



Hampshire
County Council

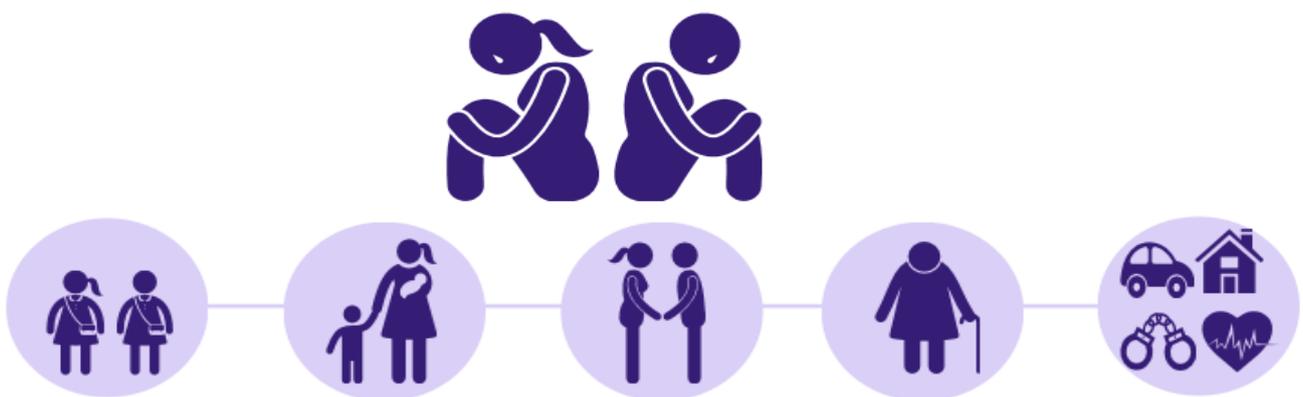
Social Isolation and Loneliness in Hampshire

A Health Needs Assessment

January 2016 – December 2019

“Social relationships, or the relative lack thereof, constitute a major risk factor for health – rivalling the effect of well established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity”

House, Landiss and Umberson (1988)¹



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Social Isolation & Loneliness in Hampshire



Social Isolation 'An absence of social contacts or community involvement or a lack of access to services'



Loneliness 'Unwelcome feeling of a lack or loss of companionship'

Groups at risk of isolation or loneliness

Children & young people (CYP)



CYP who do not conform to social norms.

Teenage mothers

Young people Not in Education, employment or Training (NEET)

New parents



Mothers of young children

Teenage mothers

Postnatal depression

Carers



Young people & adults who care for others

Giving up being a carer

Informal/unpaid care

Older people



65 years and over

Retirement

Widowed

Long-term health condition (LTC) or disability

Bereavement

Sensory impairment

Other life factors



No car

Unemployed/Low income

Addiction

Homelessness

Working-age men

Ethnic minority groups

LGBT groups

Living alone/single/divorced

Areas of high deprivation/crime

Poor general health/LTC

Impact on Health and Social Care Services



Increased GP visits
Increased A&E attendances
Increased hospital admissions



Increased rates of dementia and depression
Increased likelihood of entry into care
Longer hospital stays



Greater reliance on home care providers





Social Isolation & Loneliness in Hampshire



Impact of social isolation & loneliness in Hampshire



1,130 looked after children in Hampshire

377 under 18 conceptions in 2014

1,500 young people who are NEET



27,000 people aged over 65 years in Hampshire are lonely most of the time

13% of over 65 year olds live alone



On average 4,200 new mothers in Hampshire per year may feel isolated or lonely



28% of Hampshire people are single

7% of Hampshire population are widowed

3% report bad health



106,500 carers in Hampshire may feel lonely or isolated as a result of caring for a loved one

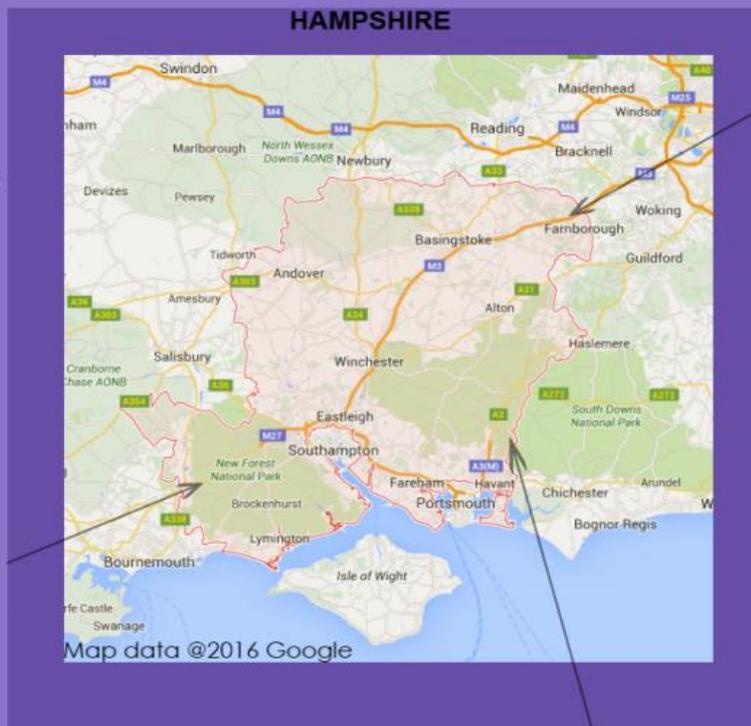
15% do not own a car

29,000 are unemployed

Social isolation and loneliness prevalence in Hampshire is predicted to be higher in urban areas and those of greater deprivation;

- Basingstoke
- Andover
- Gosport
- Havant
- Rushmoor

27% of the New Forest population are aged over 65yrs



1 in 5 of the Rushmoor population are non-white British compared to 1 in 10 across Hampshire

Gosport, Havant and East Hampshire have the highest levels of homelessness

Full Social Isolation and Loneliness in Hampshire report can be downloaded from www.hants.gov.uk

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RECOMMENDATIONS

1. There are evidence based interventions that should be used to inform local interventions and be targeted to where they are most needed.

Both individual interventions and group-based activities are effective and cost-effective. Where possible use the evidence base, or ensure evaluation to demonstrate a positive social return on investment. Information and predictive analytics from this Needs Assessment should be used to target resources. Environmental planning should aim to promote social connectedness by using the evidence base and consulting with local residents.

2. Equip staff working in the public sector to signpost people towards help.

Identify social isolation and loneliness in 'business as usual' activities (Making Every Contact Count). Health and social care professionals need to recognise social isolation and loneliness and know how to use community resources to connect their patients/clients with organisations who can help.

3. Support people to access programmes and interventions

For some people, signposting to what is on offer is enough to support them. However for others, more help is needed. Community navigators/sign-posters should be available to assist people to engage with interventions whether this is through providing encouragement, arranging transport or by attending activities with them.

4. Foster and encourage community involvement in programmes.

Working with voluntary sector organisations to increase local volunteers to identify and engage with local residents.

5. Ensure any programmes and services meet the needs of under-served or at risk groups.

Interventions should improve the assets and resilience of all the under-served, at-risk groups, and hard-to-reach groups, in particular:

- People who are lesbian, gay, bisexual or transgender

- Men of working age
- People in ethnic minority groups
- Hard-to-reach groups e.g. those that are hidden within a rural geographical area

6. Create an enabling environment through: good urban design, creating and maintaining spaces that encourage social interaction, good transport access to services

CONTENTS

INTRODUCTION.....	8
WHAT IS SOCIAL ISOLATION AND LONELINESS?.....	10
WHY IS IT IMPORTANT?.....	12
WHO IS AFFECTED?	15
HOW CAN WE IDENTIFY THOSE AT RISK?.....	17
SOCIAL ISOLATION AND LONELINESS IN HAMPSHIRE	21
HAMPSHIRE’S OLDER POPULATION.....	22
OTHER RISK GROUPS IN HAMPSHIRE.....	25
INTERVENTIONS TO TACKLE SOCIAL ISOLATION AND LONELINESS	39
WHAT WORKS?	44
RETURN ON INVESTMENT: COSTS AND SAVINGS.....	49
APPENDIX 1: DRIVERS FOR CHANGE	56
APPENDIX 2: DATA FOR SOCIAL ISOLATION MAP.....	57
APPENDIX 3: SOCIAL RETURN ON INVESTMENT OF INTERVENTIONS	58
REFERENCES	67

INTRODUCTION

Social relationships are vital for the maintenance of good health and wellbeing². Social isolation and loneliness are associated with poor mental and physical health and increased mortality³.

Social isolation and loneliness are closely linked but distinct terms. Either can exist without the other. It is possible to be socially isolated and not feel lonely, or to feel lonely when not socially isolated. Both concepts are independently linked to poorer health⁴.

Social isolation is the objective term used to describe an absence of social contacts or community involvement, or a lack of access to services⁵.

Loneliness is subjective and describes the unwelcome feeling of a lack or loss of companionship⁶.

Social isolation poses particular challenges in a large rural county like Hampshire. Good transport links are important for helping people build and maintain social relationships. People without access to their own transport can find it difficult to get out to see friends and family or take part in community activities. In addition, delivering social care or other services is more challenging and costly due to inevitable additional costs in rural areas such as diseconomies of scale and travel⁷.

