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Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 26 March 2015

Session 4

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CONTENTS

EQUAL OPPORTUNITIES COMMITTEE
6th Meeting 2015, Session 4

CONVENER

*Margaret McCulloch (Central Scotland) (Lab)

DEPUTY CONVENER

*Sandra White (Glasgow Kelvin) (SNP)

COMMITTEE MEMBERS

*Christian Allard (North East Scotland) (SNP)
*Jayne Baxter (Mid Scotland and Fife) (Lab)
*John Finnie (Highlands and Islands) (Ind)
*Annabel Goldie (West Scotland) (Con)
*John Mason (Glasgow Shettleston) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Vivien Moffat (Institute for Research and Innovation in Social Services)
Martin Sime (Scottish Council for Voluntary Organisations)
Glenda Watt (Scottish Older People's Assembly)
Derek Young (Age Scotland)

CLERK TO THE COMMITTEE

Ruth McGill

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equal Opportunities Committee

Thursday 26 March 2015

[The Convener opened the meeting at 10:00]

Age and Social Isolation

The Convener (Margaret McCulloch): Welcome to the Equal Opportunities Committee's sixth meeting in 2015. I ask everyone to set any electronic devices to flight mode or switch them off.

We will start with introductions. We are supported at the table by clerking and research staff, official reporters and broadcasting services, and around the room by security officers. My name is Margaret McCulloch and I am the committee's convener. Members will now introduce themselves in turn, starting on my right.

Sandra White (Glasgow Kelvin) (SNP): Good morning, everybody. I am the MSP for Glasgow Kelvin and I am deputy convener of the committee.

Annabel Goldie (West Scotland) (Con): Good morning. I am an MSP for West Scotland.

Christian Allard (North East Scotland) (SNP): Good morning. I am an MSP for North East Scotland.

John Finnie (Highlands and Islands) (Ind): Madainn mhath. Good morning. I am an MSP for the Highlands and Islands.

Jayne Baxter (Mid Scotland and Fife) (Lab): Good morning. I am an MSP for Mid Scotland and Fife.

John Mason (Glasgow Shettleston) (SNP): I am the MSP for Glasgow Shettleston.

The Convener: Our only agenda item today is an evidence-taking session for our inquiry into age and social isolation. I welcome the panel and ask our witnesses to introduce themselves and to outline the work of their organisation and any current projects that they are engaged in.

Glenda Watt (Scottish Older People's Assembly): I am the co-ordinator of the Scottish older people's assembly, which has existed since 2009. In October last year, we held our assembly event in the Parliament. It was really successful.

We have provided a report each year, and over the past two years we have had a campaign trail, which has involved members of the SOPA committee meeting local older people in different parts of Scotland. We receive funding from the Scottish Government and the Big Lottery Fund to do that. We have asked people about their concerns and informed them about the Scottish older people's assembly and the action plan that we formulated after our event in the Parliament last year.

Many older people have told us of their concerns about loneliness and isolation. We do not have detailed information about that from the older people, but I know that it is a concern for many people. On the campaign trail, we have met provosts from local authorities and local officers from the local authorities and voluntary organisations, and we have become aware of a number of systems that are available for older people in the various local authority areas. Some involve a tremendous amount of opportunities and activities for older people, as is the case in Edinburgh, where many older people take up a vast range of opportunities. However people in other places might not have those opportunities. Some areas have activity programmes, which we have detailed.

Derek Young (Age Scotland): Good morning. I am a policy officer with Age Scotland. We are a national charity that supports and represents older people in Scotland, and their rights and interests. Our principal activities that relate to the area of discussion today concern the fact that we are an information and advice provider.

About 18 months ago, we formed a new partnership with a United Kingdom-wide charity called the Silver Line. Silver Line Scotland, which is the name that the new partnership operates under, provides friendship contact over the phone 24 hours a day, seven days a week, 365 days a year to older people who are feeling lonely or isolated or who just want a chat, as well as giving them the opportunity to access information and advice on issues that are concerning them.

The other avenue through which we tackle the issue is our member groups. We have 900 member groups across Scotland. Many of them are small, volunteer-led organisations that are focused on a particular activity that involves local people. They are a great way of preventing loneliness and isolation and of addressing it when it arises. We also do campaigning and policy work, such as our appearance at the committee today.

Vivien Moffat (Institute for Research and Innovation in Social Services): I am from the Institute for Research and Innovation in Social Services. We are a third sector organisation that aims to support the social services workforce and the people who use the services. Our ultimate aim is to improve outcomes for people who use the services.

On age and social isolation, we have a particular project called plan P, which aims to prevent social isolation and loneliness among older people. We have produced an evidence summary on that, which I mention in my written submission, and also some resources to help practitioners, because we are focusing on how the evidence makes a difference to people's practices. We are working with a group of older people in the community in Fife and gathering some evidence on what would work for them in order to help to address the issue.

Martin Sime (Scottish Council for Voluntary Organisations): I am from the Scottish Council for Voluntary Organisations, which is an umbrella body for the third sector in Scotland. Our primary interest in this important agenda is in how to shift public policy in the area to value better the things that people do for themselves and for each other, because the strength of the voluntary sector lies in people getting together to support one another, to address a need or to contribute to their community. Positive things flow from that, and we see a need to elevate those initiatives in the public policy debate, particularly in addressing isolation and disconnectedness among older people in communities.

One of our functions is to help voluntary organisations to work together. We have a pilot in East Dunbartonshire that is doing that in the context of reshaping care for older people and is encouraging the public sector to better value the contribution that small and local community groups make to those agendas.

The Convener: Thank you. We will start with questions from John Mason on the causes of social isolation.

John Mason: As the witnesses probably know, we are fairly early on in our study of the subject. Recently, we were at Easterhouse, where we heard from witnesses who work in Glasgow.

I start with a general question for anyone who would like to answer it. How big or small a problem are isolation and loneliness? Are they overstated or understated, and what are the causes of social isolation and loneliness? The two may not be the same, and it would be helpful if the witnesses could comment on the differences.

Derek Young: Thank you for the question. It is hard to judge the prevalence of the problem. I will mention one reason why isolation and loneliness, as distinct concepts, are discussed together. Loneliness is the subjective emotional effect that people feel, and which actually causes the harm. We have to ask people how they feel in order to be able to measure that, but our public institutions do not have a habit of doing that routinely. It is much easier to identify the extent to which people are isolated. For example, we can find out how many people live alone, how frequently they have contact with their friends, neighbours or relatives, how often they are able to leave the house, and whether they say that the television or radio or even a domestic pet is their main form of company. All those things are useful indicators that can be used as proxies to find out what the risk factors are and where the loneliest people might be.

