instead on efficiency grounds. To the extent that these are public services (local shops obviously are not), the adoption of market models or the absence of effective regulation makes the achievement of social objectives more difficult.

As time progresses, older people will become more and more confident and familiar with digital technology. This will allow and encourage more older people to use technology to contact remote family members. But in the meantime, those without the access, skills or confidence to use digital tools could become ever more marginalised, especially if public services, banks and utilities all expect people to interact with them online.

**About Age Scotland**

Age Scotland aims to help Scotland’s people love later life. We believe everyone should have the opportunity to make the most of later life, whatever their circumstances, wants and needs.

That’s why we work to make later life the best it can be. We think Scotland can and should inspire, engage, enable and support older people to change their later lives for the better and ensure there is support for those who are struggling as they live longer to achieve better, happier and healthier lives.

Silver Line Scotland is delivered by Age Scotland in partnership with The Silver Line. It provides befriending support, information and advice over the phone to thousands of older people every month.

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Age Scotland  
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i  *Loneliness: The State We’re In*, Age UK Oxfordshire (2012). See [http://j.mp/LonelyStateIn](http://j.mp/LonelyStateIn)

ii See [http://psychology.uchicago.edu/people/faculty/cacioppo/](http://psychology.uchicago.edu/people/faculty/cacioppo/) (Center for Cognitive & Social Neuroscience, University of Chicago). We recommend watching the TEDx talk he gave in September 2014 as an excellent introduction to the subject: see [youtu.be/_0hxl03JoA0](https://youtu.be/_0hxl03JoA0).