Social isolation and loneliness can affect people of any age. However many of the risk factors such as bereavement and poor physical health are more common in the elderly, making this group particularly vulnerable. In Hampshire, 20.3% of the population are now aged 65 and over⁸. This compares to 18.6% regionally and 17.6% nationally. District population projections suggest that the majority of future population growth will be in the older age groups. Younger age groups are frequently neglected in discussions around social isolation and loneliness, but it is important to consider its impact at all stages of life.

The importance of social isolation and loneliness as health issues is being increasingly recognised^{9,10}. The Care Act 2014 outlines the statutory responsibility of local authorities to promote the wellbeing of their populations, including mental health and emotional wellbeing, domestic, family and personal relationships, and individuals' contribution to society⁶. In addition, reducing social isolation features as a key indicator in the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework^{11,12,13}.

There is good evidence that a range of interventions can be effective in reducing social isolation and loneliness as well as reducing the burden on health and social care services¹³.

The aim of this needs assessment is to provide a detailed picture of social isolation and loneliness in Hampshire to inform the planning and procurement of appropriate, high quality services and interventions to improve outcomes.

WHAT IS SOCIAL ISOLATION AND LONELINESS?

SOCIAL ISOLATION

Social isolation can be defined as having few close relationships or social ties in the community and may be considered as the “objective and quantifiable reflection of reduced social network size and paucity of social contact” 2¹⁴.

Defining this apparently quantifiable concept poses a challenge. Our social relationships are complex and multi-faceted. How we build and maintain our social networks as well as the very nature of these networks varies greatly from person to person¹⁵.

Factors known to be important in social isolation are:

- Marital status (or co-habiting status)
- Degree of contact with close friends and relatives
- Participating in organisations and or community groups
- Religious affiliation (or community group participation)^{2,14}

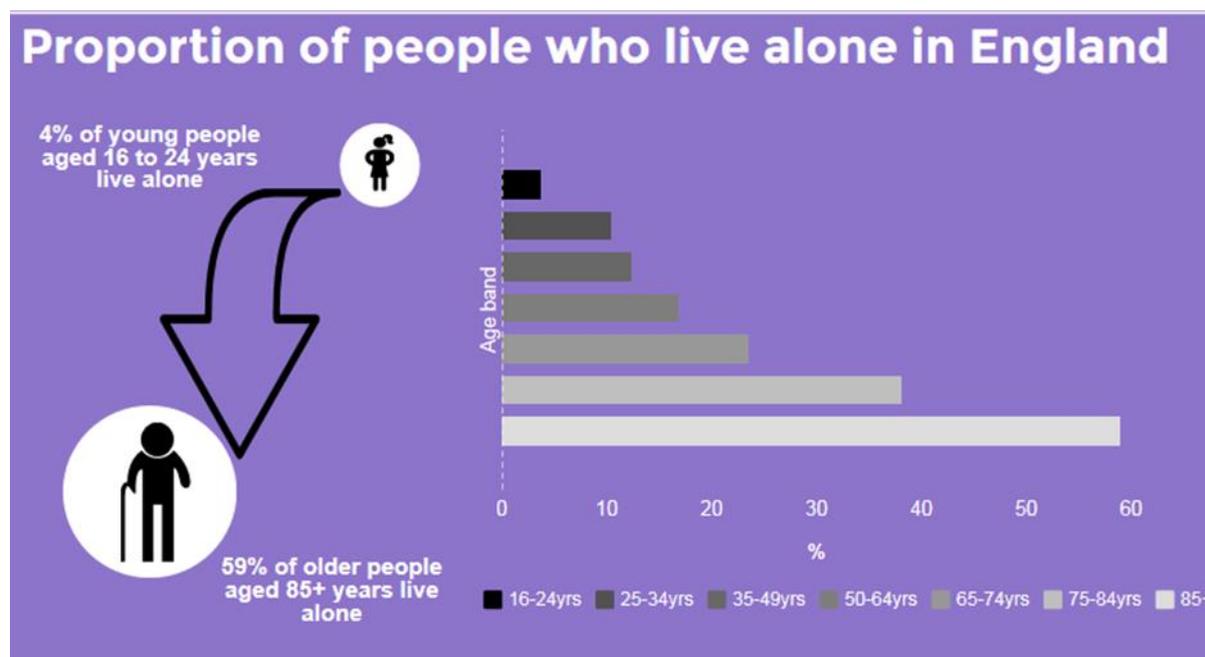
In England and Wales, 13% of the population aged 16 and over live alone, but this proportion rises with age⁶. More than half of people 75 and over live alone, a figure which is estimated to increase significantly in the coming decades.

Social isolation is closely linked with health inequalities¹³. Many of the risk factors for social isolation are more prevalent among socially disadvantaged groups.

- A person’s built environment and the availability of transport services may impact on social isolation.
- Physical access to friends and family, green spaces and community centres, as well as health services are all important.
- Economic factors could mean that someone lacks the financial resources to participate in social networks.
- Equally, discrimination (due to ethnicity or sexual preferences for example) may prevent someone building their social network.

This wider view of social isolation is vital when considering who is at risk and how the issue can be addressed.

Figure 1: What proportion of people live alone in England?¹⁶



LONELINESS

Loneliness is the subjective sense of lacking desired affection, closeness, and social interaction with others⁵.

While loneliness may be a transient experience, often precipitated by a transition such as moving to a new area or the death of a spouse, it can become recurrent or persistent⁵. Around 10% of people over 65 are lonely all or most of the time^{3,6}.

There is some evidence to suggest that up to 50% of loneliness is inherited, with the remaining 50% being due to the environment and other factors⁵. This means that some people are more likely to experience loneliness because of the genes they inherited from their parents at conception. However, whilst genetically-determined elements of an individual’s personality and the way they respond to life events may be important, loneliness develops under a complex mix of environmental factors which are explored further in subsequent sections of this report.

Loneliness is difficult to measure and difficult to treat. Foundations set in early life can have a significant impact on social relationships throughout life. Modern-day society is moving away from people living in close communities, to an increasingly isolated way of life¹⁷. With that, our notion of community is changing. Whilst social media opportunities for building relationships with people who share a common interest is greater than ever, ultimately prevention of loneliness focuses on meaningful interactions between individuals. How this can be promoted at the population level is the real challenge.

WHY IS IT IMPORTANT?

Impact on Health and Wellbeing

Wellbeing may be defined as:

- Being at ease with oneself;
- Having a sense of purpose, meaning and fulfilment;
- Experiencing positive emotions and having the resilience to deal with life's difficulties;
- Belonging to a respectful community^{18,19}.

Social relationships are woven into almost every aspect of wellbeing. It is perhaps not surprising therefore, that an absence of relationships has such a negative impact on both physical and mental health.

Social isolation and loneliness are associated with an increased risk of cardiovascular disease, cognitive deterioration and overall mortality²⁰.

Loneliness is linked to adverse health consequences throughout life including depression, poor sleep, cognitive decline, poor cardiovascular function, impaired immunity and earlier mortality²¹.

Having a lack of social relationships is comparable with well-established risk factors for mortality such as smoking and alcohol consumption²⁰. Furthermore its influence is greater than that of obesity or physical inactivity.

The routes through which social isolation and loneliness exert their influence on health are not fully understood, but are likely to comprise a combination of the following mechanisms:

- Mediation of the physiological stress response, altering how stress is perceived and how the body responds. Social isolation and loneliness are associated with higher cortisol levels, blood pressure, and inflammatory mediators^{2,14,22}. There is evidence that social relationships help to promote positive biological adaptive responses to stressors such as illness or life events²⁰.

- Good social relationships are associated with positive health attitudes and behaviours²⁰. This relates to the association with wellbeing, and having a sense of purpose and meaning, both of which are important drivers in health-related behaviour. There are of course exceptions to this, but in the main, relationships encourage conformity to social norms which promote maintaining health and self-care. One example of this is smoking cessation where the chances of quitting were found to be significantly increased if a spouse, sibling or friend had also stopped smoking²³. People who are socially isolated and lonely have less active lifestyles, increasing the risk of diabetes, stroke, coronary heart disease and disability^{24,25}.

Impact on use of Health and Social Care Services

Social isolation and loneliness lead to an increased use of health and social care services. The exact reasons for this are not fully understood but it is likely to be a result of a combination of the poorer physical and mental health experienced by people who are isolated and lonely, as well as an increased reliance on services due to a lack of social support.

Social isolation and loneliness have been shown to have the following impacts:

- Increased GP visits, A&E attendances and hospital admissions
- Increased likelihood of entry into care
- Increased rates of dementia and depression^{25,26}
- Older people who are socially isolated or lonely have longer hospital stays and a greater reliance on home care providers^{15,26}.

Conversely, being physically isolated may prevent someone accessing and utilising healthcare or other services when they are needed. The 2004 report by the Social Exclusion Unit found that over 1.4 million people said they missed, turned down, or chosen not to seek medical help in the preceding year due to transport problems^{13,27}.

This issue is likely to be most significant for the socially deprived and elderly, who are less likely to own a car. If people are prevented from utilising healthcare appropriately, it can result in higher costs to both health and social care in the longer term.