On the causes, the first point is that there is an innate human need for social contact. That is well established by much of the evidence that Vivien Moffat mentioned and by many other published reports. It exists across the life course, so it is not exclusively related to older people—that is reflected in some of the other evidence that the committee has taken. As far as it relates to individual people, there are common and well-understood trigger points around life transitions, the most common one being the loss of a partner or spouse. Retirement is a common one, too, because it may involve the loss of a professional social network as well as the status and identity that people have through their work. There can be other triggers such as moving house or losing community ties and neighbourhood connections, and loss of mobility is another one. If someone suffers a stroke or has an accident, it can become more difficult for them to leave the house and they will be reliant on people coming to make contact with them.

Many of those issues are covered in our evidence and the evidence submitted by other organisations.

John Mason: You said that there is an innate need for human contact and relationships. Can that be measured? You might disagree, but it seems to me that different people want or need that more or less than others. Some people are always with other people and are very sociable, but others quite like being on their own. Can that be measured?

Derek Young: What you say is true, in that the accepted academic definition of loneliness is that it involves a stressed emotional response to a difference between the quality of social relationships that someone expects or hopes for and the relationships that they actually experience.

The type and quality of relationships that people expect can change over time depending on their circumstances. As I mentioned, that can happen at different ages. For example, many of us will have been the new kid in school, and someone can feel isolated and lonely in that way, albeit in a different context. If a young person has a sense of abandonment—for example, if they are looked after or accommodated—that can be a prime motivator for them to engage in harmful

behaviours such as drug use, self harm, violence or an eating disorder.

How can we measure loneliness? The evidence suggests that the quality of interactions is more important than the quantity. A modern example might involve partners in a relationship in which one person is devoted to and completely distracted by their smart phone or mobile communications device. The other partner is in contact with someone, but the quality of the interaction is very poor.

In identifying loneliness, we ask people how they are reacting to their circumstances versus what they would expect. As I mentioned, attempting to identify the risk factors for isolation can often build up a picture that can help us to identify people who are most at risk.

Glenda Watt: Historical abuse is a topical issue at present, and some older people may have experienced abuse as children or adolescents. I have worked with older people who started to speak about their experiences when they were older. The question comes back to the quality and type of the relationships that people had during their younger years. Some people will have had very faulty relationships with their parents, peers and friends, which might have traumatised them early on. People may have learned to cope with that, but in the transition from finishing work to entering a different lifestyle, the memories start to come back.

John Mason: It is interesting that you talked about people learning to cope. Do some people learn to cope better than others?

Glenda Watt: Yes. I cannot quantify that, but some people have resilience. They may have learned it from an early age or through their adult life, and when they are faced with changes and obstacles, they call on that resilience to get them through the barriers and to do whatever they need to do.

Vivien Moffat: As Derek Young said, measuring loneliness is about how someone feels, and their self-reported perception of their life situation. We have pulled together some of the evidence and looked at percentages, and one point that came up was that 10 per cent of people aged over 65 said that they felt lonely some or all of the time. In the older age group of those over 80, 50 per cent of people said that they felt that way. Given that we can measure loneliness only through people's perception—it is that kind of concept—that is clearly a major issue.

Martin Sime: It is about self-perception, but there is a strand that relates to the idea of what is possible, what people believe is possible, what is available to them and what they can do. Inevitably, there are constraints on people's horizons, but there are also practical constraints. Poverty is one of the biggest indicators as it results in an inability to get out or to take the initiatives that might make a difference to their isolation.

Some older people have limited horizons in some circumstances. They do not have ambitions, and yet when opportunities are taken and doors open, a whole new life emerges, and their perception about what is possible completely changes. Situations and interactions will change over time, so perceptions will change too. That is a complicated feature.

We are dealing with the fact that people live longer, which is one of our overarching considerations. People's circumstances change, and we know that many more people live on their own, and may spend a considerable number of their later years doing so. That factor gives rise to the question of loneliness, but people will not have the same view of their situation throughout those years.

10:15

John Mason: You talked about ambition and the fact that some people have the ability to do more but are limited by their ambitions. Is that the major problem, or is it the other way round, with a lot of people having ambitions that they physically cannot fulfil?

Martin Sime: It is a two-sided coin—one feeds the other, and vice versa.

I feel from my experience of the issues that people's perceptions can vary quite a lot according to their life circumstances and their history. It is not just about their ambition, although that is sometimes circumscribed by their circumstances. If an older person has spent their whole life with their partner who is recently deceased, they may suddenly find that they are in completely new circumstances to which they are unable to adjust quickly.

Derek Young: I entirely endorse what Martin Sime said but, in response to John Mason's specific question, I note that there are enablers and gateway opportunities that can facilitate the process of engagement with the wider world, even for people in a new situation. We mention examples of that in our written evidence, but I will outline a couple of them now.

The availability of transport—particularly community transport—is important for people who have a mobility issue. If someone is getting older and they no longer have their own car or access to a driving licence, they will need transport to be able to get out and about in order to meet people.

Another example is technology. Older people as a category are perhaps less instinctively adept at

using digital technology to interact with people, but technology can be extremely effective. For those older people who do not have a history of using digital technology, the prime motivator in encouraging them to do so is the desire for contact with their family through Skype-ing their grandchildren and so on.

Those are examples of ways in which we can try to bridge the gap that Martin Sime mentioned.

The Convener: We have discussed the quality of contact—for example, for someone who has lost a partner. Allowing people to have contact and interact with others is important, but people are looking for real quality in their relationships. They want to know someone well enough that the person is able to give them a hug when they are feeling down or frightened, and can talk through their problems with them.

Ultimately, is that what loneliness really means to people? Someone can have friendships but feel that people do not really know them. They can go to groups but may find that the people there do not really share their concerns. Loneliness is about the most important thing: the feeling that someone really knows you and can cuddle you and love you. Am I right?

Martin Sime: Yes—very much so. Some people find that easier than others, and some interventions that are made in this field make that easier while others do not.

I worry that, in the social care field, we have professionalised and depersonalised the interventions that are made. I think that we would all recognise that the anonymous 15-minute care visit, with a different person coming in every time, does not make a terribly sensitive or valuable contribution beyond accomplishing the physical tasks involved. We need to do more to personalise care and to make it more of a relationship issue for everybody concerned.

For 10 years I have seen my members put through repetitive competitive tendering, along with TUPE transfers—under the Transfer of Undertakings (Protection of Employment) Regulations—and zero-hours contracts. I could go on, but that is not the point of this inquiry. Those developments have not led to a very comfortable space. Large sums of public money are caught up in the social care industry—because it is an industry—and the relationships involved are the very antithesis of the kind of relationships that the convener has mentioned with regard to giving someone a hug or whatever. We need to get back to a more personal approach to care.

Christian Allard: Derek Young has talked about young people who feel isolated using substances to excess or using illegal substances. Do we have any data or evidence to suggest that people who feel isolated and lonely in the period of transition when they retire develop a habit of drinking or of using illegal substances because of their state of mental health? Do they go back to smoking if they smoked before?