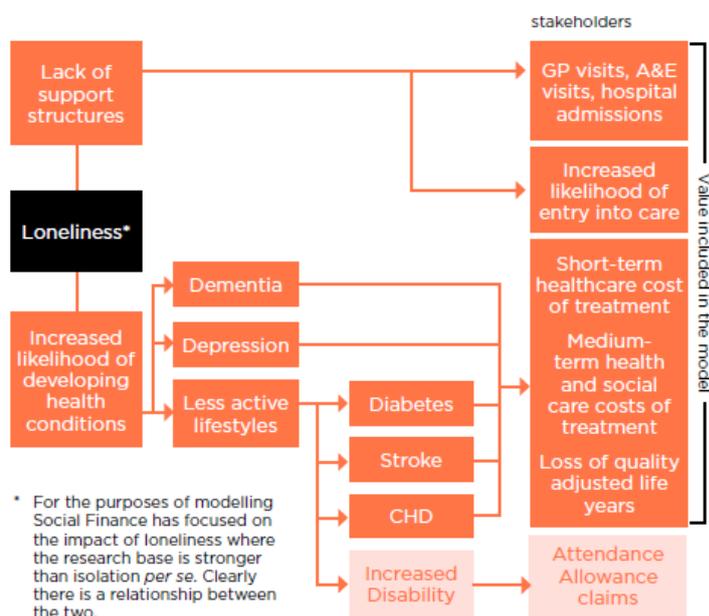
Financial Cost to Society

A discussion paper published in 2015 by Social Action in conjunction with Age UK Herefordshire & Worcestershire used existing evidence of the impact of loneliness on the factors discussed above to estimate its cost²⁵. Through a review of the literature, they estimate that, compared to people who are never lonely, older people who are lonely are on average:

- 1.8 times more likely to visit their GP;
- 1.6 times more likely to visit A&E;
- 1.3 times more likely to have emergency admissions;
- 3.5 times more likely to enter local authority-funded residential care;
- 3.4 times more likely to suffer depression;
- 1.9 times more likely to develop dementia in the following 15 years; and
- Two thirds more likely to be physically inactive.

The report summarises the routes through which loneliness can impact on public sector resources, these are shown in Figure 2.

Figure 2. The impact of loneliness on public sector resources²⁵



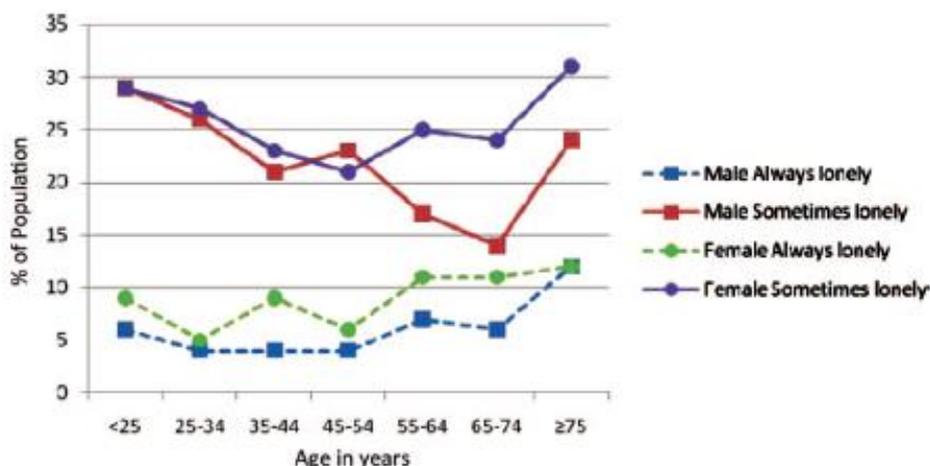
It is estimated that the increase in service usage associated with isolation and loneliness results in a cost to the public sector of £12,000 per person over 15 years, 40% of which occurs in the first five years.

WHO IS AFFECTED?

The literature surrounding social isolation and loneliness focuses predominantly on older adults, with little discussion about younger groups who may be affected.

Older people are undoubtedly a group who are particularly vulnerable to social isolation and loneliness, with many of the precipitating life events such as having poor health and living alone, being more common in this population. However, there is evidence to suggest that younger people are also at risk, with peaks of loneliness occurring in young adults as well as in old age²⁸.

Figure 3. Proportion of people reporting to be lonely by age group. Data from the UK element of the European Social Survey (2393 responses)²⁸



The findings from this study suggest that there is a general upward trend in the proportion of people who would describe themselves as always lonely (dotted line), but the proportion of people reporting to be sometimes lonely (solid line) peaks in young and old age²⁸.

In addition, research suggests that the factors driving social isolation and loneliness at different ages may differ²⁸. For example, it appears that the size of social network may be more important for young adults, whilst the quality of social contacts may be more important as people get older. Differences in risk factors between men and women have also been observed¹³. Individual risk factors are discussed further below.

In a key document from Public Health England and the UCL Institute of Health Equity, the authors take a life course approach to considering who is at risk of social

isolation and loneliness at all stages of life (prenatal, pre-school, school and training, employment, and retirement and later life).



Groups at particular risk of isolation and loneliness:

- Mothers of young children
- Children and young people who do not conform to local norms of appearance, language or behaviour
- Young people and adults who care for others
- Teenage mothers
- Lesbian, gay, bisexual and transgender people
- People in ethnic minority groups
- People with long-term conditions and disability
- Young people NEET
- People who are unemployed
- Working-age men
- People who suffer from addiction
- Homeless people

These groups are explored further below.

The Campaign to End Loneliness estimates that around 10% of people over 65 years of age often or always feel lonely⁶.

Whilst data relating to younger people is lacking, it has been suggested that 7% of people aged between 18 and 64 years are socially isolated¹⁵.

HOW CAN WE IDENTIFY THOSE AT RISK?

Determining the Risk Factors

There is evidence that factors which contribute to loneliness differ during the life course.

Unfortunately our understanding of the risk factors in younger age groups is limited, but some research into this has been done²⁸. Table 1 shows those factors which were found to be significantly associated with self-reported loneliness (feeling lonely all or most of the time) at different ages.

Table 1. Risk Factors for Loneliness in different age groups²⁸

Risk Factor	Young Adults (15-29 years)	Mid-life Adults (30-59 years)	Older Adults (60+ years)
Subjective health rating	Yes	Yes	
Self-reported limitations in daily activities	Yes	Yes	
Frequency of social contact	Yes	Yes	
Self-reported depression	Yes	Yes	Yes
Gender		Yes	Yes
Marital status		Yes	Yes
Household size		Yes	Yes
Education		Yes	Yes
Rating of social activities		Yes	Yes
Availability of confiding /intimate relationship		Yes	Yes

The findings relating to marital status and household size are perhaps not surprising. One might have predicted that these factors would be more important in the older age groups, reflecting expectations of individuals at different points in their lives. More surprising is the finding that health rating and limitations in daily activities were not found to be associated with loneliness in those aged 60 years and over.

This is in direct conflict with the findings from other research and work by The Campaign to End Loneliness and Age UK^{5,6}. These groups found that poor health and disability were amongst the most significant risk factors for loneliness in older

age. Results from the English Longitudinal Study of Ageing (ELSA) demonstrated a strong association between self-reported loneliness in people aged 65 and over, and the following factors:

- Health and disability
- Being widowed
- Living alone
- Age

The Campaign to End Loneliness identifies a much broader range of risk factors associated with loneliness in the older age, grouping them into five categories: personal circumstances, transitions, personal characteristics, health and disability, and geography (Table 2).

Table 2. Risk Factors for Loneliness in older age⁶

Personal Circumstances	Transitions	Personal Characteristics	Health and Disability	Geography
Living alone			Poor health Immobility	
Being divorced, single, or never married	Bereavement	Age 75 plus	Cognitive impairment	Living in an area with high deprivation
Living on a low income	Becoming a carer or giving up being a carer	From an ethnic minority community	Sensory impairment	Living in an area with high levels of crime
Living in residential care	Retirement	Being gay or lesbian	Dual sensory impairment	

This disparity between studies demonstrates that we are still learning about these issues. One explanation could be the differing way in which loneliness is defined and measured. What is clear is that the nature of how risk factors for social isolation and loneliness develop and impact on people is complex. However, using what is known about the risk factors, we can achieve two primary aims. The first is to use those risk factors, or other factors associated with social isolation and loneliness, as a proxy measures. We are then able to estimate who is likely to be affected by isolation and loneliness in our population. This is explored further below. The second way we can use this knowledge is to better understand how social isolation and loneliness can be prevented and addressed.

The Importance of Getting it Right

The way in which social isolation and loneliness are measured matters because it determines who is classified as being isolated and/or lonely and therefore where services and interventions should be targeted.

One challenge is that there is no universally agreed way of defining or measuring these issues. Published studies on the subject vary widely in how they classify individuals as experiencing social isolation and loneliness, with some using direct questionnaires and others relying on proxy measures. The issue is particularly complex when it comes to loneliness because of its subjective nature. Unfortunately, surveys which directly ask about isolation and loneliness only sample a small proportion of the population and therefore have only limited use in trying to measure these issues at scale.

A Measurement Tool

Measurement of social isolation at the population level therefore relies on measuring factors which are known to be associated with it. Work undertaken by Surrey County Council found that measuring the following factors is a useful way of predicting who is likely to be isolated in a population:

- Living alone
- Being a carer
- Being widowed
- Level of deprivation
- Having a long-term health condition or disability
- Not having access to a car (a proxy measure for ability to access social networks and services)
- Being 65 and over.

Many of these factors are primarily applicable to those in older age groups, and the extent to which this tool can be used to identify social isolation in younger groups is unclear. However, this is a helpful guide as to where social isolation is likely to be most prevalent in Hampshire.

Measuring loneliness poses a different challenge. A recent report by Age UK argues that, although there have been many attempts to measure loneliness at the population level, these only succeed in measuring isolation²⁹. In response to this, the authors developed their own tool using the findings from the most recent ELSA which directly asks about feelings of loneliness. Results from the ELSA were cross-matched with variables which are easily measurable at the population level. Those

found to be significantly associated with self-reported loneliness in the ELSA were used to establish a formula for predicting loneliness. Furthermore, factors were weighted according to their relative importance. The factors found to be significantly associated with self-reported loneliness were:

- Self-reported health
- Household size
- Being widowed
- Having an eye condition
- Not having pets
- Difficulty with activities of daily living
- Being 75-79 years of age.

This tool is only applicable to identifying loneliness in those aged 65 years or over, and does not include people in care homes. The authors estimate that this accurately identifies 50% of people aged 65 and over who are lonely.

Both of these measurement tools can be used to create maps showing the geographical areas where social isolation and loneliness are most prevalent. Subsequent sections of this report explore who is likely to be affected by isolation and loneliness in younger age groups.

SOCIAL ISOLATION AND LONELINESS IN HAMPSHIRE

Hampshire's population is older than that of the England's population as a whole, with 20.3% of people in Hampshire being 65 and over compared to 17.6% of those in England⁸.

Hampshire is a diverse county with large rural areas. The relationship between social isolation, loneliness and rurality is complex. Urban areas are often more deprived than rural areas, and aspects of the built environment in modern towns and cities can have a negative impact on social integration. These factors, and others, mean the prevalence of social isolation and loneliness is often higher in urban than rural locations.

However more people living in rural communities are over retirement age compared to those living in urban areas, a disparity which is expected to continue in the future⁷. Levels of poor health and immobility, factors which are significantly associated with loneliness, increase with age and may exacerbate the physical isolation of those living in rural areas.

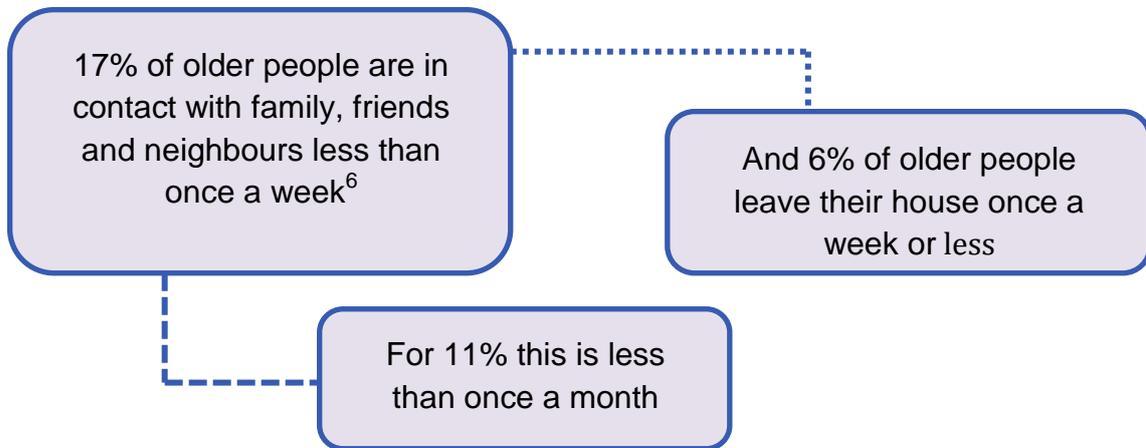
Providing health and social care to rural populations carries a higher cost than the equivalent in urban areas due to factors such as travel distances and diseconomies of scale⁷.

Hampshire has a total population of 1,364,136 of which 273,887 are aged 65 and over⁸. Using the suggested proportion of the population who are lonely (10%⁶) this means that **there are potentially over 27,000 people aged 65 and over in Hampshire who are lonely all or most of the time**. For this estimate the prevalence of loneliness of 10% has been extended one year to include those aged 65 years so as not to exclude this age group and simplify calculations going forward.

In addition, using the estimate of loneliness prevalence in those under 65 (7%¹⁵), **there are potentially 55,355 Hampshire residents aged 18 – 64 who are lonely**.

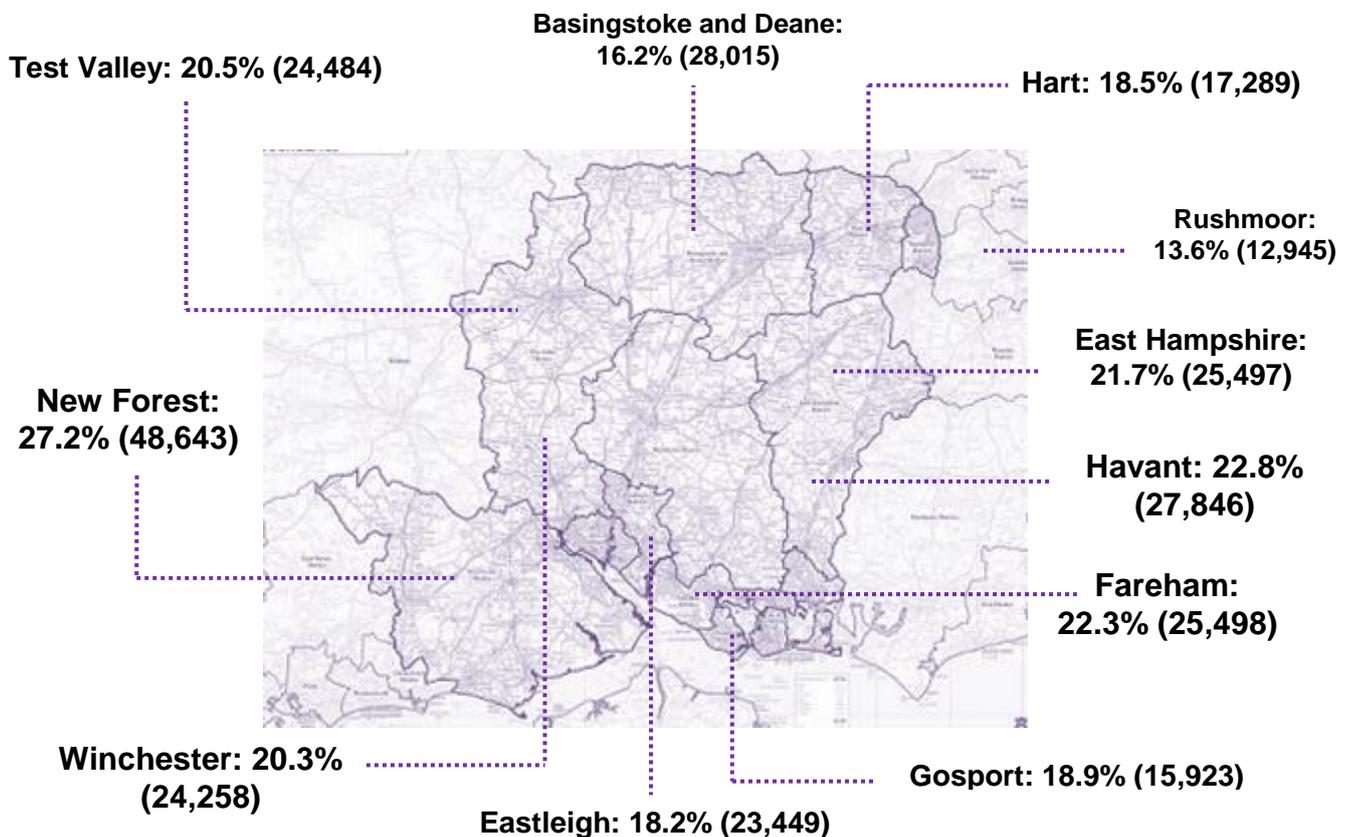
The estimate put forward by Social Action (discussed above) of the financial cost of social isolation and loneliness in older people was £12,000 per person per year. Forty percent (or £4,800) occurs in the first five years, equating to £960 per annum for five years. Applying this to Hampshire's older population, the cost of isolation and loneliness can be estimated at **£25.9 million per annum during those first five years** (acknowledging that this cost would not occur all at once given people become lonely at different times). Estimates of the financial cost of isolation and loneliness in younger age groups are lacking.

HAMPSHIRE'S OLDER POPULATION



The geographical distribution of people aged 65 and over within Hampshire provides a useful guide to areas where the prevalence of loneliness is likely to be highest (Figure 4).

Figure 4: What proportion of the population is 65 and over?⁸



Using the tools discussed above to produce maps of social isolation and loneliness in Hampshire (Figures 5 and 6) is useful in helping to guide service provision and identify areas of particular need. The indicators and methods used to create the maps below are detailed in Appendix 2.