Vivien Moffat: There is some evidence of that. Our evidence review—I have given you a link to it, and I have a copy of it here—suggests that people who are lonely are more likely to have health issues such as high blood pressure, poor sleep and depression, and it makes links between those things and lifestyle factors such as alcohol dependence, inactivity and poor diet. There is evidence that some of those things come into play in those circumstances.

Derek Young: It is probably best if we provide specific information about the evidence that exists, as there is a lot of it.

Loneliness and isolation are social conditions that have profound health effects, and the integration of health and social care might offer opportunities in that respect. We know that social issues such as poverty and poor housing, which Martin Sime has mentioned, can have profound health effects, but loneliness and isolation are other factors that have been given less attention than those issues—and less attention than they should have been given—in our public health discussion.

The convener talked about the quality of relationships. I do not know how robust the evidence is, but there have been numerous indices of how happy people feel and how good they feel their quality of life is, and people say that they are much happier and more stable when they have five or six very close friends as opposed to 100 acquaintances.

Such friendships can have a knock-on effect. When an older person has a trusting relationship and can confide in the other person—when there is no power difference in the relationship and neither person has control over the other—that is an extremely useful protection against the risk of exploitation and abuse. If the older person can confide in someone that they are facing such circumstances, that can lead to signposting and the alerting of the authorities.

The Convener: Have you finished your questions, John?

John Mason: I could go on, but I will give somebody else a chance and will come back later if I can.

The Convener: I am sure that, if we have time at the end of this evidence session, there will be further questions. Let us move smoothly to Jayne Baxter.

Jayne Baxter: I would like to know about the ways in which older people find out about the services and activities that are available and how they can be encouraged or supported to participate. It is one thing to say to people that there is a lunch club around the corner, but it is another thing for them to feel able to go to that lunch club. What can public and voluntary services do to reach out to older people, and what more can be done to get the information about what is available to older people in a format that is useful to them?

Glenda Watt: It is really important that people know what is available. On the campaign trail for the Scottish older people's assembly, we came across a number of publications including *Get Up & Go*, which covers Edinburgh and contains information about a lot of opportunities and activities for older people. The idea of its production came from an older person about 15 years ago, and other local authorities have started to produce similar publications. They might all be slightly different, but the idea is the same: they provide information about what opportunities exist in their areas and where people can go to find more information.

Jayne Baxter: How is that publication distributed? Does it go to every household, or is it distributed through health centres?

Glenda Watt: The publication is distributed through the libraries. It is produced by the Edinburgh libraries, but it goes to all the general practices as well as the libraries and it is in the public departments of the council. It is free, and information is also available online.

Jayne Baxter: Arguably, that publication is being distributed to places that people are already going to; it is not hitting the people who are sitting at home without that information. There could be other ways of getting the information to those people.

Glenda Watt: In the case of this particular publication, people know about it because it has been around for a long time in Edinburgh. People know about it through the older people who have used it themselves. There are older people who carry it around and distribute it. General practitioners, physiotherapists and occupational therapists will also use the publication as a tool to help people connect, so they can give people examples of what to take up. People might find something else of interest to them in it, too. People's own personal interests are very important.

Martin Sime: The role of GPs has been rehearsed elsewhere in the evidence that you have heard, but it seems to me that we need to do an awful lot more to arm GPs with knowledge about what is available in the community so that we get more of a social prescribing approach for older people—and for everyone, really—about the options beyond medication that are available to support and assist people.

If GPs had even half a clue about everything that was going on in their communities as opposed to just saying, "There are a whole lot of leaflets on a table somewhere," we would be on a virtuous cycle of reduced drug bills and better connectedness in our communities.

The other point is about communication. We have voluntary organisations doing things in communities and working with older people. Derek Young mentioned that there are 900 Age Scotland member groups. Those older people's voluntary organisations are entrenched in the community—they are stable and they are there for more than just a three-year grant-funded cycle. The groups become part of the community, and it is much easier to reach out to everybody on the basis of asking existing participants to knock on their neighbours' doors to see whether they want to come along on a Tuesday night, for example. It is that very personal connection that makes a difference and is more likely to bring people in from the margins into activities.

However, a lot of community groups are here today, gone tomorrow when it comes to the funding and support that they receive. Often quite modest sums of money would make the difference between those groups surviving or otherwise. I compare their existence and how central they are to supporting people in the community to the billions that were spent on the care industry and I think that we have the balance wrong. It is as simple as that.

Derek Young: It is interesting—the last two contributions have covered the two points that I wanted to make in slightly different ways.

First, there is what the voluntary sector can do not only in terms of advertising its own services but in terms of signposting. The best example of that is the Silver Line, which started in November 2013. It is now taking 3,500 calls a month in Scotland and it is training 100 volunteers, who are making personal contact calls to other older people every week.

There has been such a level of interest that the Silver Line has had to stop encouraging people to come forward and volunteer until June because such a high number of people are waiting to be trained. It has certainly tapped into a need that the public recognise, and they feel that they want to be able to contribute something to address the problem.

Martin Sime addressed the point about public institutions. It is important for health and social

care professionals to understand and agree that loneliness is a contributory factor in the way that we say that it is. Social prescribing has been around as a phrase for a long time, but we do not have a tool to measure how widely it is used or how effective it is. We could certainly make some progress on that and, if the committee wanted to recommend that some attention should be devoted to that, it would be a useful driver to encourage the greater use of social prescribing within health services.

I mentioned trigger points earlier in response to John Mason's first question. A public authority will know when someone has suffered the loss of a spouse. It may be harder for an authority to know that someone's children have grown up and left the family home, but it will certainly know about a diagnosis of a cognitive impairment or a sensory impairment that has developed, or a diagnosis of a loss of mobility.

It will know when someone is moving into a care home. Although a care home is an environment that contains other people, a person will not necessarily know those people or have particularly strong bonds with them and they can therefore feel lonely in that environment.

When trigger points are identified, we would like the public institutions that are aware of them to ask people not just about their physical symptoms but about their social circumstances. For example, they could ask someone whether they feel that they have people they can talk to and whether they would like that public body to investigate what might be relevant for them. It would be really helpful if public bodies were more proactive.

10:30

The Convener: I was going to ask about that, too. I was also thinking about whether general practitioners and even health visitors would have a role to play. If someone says that they are depressed, GPs and health visitors could find out whether loneliness is the problem and, before giving them medication for depression, they could first look at how that person could interact with other organisations. Would that be beneficial?

Vivien Moffat: Fundamental to all of this is the idea of person-centredness. Integration presents an opportunity for people to look at how they come together and work around a person, as opposed to different agencies coming in with their own agendas. There can be processes that set out the situations in which we have to think about loneliness and screen for certain issues, but we need a culture shift across health and social care in which people think differently about the person they are supporting.

We have little prompt cards that could have been designed as a screening checklist but are actually designed for the practitioner who goes out and meets an older person, so that they think about not only the issues on their list but the whole person. It is a matter of building services around what people need and want and involving them in that.

The Convener: Annabel Goldie wants to come in on that issue.

Annabel Goldie: If Jayne Baxter will indulge me, I have a question specifically for Mr Young—who has such an encouraging name for someone who works for Age Scotland—about the Silver Line.

Mr Young, if you could let the committee have such data as is available, it would help us enormously. I understand from what you are saying that you are doing some form of assessment or evaluation of how the Silver Line is working.

Derek Young: The Silver Line has provided its own written submission to the committee, and much of the data that you seek might be available within that. The Silver Line is working with Anglia Ruskin University on an evaluation. It received two-year funding from the Big Lottery Fund, which is now 18 months in, and it is having to produce evidence of the impact that it is having in local communities.

By its nature, a lot of it is anecdotal, in the sense that when people are contacted through the Silver Line or by a Silver Line friend—which is a one-to-one conversation with another older person rather than an employed adviser—they will provide their own feedback, which is recorded. People say, for example, that they feel human again. Some people say that, before they were contacted, they were sitting at home waiting to die, because of an absence of contact. If there is more information that we or the Silver Line can provide, I am willing to do that.

One thing that I omitted to mention in the previous discussion is that, as well as what can be done by the voluntary sector, such as the Silver Line, and public institutions, there is also what employers can do, given that retirement is known to be one of the trigger points.

There are organisations that offer pre-retirement training, a lot of which will deal with practical issues, such as financial and legal matters. However, it can also address what Vivien Moffat referred to, which is the whole-person approach. What does someone need to do to keep fit and healthy, keep active intellectually and have good social relations?

Employers could take a more proactive approach to identifying the category of people who might be at risk of the trigger points and ask themselves what they can do to help arm and equip those people before they face that stage in their lives.

Annabel Goldie: Could I beg a favour, convener?

The Convener: No. [*Laughter*.] We will go back to Jayne Baxter.

Jayne Baxter: Given what has been said already, what can the powers that be, community planning partnerships, health and social care partnerships, councils and health boards do to ensure that there are enough services to meet the needs of older people? Martin Sime spoke about community groups that are here today, gone tomorrow. I have spent my life working in that sector, so I know about that. I could probably answer this question but it is my job to ask you. What can the powers that be do to ensure that there are better and more available local services?

Martin Sime: I suppose that this is my territory in the sense that, over the past 15 years, we have been experiencing the gradual commercialisation or marketisation—call it what you will—of a lot of what the voluntary sector does under contract to local government. I think that the method of commissioning is part of the problem. I do not see enough of a cultural shift away from people saying, "We need to write a contract for it and have different groups competing. That's the way we're going to get best value for the public pound." When we apply that method to the kind of issues and interventions that we are talking about this morning, we realise that it is just not the right method. The public sector needs to find new interventions beyond make or buy—that is, if we cannot throw more professionals at a problem, we will have a competition to see who gets the money—because neither of those strategies really works.

First, in public policy terms, we need to better appreciate the contribution that the groups make and that people make to their own health and wellbeing. Secondly, the state has to nurture—that is my word for it—and support the initiatives that are out there in a much more strategic way. I do not know whether European procurement rules get in the way of that—that is the kind of stuff that is thrown back at us, and I was never a great believer in it. We need to get round those barriers and support the fantastic things that go on.

The committee heard recently from Michelle McCrindle of Food Train. I had the privilege of spending a day at Food Train's Dumfries operation, during which I went out with the drivers and met the housebound people. What a fantastic service it is. What an extraordinary experience it was, not just for the recipients, who were really appreciative and engaged, but for the people who were volunteering for Food Train, too. Some three weeks later, I learned that the volunteer driver that I was with had been sanctioned by the Department for Work and Pensions. Because he was volunteering for Food Train, he was considered unavailable for work. That little microcosm of a story tells us that we have a long way to travel.

Food Train is an interesting operation. In a way, community transport has the same problem in that its method of operation—what delivers the real benefit—is not the subject of competitive tendering locally to decide who can deliver the most efficient service. It is about not numbers but the quality of the relationship. You cannot write a contract for that, and you cannot transfer staff under the TUPE regulations from one organisation to another in order to deliver that. What is required is long-term, secure funding that enables Food Train, community transport and so on to deliver their services over a long period and to build up quality relationships with communities for a fraction of what is spent in other areas.

My last point relates to why I was so interested in coming to the committee this morning. The challenge for us in the voluntary sector is to encourage community transport, organisations such as Food Train, the local befriending and lunch clubs and the other things that go on to work more closely together to deliver a more joined-up approach. We direct older people to 20 different organisations that do not really connect up. It may be possible for somebody who has a problem in one area or in their relationship with one organisation to be helped by another organisation, but the current system does not encourage that kind of collaboration. We need to build that ourselves from the bottom up.

The Convener: Would you say that all the organisations are working in silos and that they are not sharing good practice or communicating with each other to the extent that you would like?

Martin Sime: It is a question of extent, and the culture argues against it. The adult care model, for example, pits organisations against each other in competition, so it is difficult for them to work in partnership. We need to grow up and move on from that sort of new public management approach to those services.

Annabel Goldie: I ask for Jayne Baxter's indulgence—I do not wish to usurp any of the questions that she wants to ask, but we have rather skirted round an issue. We have talked about it in general terms, but we have not really focused on it specifically. This may be more a philosophical question, but I wonder where neighbours and the concept of neighbourly

support and neighbourhood fit into all this. Is it remiss of us not to acknowledge what we can do as neighbours in communities and what we could encourage other people to do? I am interested in what Glenda Watt and Derek Young have to say about that. Nowhere in the whole agenda do we talk about our personal responsibilities as members of society.

Glenda Watt: I will answer the previous question first. The voice and experience of older people are really important in all this. The community planning arrangements include opportunities for older people to have a say, so the situation is getting better. However, there are still problems and it is still difficult for people to have a true opportunity to describe their experiences and for those to be listened to and acted upon. Their experiences will not be the same as those of the people who provide the service. There is also a range of older people. People from the lesbian, gay, bisexual and transgender community and from the black and minority ethnic community have very different experiences. We have to become much better at listening to the voices of older people, gathering their experience and getting that into community planning and service development.

The integration arrangements for each local authority and the national health service provide opportunities for laypeople to be involved, but we have heard mixed views from around Scotland about them. Some arrangements do not involve the layperson's perspective or, if they do, they do not include the older person's perspective. Why do people who represent the lay perspective not have voting rights on the integration boards? We need to look at that.