The overall finding from comparison of the maps for social isolation and loneliness is that their geographical distribution is largely comparable. This is not surprising given that there is some overlap in the variables used to measure them.

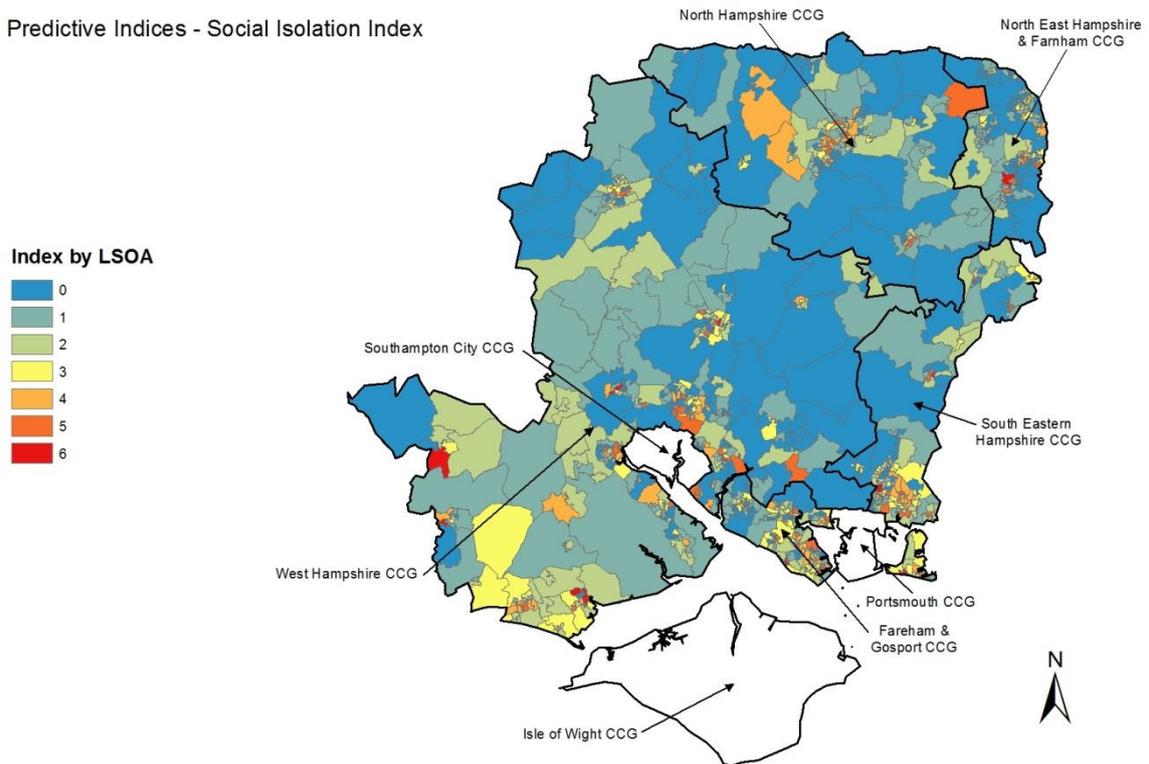
Both social isolation and loneliness are associated with material deprivation, and their prevalence is higher in those areas where there are greater levels of deprivation such as Basingstoke, Andover, Gosport area, Havant and Rushmoor.

The maps also suggests that both social isolation and loneliness are more likely to be prevalent in urban areas rather than rural areas and, perhaps surprisingly, they are clustered into the most densely populated Lower Super Output Areas (LSOAs). This data does not suggest that there aren't individual people who are socially isolated in rural areas; rather the clustering of people with risk factors for social isolation is higher in urban areas.

Areas with a higher prevalence include Farnborough, Fleet, Eastleigh, Romsey, Winchester, Lymington, Fordingbridge, Ringwood and those surrounding Southampton. Two LSOAs which do not follow this pattern lie directly West of Basingstoke. Examination of the data reveals they are home to a large number of people providing unpaid care and people over 65 living in a household without a car. Further scrutiny of these maps by local service providers will be of value in helping to target those most at risk.

Figure 5: Map of social isolation in

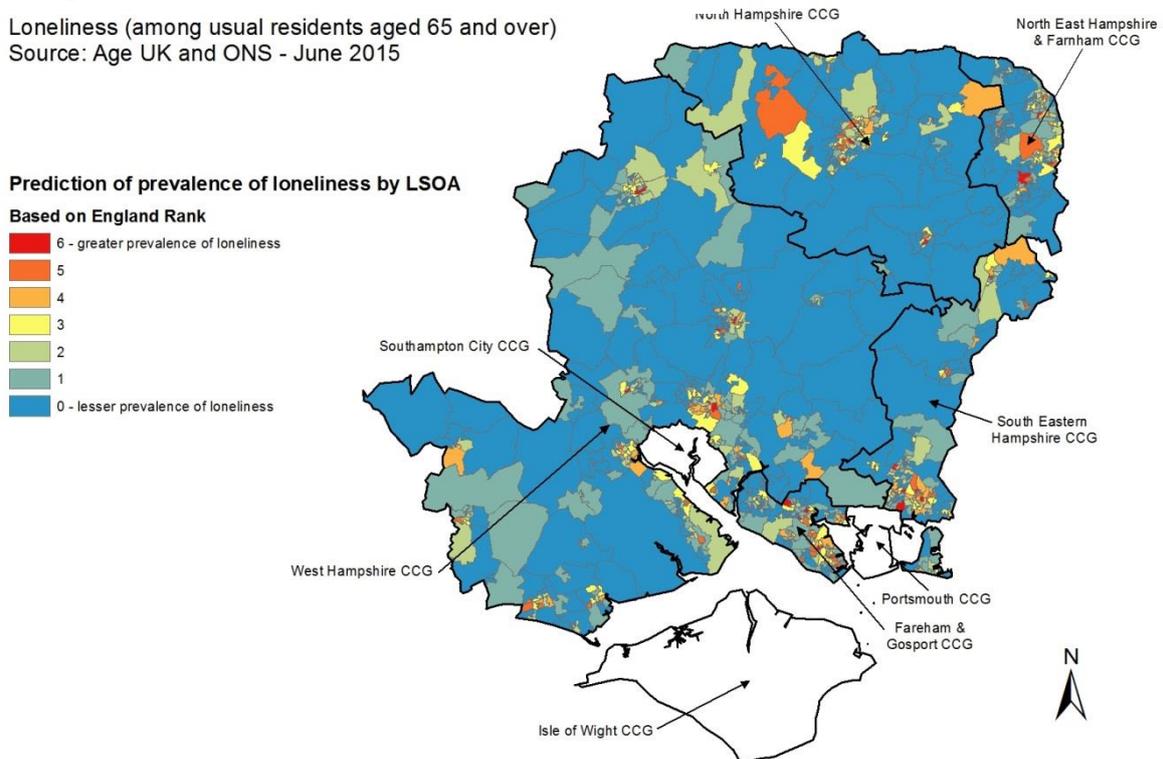
Predictive Indices - Social Isolation Index



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Figure 6: Map of loneliness in Hampshire

Loneliness (among usual residents aged 65 and over)
Source: Age UK and ONS - June 2015



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OTHER RISK GROUPS IN HAMPSHIRE

Aside from those of retirement age and older, there are a number of groups who are at particular risk of social isolation and loneliness.

Parents of young children

Becoming a parent is a significant time of change and adaptation. It can also be a time of sudden imposed isolation and loneliness as the needs of the baby replace those of the parents. Although population-level data is lacking, it is widely reported that loneliness is common among new parents.

The charity 'Action for Children' surveyed 2,000 parents in Britain and found that 24% reported feeling isolated and lonely³⁰. Isolation and loneliness are known risk factors for post-natal depression^{31,32}.

Within this group, teenage mothers are particularly at risk. The number of women giving birth under the age of 18 years is decreasing and the rate in Hampshire is lower than that in England, 17.1 per 1,000 women aged 15-17 compared with a rate of 23.4 nationally³³. However, there remains a significant number of young mothers in Hampshire, particularly in certain areas.

There is also evidence to suggest that women who have migrated from another country and do not have the support of family are also at greater risk³⁴. In qualitative interviews with Bangladeshi women in London, women reported feeling rejected and isolated after giving birth, receiving very little social support from their husbands or the extended family³⁵. High scores on the Edinburgh Postnatal Depression Scale have been associated with being non-White (especially Asian) and also being born in a non-English speaking country³⁶. The number of births to non-British born mothers in Hampshire is increasing, and accounted for 15.8% of all Hampshire births in 2013³⁷. It is therefore vital that all Public Health services which aim to provide support to families and offer opportunities for parents to meet and socialise, have activities tailored to all relevant ethnicities.

A recent change to the law enabling parents to share parental leave is likely to result in an increasing trend for fathers to provide home care for young children. It is important to consider the impact this may have in terms of placing men at risk of

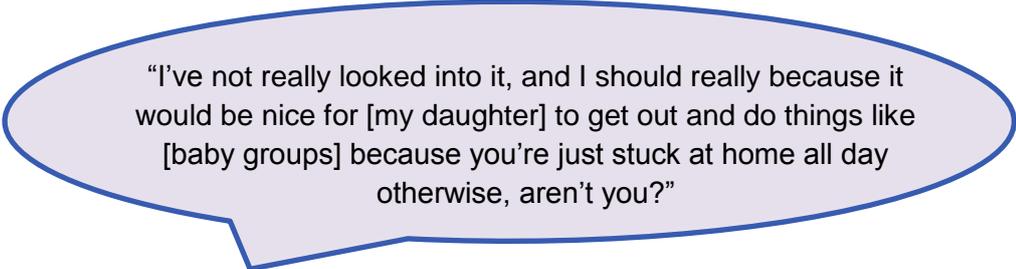
social isolation and loneliness, which may be compounded by the fact that men remain the minority group in this sphere.