There are more than a million older people in Scotland but not all of them have these problems, so we must be a little bit careful that we do not problematise all older people in Scotland. Older people have told us that they do not want that and that they do not want to be used as a political football. They want to be able to get on with their lives, to have opportunities according to their needs and to be with like-minded people. That brings us back to the quality of relationships. It can be a bit difficult to find like-minded people; it is the same with neighbours, because they might be out working for most of the day. In mixed communities, where there are older people and younger people, the younger people might be out working through the day and there may not be connections. It can help if there is some kind of community facility or an organisation that brings the community together and gives everybody the opportunity to mix.

The Convener: We return to Jayne Baxter. I am aware that quite a few other members want to ask questions and that we will run out of time. I therefore ask witnesses to keep their answers concise.

Jayne Baxter: A lot of what I was going to ask about has been covered, but I will address one other topic. The barriers that can be created by a lack of access to appropriate and affordable transport have been mentioned. I would like to hear your comments about that. I want you to talk not only about community transport, because too often that is cited as the solution. We have a whole public transport system in Scotland, and I want to hear how public transport and community transport could be made more appropriate for older people.

Derek Young: Age Scotland has some history on this. For the past couple of years, we have campaigned specifically on community transport, but the campaign is about community transport as a complement to the public transport services that already exist.

Public transport makes a great contribution by moving people, but there is also some evidence to suggest that older people who use public transport strike up contacts and relationships through their use of transport services. By using the transport services, they form connections with people in their local neighbourhood.

Jayne Baxter: That was my dad. He did that every day on the bus.

Derek Young: There is some evidence of that—it is documented.

Annabel Goldie asked about the personal responsibility aspect. As Glenda Watt notes, a lot of this is about how well people now know their neighbours. Because of improved economic mobility, it is much more likely that families will separate and will no longer live together. In the developing world there is no institutional care, because families take responsibility and there is much more multigenerational living. However, that is not the society that we live in now.

10:45

Jayne Baxter's original question was about what the public sector can do. First, it can recognise and accept the direct link that exists between loneliness and health impacts in a way that many people are not prepared to accept it because they do not think that the evidence base for it is as strong as the evidence base for the links to obesity, smoking and alcohol misuse, for example. Age Scotland thinks that the case has been made, and some of the evidence that we have outlined, which has been referred to in all the other submissions, really helps to pinpoint that.

It is an emerging area of study, social science and clinical practice. We have not been able to find another inquiry at any other parliamentary institution anywhere in the world that has specifically considered isolation and loneliness. This inquiry should, in itself, attract international attention, and we will encourage that. It should promote a conversation on a wider scale that can tap into some of the evidence, much of which is based in America.

I return to the point about transport, which is partly covered in our submission. Transport is an enabler, allowing people to reach services that they need or know about that are communities of interest but not necessarily local ones.

Martin Sime: A bigger role could be played through integrating approaches to transport, so that people could use their bus pass more effectively across bus and rail services, given that there are no parallel schemes. That would help older people to feel that they could plan journeys more effectively. We undervalue the bus pass process at our peril, as it liberates people and allows them to get out.

If we are thinking about transport, we should think about cycling and walking, and we should elevate those as public transport priorities. People want to feel safe in getting out, exercising and enjoying the obvious benefits that follow from that. People are more likely to be isolated if there is no street lighting, if the neighbourhood is dangerous or if there are big articulated lorries going past every five minutes. Those things do not encourage people to get out and about.

I agree with Derek Young that transport underpins an awful lot of agendas about addressing loneliness and isolation. If we do not get the transport infrastructure more appropriately organised, that will not happen.

I could not leave the subject without saying that community transport has an enormous role to play. It is undervalued, and it is available only in some parts of Scotland. It is a national scandal that there is no community transport process and service available everywhere.

The Convener: Have you asked all your questions, Jayne?

Jayne Baxter: Yes, convener—that was great. The other things that I was going to ask about have been covered.

The Convener: I have some questions about social media. We have heard in evidence from various organisations about young people and elderly people using social media. Is social media becoming a replacement way for people to connect and make friends? Is it a good way of doing that? Does it lead to people becoming more socially isolated in that they will not go out and tend to stay in? Does it help people to reach out and connect with other people and then to build on those relationships?

Vivien Moffat: Social media is not the solution in itself; it is a matter of how people use it and engage with it. Similar to all kinds of technology and digital advances, it can be a great help for some people but it does not replace human contact for a lot of people. If social media is a tool to be used among other things, that is more important than its being seen as the solution.

Derek Young: I support those comments. The real question is whether social media replaces anything else. When social media is used to make contact where there was no contact before, that is clearly an improvement. There are many people with restricted mobility for whom it is of huge benefit. If, however, it is replacing face-to-face interaction, it may be harmful. There is evidence that people feel real quality much more through face-to-face interaction than through using purely digital tools.

The intergenerational point that the convener made has been made before. The Royal Society of Edinburgh, as part of its digital participation work, looked at the problems that older people face, which are access, motivation and confidence leading to skill. It is a stereotype but it is mostly true that young people have an innate ability to use technology because they have grown up using it and it has become intuitive. Being able to demonstrate the possibilities of technology to older people, especially when that leads to continued contact between them, can offer real opportunities. I mentioned grandparents Skyping their grandchildren, which can build bonds and ensure that contact continues over a period of time.

The Convener: You have talked about young people and older people coming together. Are there any groups or organisations that develop those relationships and bring people together so that they can share knowledge and skills at either end of the age scale?

Glenda Watt: There is an organisation called Generations Working Together, and there are networks around Scotland that bring older and younger people together in a variety of initiatives. Younger and older people have been working together to learn how to use computers, share knowledge about mobile phones and so on, and all of that is documented on the website. There are specific projects in various cities. In Edinburgh, there is one called ACE IT Scotland, which has been in existence for about 15 years and has become very knowledgeable about bringing younger and older people together to learn different things. There is also a project in care homes called moose in the hoose, in which

volunteers work with the residents to help them to use Skype, computers and mobile phones.

The Convener: Even when people are information technology literate and use computers in their own homes, they might not know that there is a lunch club, a social club or some event just around the corner from them. I know that there are lots of wee organisations that run such things, but they are not necessarily on the internet, where people can Google them and find out that they are just around the corner. Are any organisations trying to pull all that information together and get it out there for people who are isolated even though they are using IT, so that they can tap into that resource?

Martin Sime: Yes. A couple of projects in our sector are trying to pull together a database of all known voluntary organisation activity but, as you can imagine, that is no small task. SCVO is associated with both projects and we recognise the value of being able to do that, but it requires a huge investment in intelligence gathering. The goal is worth while, because somebody who needs help, wants to connect and wants to know what is going on, or who simply wants to join something locally, should be able to find the information. Not all voluntary organisations have the capacity to have their own web presence, so searchable databases are definitely the answer in that field. Of course, if there were such a resource, it would be available to GPs, too.

The Convener: That is a good idea.

Vivien Moffat: I was going to mention ALISS—a local information system for Scotland—which is an easy-to-use database hosted by the Health and Social Care Alliance Scotland, which has done a lot of work to promote it and spread information about it. People can access it and search a collection of local resources very simply, just by typing in where they are and what they are looking for. It is something that is out there and available.

The Convener: You could call it doon your street, or something like that.

Vivien Moffat: It is about people knowing what is going on and being connected. There is a real need for local solutions and for people to come together in local areas to build local communities that are better connected, using those resources but also building local networks.

The Convener: John Finnie has some questions about health and social care.

John Finnie: Good morning, panel. I would like to pick up on the issue of referrals. We have heard that most referrals are from the individuals themselves. I am particularly interested in Food Train, which Mr Sime talked about. Last week, we heard from Michelle McCrindle that that organisation was continuing to get referrals, notwithstanding the fact that she said that it did not know whether it would have diesel for the bus in a few weeks' time. Can the panel talk about referrals and whether the health and social services are making referrals to deal with loneliness and social isolation?

Glenda Watt: I know of some initiatives in Edinburgh. Local opportunities for older people have come from the reshaping care for older people fund. The Edinburgh Voluntary Organisations Council is working with other voluntary organisations such as community connecting to help older people to connect to what might be available in their area. Volunteers buddy the older people and help them to build their confidence, find their way around again and make the connections that they want. I have heard about similar arrangements in other local authority areas.

However, we have discovered on the campaign trail that older people do not know about what is going on. I would not say that more information needs to go out, because there is a lot of information; rather, I wonder whether learning opportunities are needed for older people on what is out there and how people can connect to the systems and make best use of them.

John Finnie: I am sorry; maybe I did not phrase my question properly, but I am more interested in referrals from the point of view of social services or health personnel, whether they are referring and whether the basis of those referrals is social exclusion or isolation of the older person.

Glenda Watt: Referrals are being made by social workers and GPs to the systems. There may be a formal referral or an informal referral in which it is said, "Do you know about this?" I do not have the statistics for that, but I know that there is communication between the systems.

John Finnie: I am already dizzy from hearing about all the bits of information that are out there. For a lot of older people, if the referral is to a finely typed book that gives lots of contacts, that will go behind the clock on the mantelpiece with the other stuff that has come through the door. To what extent are the referrals built into an assessment or care plan?

Martin Sime: One would hope that the public agencies and professionals have knowledge of what is available and that they would recognise that isolation and loneliness could be addressed, but I have no evidence on that. I do not know whether my colleagues can help you.

Derek Young: The first issue is that we do not record that. That is one of the reasons why there might be a limited amount of evidence. There is not a measure of whether there have been referrals to social groups during interactions with

GPs and care assessments. We have heard anecdotal evidence that a particularly active or proactive, well-informed and connected health and social care professional who spots isolation and loneliness in interacting with an older person will realise that that is something that they need to address as well as the care plan, the prescription or whatever it is. However, that certainly does not happen universally.

One reason why we have particularly recommended that the health and social care partnerships should recognise that loneliness and isolation are a public health issue, should be seen as such and should be included in their strategic planning is that that will create an on-going driver to think of such things. Guidance and training packages for the professionals should then be created that say that that should be regularly incorporated in their work. They should at least ask the questions so that they can use the tools that the third sector can help to provide to identify what the opportunities are.

Vivien Moffat: I cannot really give the committee evidence about how many referrals are being made. That probably varies quite a lot. There are things such as the links worker programme with GP practices in Glasgow, in which someone is in a role specifically to look at how to build connections around a community.

I go back to the fundamental point that I made earlier about a person-centredness approach. Health and social care professionals should approach everyone whom they support in a more holistic way and should not assess only the medical concern; they should look at all the other issues and think about where they can refer people to and what other resources might be needed.

11:00

John Finnie: Mr Sime, you talked about the potential to reduce the drug bill. If we want to look at things as inclusively as possible and to centre on the individual, it would seem to be far more attractive to refer someone to the extensive services that Ms Moffat talks about than it would be to fill out another prescription.

Martin Sime: I react with horror to the number of antidepressants that are prescribed in this country. It is a national scandal that we have got to the point where someone goes to the doctor because they are feeling a bit down, the doctor writes a script and the patient goes off with their medication. Social interaction might produce a better long-term result that is more sustainable for the individual and it might be better for public policy, public health and all the rest of it.

We are heading in the wrong direction. The sums of money that are spent on prescriptions vastly outweigh the sums of money that are available to support the kind of initiatives that would make a difference to people's lives. That is out of kilter and we need to turn it around.

Derek Young: I have one sentence to add to that; it is the point that Mr Allard made previously. Many people are medicalising themselves through their alcohol intake instead of taking drugs that have been prescribed by a doctor.

John Finnie: Is there any evidence that people are staying out of the way, not referring themselves or keeping away from professional contact for fear that they would get caught up in a system that would ultimately result in them being institutionalised?

Glenda Watt: I do not have evidence of that, but I have stories from some older people who say that they will not go to the doctor. They find a way of getting over whatever is bothering them. They might rely on friends.

One important organisation that I have not yet mentioned is the University of the Third Age, which is Scotland-wide, Britain-wide and worldwide. Many older people are connected to that organisation. It does not receive any public funds and it is run by a group of older people who are volunteers. The chairperson is also the chairperson of the Scottish older people's assembly. More than 7,000 older people are connected to a variety of different learning opportunities that are organised locally. Tom Berney and other people who are connected to the University of the Third Age tell me that it has been a lifeline for many older people. It is where they go to connect, to make friends, to learn and to continue their connections.

However, people are also beginning to tell us that some of the people who are involved are deteriorating and they cannot quite do what they used to do, so there is awareness that people are ageing within the arrangement.

The Convener: I think that I am right in saying that you have to pay to attend the courses. That would be a barrier for people who could not afford it.

Glenda Watt: There is a small membership fee and people seem to be willing to pay it. I do not know how much it is, but people pay it. Some people might say that it tends to be a middle-class arrangement, but the people who organise it are looking at ways of making it much more inclusive.

Derek Young: Why are people not referring themselves? There is a stigma around the issue of loneliness and many older people feel that they do not wish to be seen as needy or a burden. It does

not help when we have a public conversation about care costs, for example, that taps into that exact theory.

One of the philosophies or approaches that we suggest in our evidence is that we should recognise that the need for contact is an innate human need in the same way that feeling hungry or thirsty or tired or in pain is. Those are seen as perfectly natural reactions to external circumstances and we do not feel guilty because of them. Similarly, organisations should not be telling people who are feeling lonely that they should get over it or regard it differently. It is a perfectly natural and understandable condition, there are ways of addressing it and we should encourage that. If we created a climate of conversation around the issue, it would probably help to reduce the problem that we have identified.

Sandra White: I want to ask about health and social care integration, which has been mentioned. As we are running out of time, I will ask all my questions quickly, and then leave it up to the witnesses to answer.