Through interviews with mothers of young children and Health Visitors in Hampshire, the following themes were identified:

- Isolation in early motherhood
- Support from friends and family
- Making new friends
- Awareness of baby groups
- Attending baby groups

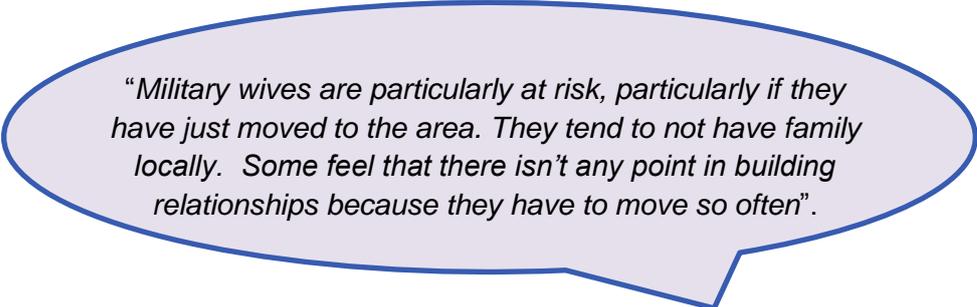
Isolation in Early Motherhood

Many of the women and HVs recognised that early motherhood could be a time of social isolation. One mother, when asked about whether she attended any baby groups, said:



“I’ve not really looked into it, and I should really because it would be nice for [my daughter] to get out and do things like [baby groups] because you’re just stuck at home all day otherwise, aren’t you?”

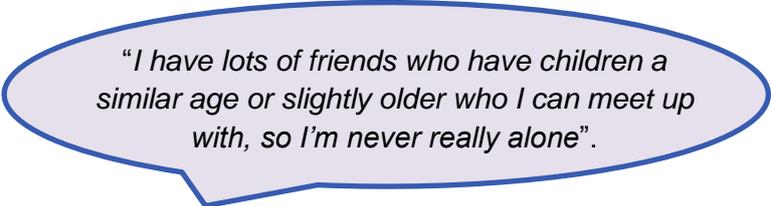
One HV who worked with military wives felt that this group were especially vulnerable:



“Military wives are particularly at risk, particularly if they have just moved to the area. They tend to not have family locally. Some feel that there isn’t any point in building relationships because they have to move so often”.

Support from Friends and Family

Some women felt they had good support from friends and family which helped to prevent them from feeling isolated.

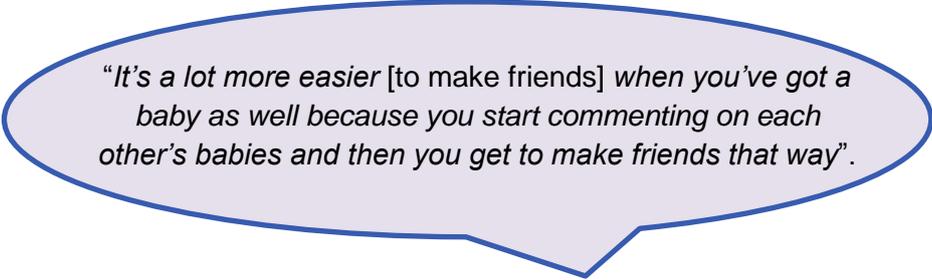


“I have lots of friends who have children a similar age or slightly older who I can meet up with, so I’m never really alone”.

Of course this is not the case for many mothers. The example given above about military wives could likely be expanded to include families who, for whatever reason, do not live close to family or friends. One of the women interviewed explained that all her friends were at work during the day.

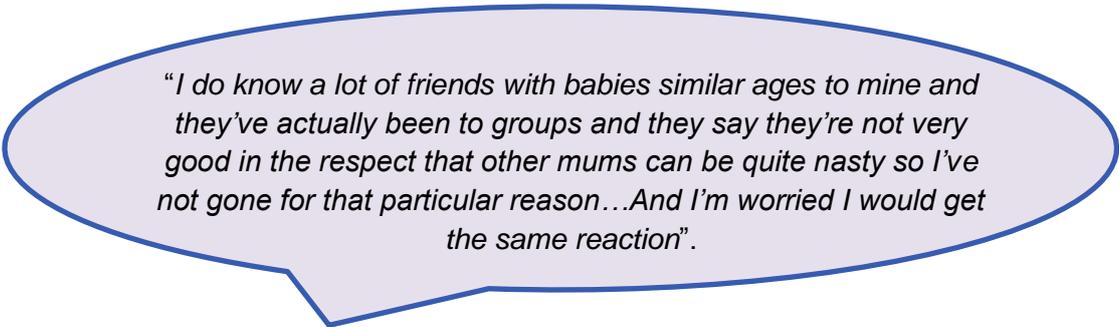
Making New Friends

For some women, new motherhood presents the opportunity to make new friends. A number of the mothers interviewed felt that making new friends during this time was easy.



“It’s a lot more easier [to make friends] when you’ve got a baby as well because you start commenting on each other’s babies and then you get to make friends that way”.

However, some women had concerns about other mothers being judgemental.



“I do know a lot of friends with babies similar ages to mine and they’ve actually been to groups and they say they’re not very good in the respect that other mums can be quite nasty so I’ve not gone for that particular reason...And I’m worried I would get the same reaction”.

Awareness of Baby Groups

One of the primary ways in which parents of young children can be supported to build social networks is through the provision of dedicated ‘baby groups’. These are run throughout the county by both the public and private sector. Whilst some incur a charge, many of those run at Children’s Centres are free. HVs give women information about local baby groups and are able to support them to attend (see below). Whilst most of the women interviewed did know about local baby groups, some felt they would like more information.

"I was given a leaflet in the early days but I didn't really look at it".

"I haven't heard of many [groups]. I know there's one at the Sure Start centre but that's the only one".

Attending Baby Groups

The final theme which was identified from the interviews related to what determined whether women attended baby groups and the reasons for doing so, or not. The HVs felt that there were some women who, whilst they would be likely to benefit from attending groups, lacked the confidence to do so. One HV summarised it very clearly:

"It's about getting over the first hurdle. The biggest barrier for nine out of 10 mums who don't go to groups is walking into a room full of people. If you can get a mother along to a group for the first few times they will usually then become independent and go along to other groups".

Support for women who are apprehensive or have reservations about attending groups does exist, and the HVs felt that this was very positive. However, they had concerns about capacity of the service.

"The best thing is to use Home Start volunteers to take mothers along to groups for the first time".

"What we really need is more Home Start volunteers. Sometime they have no spare capacity and can't take any more referrals"

Children and young people who do not conform to local norms of appearance, language or behaviour

As in adulthood, social relationships in childhood and adolescence are vital for good health and wellbeing. Young people with strong and supportive peer relationships have higher levels of self-worth and have higher levels of performance in school³⁸. Isolation and loneliness among children is being increasingly recognised as an issue. The role of relationships in childhood differs somewhat from those in adulthood. For children, good relationships with both family and peers are important. In addition, the drive to conform to social norms is arguably stronger in childhood and adolescence than amongst adults and therefore children who do not conform in any way are particularly at risk of isolation. Whilst this may present in a subtle way, overt peer victimisation and bullying is not uncommon. This is associated with loneliness and social anxiety³⁹.

In the Hampshire ‘What do I Think Pupil Attitude Survey 2012’, 14% of year 6 pupils, 23% of year 7 pupils, and 19% of year 9 pupils reported that they had experienced bullying in school⁴⁰.

Bullying is often experienced by children who may be perceived to be different, for example because they are overweight or obese. Studies have found that children who are obese are at a significantly increased risk of both peer victimisation and loneliness^{39,41}. In Hampshire, 7.6% of 4-5 year olds, and 15.0% of 10-11 year olds, are obese, which highlights a significant proportion of the younger population who are at risk⁴².

Children with a long-term health condition are particularly vulnerable to isolation for two reasons. Firstly, their condition may be viewed as stigmatising and therefore act as a barrier to developing relationships. For example, it is recognised that children with epilepsy can experience rejection and loneliness related to the stigma of their condition⁴³. Secondly, opportunities to create and maintain relationships with peers may be disrupted by symptoms, treatments and medical appointments³⁸.

Children with special educational needs (SEN) are also more likely to be bullied than their peers¹³. A child or young person has an SEN if they have a learning difficulty or disability which calls for special educational provision. This represents 2.9% of the school population in Hampshire⁴². The Children and Families Act 2014 details the duty of Local Authorities to exercise functions to promote integration and well-being (which includes domestic, family and personal relationships)⁴⁴. The challenge remains as to how best to support children and young people with SEN, in mainstream schools where appropriate, so that they are able to build relationships and thrive.