First, should the third sector be more involved in health and social care integration, as it comes in in April? I think that Mr Young has already answered my second question, which is whether social isolation should be included in the plans for integration boards under the Public Bodies (Joint Working) (Scotland) Act 2014.

My final questions are on housing providers. As I asked the minister last week in the debate in Parliament on health and social care integration, should housing providers, particularly sheltered housing providers, be included in the social care integration plans? Would building more sheltered housing help to deal with—although perhaps not solve—the issue of isolation among older people?

Those are my questions, which I throw out to the panel.

Martin Sime: In my 25 years at SCVO, there has always been a need to integrate housing, whether with community care, healthcare, social care, health and social care or whatever. We have always struggled to get thinking about housing properly integrated. On the other hand, imaginative housing solutions are available. We do not have enough of them, but there are some really good models that are not about ghettoising older people in colonies or whatever. There are creative models that involve using communal and personal space in a good way that gets the balance right. Of course we need more social housing that is appropriate for older people. It can be designed in a way that minimises the potential for complete isolation, so that would work.

I must confess that I am not an enormous fan of health and social care integration, because it is just one set of institutions coming together with another set of institutions to create some more institutions. We should not automatically expect that that will deliver a better answer for people. In fact, the Christie commission proposed that the focus should be on the front line, where people experience services, and that we should not do all the institutional stuff.

In terms of public policy, the third sector is part of the solution, so of course it should have a seat at the table, but that does not give us much leverage over the behaviour of public authorities. What matters is what the third sector does on the ground. We expect a better deal out of whichever public authority arrangement is put in place, because there is no plan B to deal with the demographic that does not involve doing more of the kind of stuff that we have talked about this morning. It is quite simple, but it will take time for public agencies to get to the point at which they realise that it has to be done.

Derek Young: My answer to all Sandra White's questions is yes. My answer is strongly yes to the question about inclusion in the plans, which is a slightly different emphasis from Martin Sime's, although I do not disagree with much of what he said.

I have a small additional point on sheltered housing. We took part in the ministerial task force on residential care for older people, which reported last year. That report talked about the need for a variety of options and different stages with various levels of support available. The advantage of having support available is that it can be an early warning system that can identify the risk of a lack of social interaction. The information that the third sector provides through ALISS—a local information system for Scotland—and other things can suggest that risk, and then support can be provided.

Sandra White: The voluntary and third sector is important. The issue of care charges for elderly people going to things such as clubs is really important, because choice is being taken away from people.

Some sheltered housing complexes have places for people to meet, and it is not all older people who live in them—for example, there might be people who are disabled. Examples of organisations that provide such housing are Bield Housing & Care, the Hanover (Scotland) Housing Association and the Trust Housing Association. My point is that "sheltered housing" might be the wrong term; maybe we should talk about "community housing". Would the approach of having a mixture of people help to tackle isolation for older people?

Vivien Moffat: It certainly might have a role to play. There are solutions for different people. The project that I work on involves working with a group of older people who are tenants of a housing association. They are not necessarily lonely and isolated older people, but they are tenants. They are working together to develop an intervention that suits their local community. The very act of being involved in that is a preventative measure for themselves—there is that preventative aspect of getting in early. The housing association link has been useful in bringing together people who then reach out to their community.

Martin Sime: Looking at the issue from a slightly different perspective, Greater Glasgow and Clyde NHS Board reports that there are double the number of people who are in hospital and looking to be discharged who live on their own. In the past 10 years, that number has increased dramatically.

One of the issues with bed blocking is the inability to get people out because they are isolated and do not have an infrastructure around them. One can imagine that, if there was more communal housing—social housing with a communal aspect—it would be much easier for us to address issues with delayed discharge.

My other question is, why is communal housing an option only for older people or people with disabilities? In fact, there are more people living on their own across the whole of society. Can we not invest some energy in running pilots of communal housing where there is a little bit of communal space for those who want to use it when they want to, but where people also have their own space because that seems to be what they want.

It seems that, as a society, we have not really thought about the matter creatively. We will have to think about it now because of the scale of the issues that confront us. There is no way that more public professionals, care homes and hospitals are going to be funded to meet the challenges of demography. We need to enable older people to sustain themselves and to stay healthier for longer, and to live more active and engaged lives in their communities. There is no plan B.

The Convener: Does Annabel Goldie want to come in?

Annabel Goldie: A lot of my questions have been covered, convener. I am taking a keen interest in the inquiry, not just as an MSP and a member of the committee, but from a personal perspective.

One positive aspect that has struck me in the welcome evidence that we have heard is that there is a lot out there. My impression is that the challenge is to gather it all together. A lot of things are happening, and a lot of initiatives exist but, as the convener mentioned, they seem to be operating in silos. There is a question about who is talking to whom.

Should there be a public campaign on social isolation, and/or should goals to combat the problem be built into existing policies?

Derek Young: Goals to combat social isolation should certainly be built into existing policies, and we have suggested that that should be done through the integration planning route.

With regard to signposting, the most effective resource that we have come across is the Silver Line. Through that service, we refer people to what is available locally. Knowledge is not perfect and it is always being built up, but the fact that the service—which is a freephone telephone service—is freely available 24/7 means that it is an important route. Older people who are not familiar with digital technology and who are not used to finding things online appreciate an interface that involves being able to speak to someone and ask them questions.

Martin Sime: I do not have a problem with public agencies being encouraged to be more alert to the issues and to refer people to community supports where that is appropriate. However, I worry that public authorities will feel that it is their job to stop loneliness. The public sector has a role to play, but that role is necessarily circumscribed.

As I said earlier, the key approach is for the public sector to nurture and sustain the many services that are out there. The challenge for people who run the services in the voluntary sector is to take a more joined-up and co-ordinated approach across the different initiatives.

Annabel Goldie: I was not talking about the public sector; I was talking about a public campaign to raise awareness at national level that social isolation is an issue, and feeding down from that with signposts all over the place to let people know where they can go, what they can do and whom they can speak to.

Martin Sime: I would worry about a reaction from older people to such a campaign. They may feel that it is quite patronising and inappropriate. Some older people may be worried about the consequences of putting their hands up or making contact.

If a campaign was run by older people themselves, and was focused on what they can do with their lives and the way in which they engage with their communities and what that means for them, I think that it would work. However, I would worry about such a campaign ending up in the wrong space, where it is seen to be lecturing

people, as we have seen with the healthy eating campaign.

Annabel Goldie: It has had a big effect on me. [*Laughter*.]

The Convener: It strikes me that, although we have been talking about loneliness and isolation among older people all the way through the meeting, we have not mentioned extended family and how they could help to combat loneliness. We have been talking about voluntary organisations and GPs helping people, but we have perhaps forgotten that family members have a responsibility to connect with their parents and aunts and uncles.

Derek Young said that there seems to be a stigma attached to people saying that they are lonely; they are seen as a failure if they admit it. What can we do in that respect to make families realise that they have responsibilities, and that, if someone's parent is lonely, they have to do something to help them?

11:15

Derek Young: Annabel Goldie mentioned a public information campaign, but I think that Martin Sime is right to highlight that such a campaign would be a double-edged sword. However, rather than have Governments run such a campaign, public figures could do it instead. For example, in America, Oprah Winfrey has started a campaign to encourage people to have contact with their neighbours, relatives and so on.

A lot of informal care already takes place in families, and families are the first point of contact for most people. We have talked about grandparent-grandchild relations where there is a real quality of interaction anyway without it having to be created separately, so the convener's point is absolutely right in that respect. However, one reason that we are talking about care assessments and professionals is that they ought to be able to spot where those interactions are not happening or are not available to older people, who are therefore at risk. Those professionals can then step in, or at least try to find some way to recreate interactions and address the problem.

The Convener: I could ask more questions, but I am conscious that Christian Allard has yet to come in.

Christian Allard: Some of my questions have already been covered, but I have three quick questions. The first is for Martin Sime. You talked about public transport and said that it is a national disgrace, but then you said that the real problem behind isolation is the way in which we plan our towns and villages. Would you like to rephrase what you said about public transport and community transport? If towns and villages are not planned properly, we end up operating so many empty buses everywhere that do not run on time because it is not physically possible.

Martin Sime: We are where we are. One can plan a new community with a blank piece of paper and include those initiatives more effectively, particularly with regard to the location of housing and so on. For many people, however, community transport is the only lifeline that they have, and the only way in which they can get from A to B or to the shops or the doctor.

There was a case in Dumfries and Galloway a couple of years ago in which the council retreated from providing community transport, famously for £30,000-worth of savings. The council leader appeared on television that night claiming that some really hard choices had to be made. Lo and behold, the decision cost the Scottish Ambulance Service twice that sum in ferrying people to and from hospital as a result. Whether integration solves that problem remains to be seen, but why does community transport have to go round 32 local authorities looking for £30,000 in each authority? That seems to me to be a waste of everybody's time and energy. There must be a better way of doing it.

I am not saying that, in an ideal world, we would not have more effective public transport where people need it. However, in the current world, many places do not have public transport. There is a lot of privatised public transport and a great deal of retreating from rural bus routes. Community transport is an ever more crucial component in mobility, and mobility is one of the underpinning factors in addressing isolation.

Christian Allard: I am just making the point that we are making it worse. Even in a new town, the public transport is impossible. We end up running plenty of buses that are empty.

Martin Sime: Yes, because, in planning new towns, we still thought that everybody would have a car, and that that would be the answer. New towns are all roundabouts—it is a nonsense.

Christian Allard: Glenda Watt spoke about the generations working together, but she put a dampener on that when she said that there could be problems, and that it is perhaps better for people of the same generation to be friends. She said that friendship works a lot better and there is a lot more trust when people are the same age, and that, if people are different ages, there can be an element of control or of wanting to profit from one another. Should we push for intergenerational activity to work?

Glenda Watt: Yes, I think so. Some people might not have had good experiences but a lot of older people to whom we spoke when we were on

the campaign trail said that it is important that the generations work together. At one meeting in Irvine, a lot of young people came along and contributed, speaking about their grandparents and so on. The older people who attended really enjoyed that arrangement and wanted to build on it.

In my experience, older people and younger people want to have that connection. Sometimes, it is the media that causes the problem by, for example, dramatising some stories about groups of young people who might be threatening older people. A number of years ago, we addressed the issue of fear of crime. When we brought younger and older people together to discuss the issue, they told us that they were fearful of the same thing. Older people were fearful of the younger people and the younger people—well, when they got together and shared their feelings, they realised that the media had caused the issue by giving an erroneous perception of each group.

Christian Allard: Do you think that, because people are living longer, we should recognise that, when we talk about intergenerational activity, we are not always talking about the very young and the very old? When my grandmother was in her 90s, she ended up living around people who were 60 and she had to make contact with them. Should we do more work with successive generations?

Glenda Watt: I agree with that, too. We think of a generation as covering about 20 or 25 years, and people's experiences of life are very different over that timescale. Earlier, I spoke about people having to have friends who have had the same kind of experience as them. That can be supportive and it can feel life affirming for a person to meet someone who had similar experiences in their youth, such as going to the same kind of school. Equally, people find it beneficial to hear about new experiences and other people's experiences. That can enrich their lives.

Christian Allard: Maybe it would be good to have a new kind of project that could bring together people from closer generations.

Regarding new projects, we heard earlier about one that concerned dementia, which is an issue that is close to my heart. However, this morning, we have heard nothing about the problem of older men. Is that the elephant in the room? Are older men a section that we never think about?

Martin Sime: You are right, but there is hope for the future, because men are beginning to get their act together. The men's sheds movement has had a significant impact psychologically, and has got people thinking about the fact that there are some things that men can do together beyond the inevitable golf and bowls. There are exciting developments around dementia in the voluntary sector just now. There is a famous project in Aberdeenshire and there are new ones developing in all kinds of places. I am encouraged by the stuff that is going on in East Lothian on men's sheds. The solutions are there and they involve the social interaction that men get from coming together for a purpose.

Last week, I was at the launch of a report by Derek Young's sister organisation, Age UK, on age in the voluntary sector. It is really a wake-up call to voluntary organisations. The men's shed issue is a useful segue into this, because it is about the capacity of older people, and older men in particular, to make an enormous contribution to their society. If we can build on those positives, we can start to address the negatives in the right way, as opposed to thinking of the issue as a problem that some professional is going to sort out for us. That applies to loneliness in particular.

Christian Allard: Do you think that the issue of bereavement is important as well?

Derek Young: Martin Sime has made many of these points already. Men tend not to join organisations as readily as women. Further, by the time that we get to later life—85-plus—there are fewer men around. Most of those in the 85-plus bracket are women.

Some projects have met with real success. There are 15 active men's sheds in Scotland. If we had the same number per head of population as they have in Australia, we would have 250. We want every community in Scotland that wants one to have one, and we are trying to assist with that work. Walking football is another important project. The best projects for men are those that appeal to a shared interest and, in particular, the ones that do not have an overtone of a suggestion that the person is needy or isolated but, instead, say, "You could help the local community by doing something active." As Vivien Moffat said, if people feel that they are volunteering and making a contribution, that has benefits not only for the people who are being helped but for the person who is volunteering.

A particular issue with men is that, often, older men who do not interact socially go down the pub, which has a knock-on public health effect, because of the health effects of alcohol misuse.

The Convener: Thank you all for coming along. It has been an interesting and useful meeting.

Our next meeting will take place on 2 April, when we will take further evidence in our inquiry into age and social isolation.

Meeting closed at 11:25.

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