Addressing the complex issue of isolation and loneliness in children and adolescents is important and likely to require involvement of parents, schools, teachers and other professionals who work with children at risk. However, a thorough exploration of this issue is required and beyond the scope of this report. Therefore a recommendation is made for this to be looked at, in depth, together with ongoing work on mental wellbeing in children.

People who Provide Unpaid Care for Others

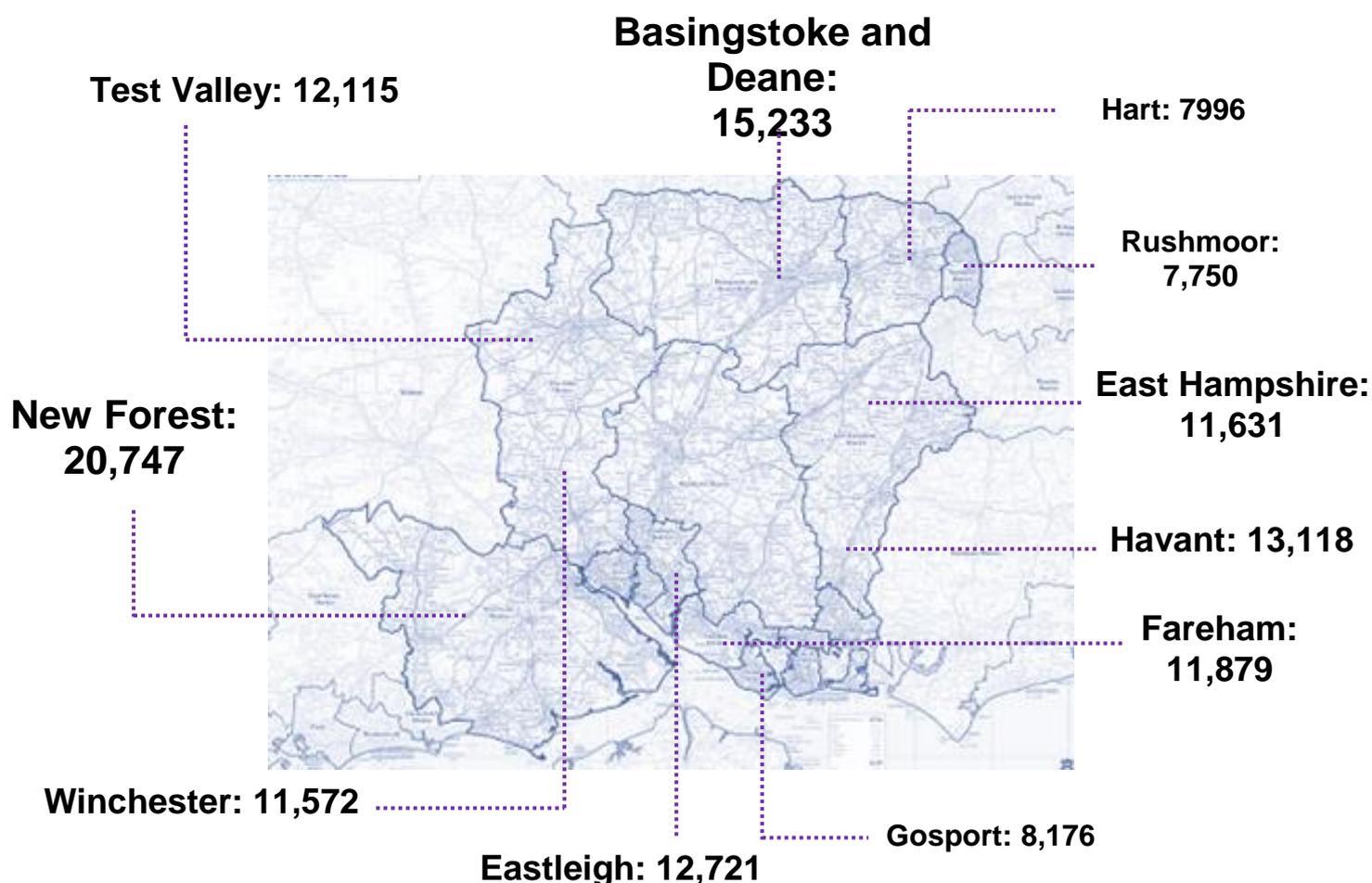
The number of people providing unpaid care across England increased by 600,000 between the 2001 and 2011 census⁴⁵. The increase was seen across all regions of the country, except in London. Furthermore, the demand for care provided by spouses and adult children will more than double in the next thirty years.

It is well recognised that people who provide unpaid care for others are at an increased risk of isolation and loneliness. In a survey of more than 5,000 carers by Carers UK, 80% of responders reported that they have felt lonely or isolated as a result of looking after a loved one, and 57% said they had lost touch with family or friends as a result of their caring role⁴⁶.

In 2011, there were 132,938 people providing unpaid care because of long-term physical or mental health or disability, or problems related to old age, in Hampshire. The numbers across the county are shown in Figure 7⁴⁵.

People providing unpaid care represent a diverse group and it is important that we understand who they are so that we can ensure the appropriate support is provided. For example, in 2011 there were 4109 people under the age of 18 years in Hampshire who provide care for another person, most commonly a parent or brother or sister, because that person has an illness or disability, mental health problem or problems with addiction to alcohol or drugs⁴⁷.

Figure 7: How many people are providing unpaid care in Hampshire? Error!
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The New Forest and Basingstoke and Deane are notable as areas with high numbers of carers. Whilst this to some extent represents the large populations of these areas, this also reflects the age of those populations. For example, 27.2% of the population of the New Forest are aged 65 years and over⁸. The geography of this area means that carers are likely to be particularly vulnerable to isolation and may not be able to access support services easily. Research looking into how the needs of carers may be met identifies a number of aspects which are important when providing support. These are summarised below.

An example of a programme which incorporates many of these aspects is discussed in the section on Social Return on Investment.

Flexibility to address specific **individual needs and carers** such as provision of transport and arrangements for respite care.

Having a **dual carer-care recipient focus** can be useful for carers who are concerned about leaving the care recipient, and avoids the need for respite care.

An **educational component** to the intervention can help to reduce carer's guilt about attending, for example providing important care-related information or training.

Opportunity for **informal interaction between carers** (allows friendships to develop more naturally).

Employment of **existing networks and experienced personnel** (helps to identify vulnerable carers and ensures they have the necessary support to attend).

Ability to be **sustainable and long-term** (builds support for local ownership).

Lesbian, Gay, Bisexual and Transgender People

People who are lesbian, gay, bisexual or transgender (LGBT) are at a disproportionate risk of mental and physical health problems and have higher rates of suicidal ideation^{48,49}. Studies suggest that this is, at least in part, due to poorer relationships with close peers, and loneliness.

There is no census data about sexual orientation and large studies looking at this are lacking. According to experimental data from the Integrated Household Survey conducted in 2013, 1.3% of people living in the South East of England are gay, lesbian or bisexual, compared to 1.7% nationally⁵⁰. However, other studies have shown rates of LGBT to be significantly higher and Stonewall estimate this to be between 5 and 7%⁵¹.

Although there is a perception that society largely accepts an individual's sexual orientation, many people who are LGBT do not find this to be true in reality.

More than half of gay, lesbian and bisexual young people experience homophobic bullying in Britain's schools⁵². But the issue is not limited to young people, with 19% of lesbian, gay and bisexual employees reporting to have experienced verbal bullying from colleagues, customers or service users because of their sexual orientation in the last five years⁵³.

Tackling the issue of isolation and loneliness in this group is likely to require not only opportunities for people to meet others and develop social relationships, but also work to address the discrimination faced by people who are LGBT in their schools, workplaces, social settings and online.

People in Ethnic Minority Groups

People in ethnic minority groups may experience barriers to social inclusion such as those associated with social disadvantage, housing, and language¹³.

Although large-scale prevalence data on loneliness among ethnic minority groups is lacking there have been some smaller surveys⁵⁴. They have found that whilst the older people of Indian decent have similar reported rates of loneliness to those found for Britain as a whole (around 10%), the rates are much higher amongst those in other ethnic groups such as Chinese, African, Caribbean, Pakistani and Bangladeshi communities, ranging from 24 to 50%. It is reported that these rates are similar to those observed amongst older people in the countries of origin.

The population of Hampshire remains predominantly white British (89%) although the ethnic diversity is increasing and varies considerably across the county⁵⁵. Rushmoor has the largest non-white British population (19.5%), mostly due to a growing Nepalese population. In the 2011 census, 7.6% of the population in Rushmoor described themselves as being 'Asian/Asian British: Other Asian'.

Table 3. Percent of population in Hampshire who are white British and non-white British⁵⁵.

Area	Percentage of population who are white British	Percentage of population who are non white British
Basingstoke and Deane	88.2	11.8
East Hampshire	93.0	7.0
Eastleigh	91.8	8.2
Fareham	94.7	5.3
Gosport	94.4	5.6
Hart	90.7	9.3
Havant	95.2	4.8
New Forest	94.9	5.1
Rushmoor	80.5	19.5
Test Valley	92.6	7.4
Winchester	91.8	8.2
HAMPSHIRE	91.8	8.2

Further work is needed to establish the prevalence of social isolation and loneliness amongst ethnic minority groups in Hampshire, as well as to establish how this can best be addressed. Ensuring that services and interventions which can reduce isolation and loneliness are accessible and appealing to those from ethnic minority groups is paramount.

People with Long-term Conditions and Disability

It is well recognised that having a long-term physical or mental health condition (that is any condition which cannot, at present, be cured but is controlled by medication and/or other treatment therapies) is a risk factor for social isolation and loneliness⁶.

Although long-term conditions are most common with advancing age, 14% of people under 40 report having a long-term condition⁵⁶.

Within this cohort, those with a physical disability may be particularly impacted. Physically disabled people face social, environmental and attitudinal barriers, which can restrict their participation in society. Long-term conditions and disability can mean that it is physically difficult for a person to get out the house, and may be associated with low self-esteem, a lack of confidence, and actual (or perceived) discrimination. All of which may prevent someone developing and maintaining social relationships.

In 2011/12, 6% of children and 16% of adults of working age were disabled⁵⁷. Hampshire population estimates predict that, over the next five years, there will be approximately a 2.4% increase in the number of people aged 18-64 years with a moderate disability and a 3.3% increase in the number of people with a severe disability⁴². The impact on bullying and social exclusion is discussed above.

In a similar way, having a mental health condition can be a barrier to participation in social activities. People with a mental health condition may lack the confidence to join groups or even travel to them. There may also be a fear of stigma associated with the condition, and maintaining relationships through mental illness may be difficult. One in four people in the UK will experience a mental health problem in the course of a year^{58,59}. Amongst working-age adults, 20% of women and 17% of men are affected by depression or anxiety at any one time. Dementia affects 5% of people aged over 65 and 20% of those aged over 80.

Working-age Men

Evidence suggests that loneliness can be a significant issue for men in their 30s, 40s and 50s and that beyond the age of 30, men have fewer supportive peer relationships than women⁶⁰.

A survey by the Samaritans in 2013 found that one in four contacts were from middle-aged men who wanted to talk about issues related to loneliness and isolation, and they were predominantly from disadvantaged backgrounds^{13,60}.

The highest UK suicide rate in 2013 by broad age group was among men aged 45 to 59, at 25.1 deaths per 100,000, the highest for that age group since 1981⁶¹. In the Samaritans report 'Men, Society and Suicide', the author writes "The relative narrowness of social connections among men in mid-life leaves some men vulnerable to emotional distress, mental health problems and suicide, when faced with negative life events"⁶⁰. Among the report's recommendations for policy and action is to "support men to build social relationships".

Men who are from low socio-economic backgrounds are particularly affected, and are ten times more likely to take their own life than men from affluent backgrounds⁶⁰. Unemployment or breakdown of a marriage (which may have provided vital emotional support), are particular triggers for loneliness and suicide. The way in which these life events impact on men and women appears to be different, with marriage breakdown being more likely to lead to suicide in men than women.

A report written by the Big Lottery Fund identified five broad categories of barriers to men engaging with services⁶².

1. Help-seeking behaviours: Men are more resistant to seeking help from others than women.
2. Fear of stigmatisation: This can range from peer disapproval among young men, to stigmas attached to abuse from a perpetrator and or being a victim, which are often linked to notions of masculinity and manhood.
3. A lack of visibility of men in services: A lack of male role models in the service provision was a commonly acknowledged barrier.
4. Hard to reach men: The evidence suggests that young men appear to be the hardest group to reach, followed by men from BME backgrounds. This is due to a number of factors ranging from language and cultural barriers to the susceptibility of peer influence.
5. A lack of discourse: Perhaps one of the biggest barriers in engaging men into social projects is this overall resistance to engage with gender as an issue from a male perspective.

Solutions to this issue are likely to require a range of interventions, including raising awareness of the issue, and must be sensitive to men's beliefs and concerns⁶⁰. One programme which has been particularly successful at promoting social relationships amongst older men has been the Men in Sheds initiative. It might be that this sort of programme could be adapted for a broader age group for men. Interventions aimed at men are discussed further below.

People who are Unemployed

For many people, their place of work provides a primary source of social interaction, as well as boosting self-esteem. People who are not in work or education are vulnerable to social isolation and loneliness because they may miss out on the daily interaction at work, but they also may lack the financial resources to support them in building social networks.

Particularly vulnerable are young people aged 16 to 18 who are not in education, employment or training (NEET). It is estimated that there are 1,512 young people who are NEET in Hampshire⁴². This is a diverse group and many people do not stay within the group for long periods of time.

Hampshire has a low youth unemployment rate of 1.6% of 18 to 24 year olds, as well as a low overall unemployment rate, with the Job Seeker Allowance claim rate at 0.9% (England rate 1.9%).

Support for this group should focus on prevention of unemployment as well as considering ways to help people who are out of work to avoid becoming isolated.

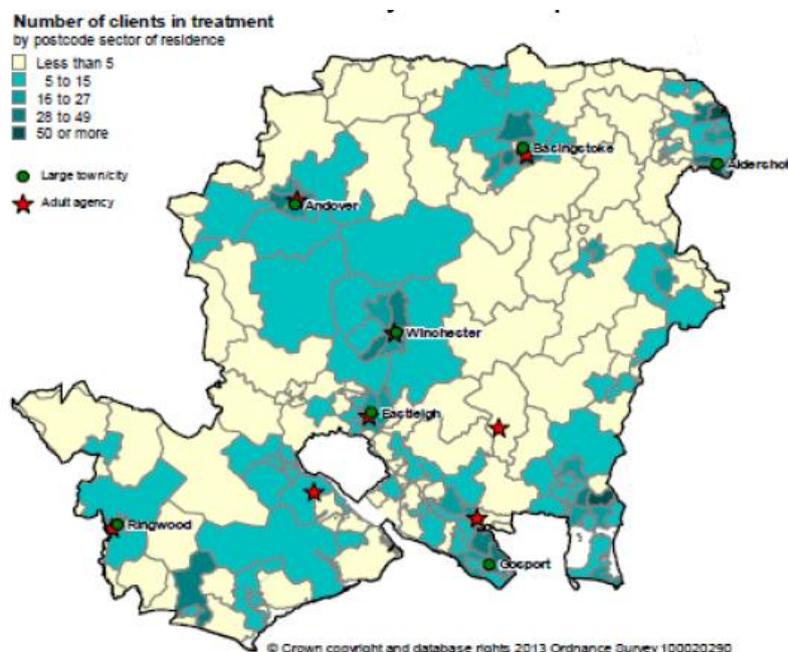
People who suffer from Addiction

People who suffer from addiction to alcohol or drugs are at greater risk of social isolation and loneliness than the general population. Use of alcohol and drugs may be associated with relationship breakdown and difficulty in maintaining social links, with usage exacerbated by relationship loss and a lack of social support.

Of the Hampshire population who drink (approximately 85% of adults in Hampshire), 6.6% drink at harmful levels and may be classified as 'dependant' on alcohol⁵⁹. This corresponds to almost 60,000 people.

In 2011/12, 2,133 people in Hampshire received structured treatment from a community drug treatment service⁵⁹. Figure 8 shows the distribution of clients by postcode.

Figure 8. Clients of community drug treatment services by postcode of residence⁵⁹.



Support for these groups has traditionally focused on a more medicalised approach to treatment of addiction. Consideration should always be given to how commissioned services can incorporate support to help service users build and maintain social relationships, or build ‘Recovery Capital’ (see below). In Hampshire the Drugs and Alcohol Action Team commission ‘Inclusion’ to provide the drug and alcohol recovery services throughout Hampshire and part of the contract is to develop people’s ‘Recovery Capital’.

Recovery Capital can be broken down into physical, social, cultural and human capital. The more of each capital a person has the more likely they will be to recover and sustain their healthy lifestyle. In addition, the Active Recovery Community (ARC) in Hampshire, supported by HCC, helps people in recovery from addiction come together to form a community to keep each other safe and well. ARC has the remit to ‘S.A.V.E’ (organise and promote Support groups; organise fun, boredom busting Activities; provide a Voice for service users through advocacy and feedback mechanisms; and develop Social Enterprises in order to become self sustaining and not reliant on grant funding).

Homeless People

Homelessness is one of the most extreme forms of social exclusion. Homeless people have complex health needs and often experience both physical and mental ill health. This, as well as material circumstances, leave homeless people particularly vulnerable to social isolation and loneliness. Homelessness can be triggered by specific events such as leaving the parental home, marital or relationship breakdown, eviction, deterioration in mental health or increase in alcohol or drug misuse⁶³. A lack of supportive factors such as strong support networks can also play a role.

The rate of statutory homelessness in districts of Hampshire is relatively low compared to other lower tier local authorities in the South East and the rate in England. However, this masks considerable variation across the county. The rate of statutory homelessness in Hampshire was 0.81 people per 1,000 households in 2011/12 with the highest levels in Gosport, Havant and East Hampshire⁶³.

Non-statutory homelessness is very difficult to measure. Applications to Supporting People (which provides support to people over 16 who are vulnerable, have housing housing-related support need, and require support to live more independently), can give an indication of the level of housing need for vulnerable people. In 2009-11 there were 2,637 applications to Supporting people for housing-related support made through Supported Housing panels. In 2012, a count of the number of rough sleepers in Hampshire found there were 39, with highest rates in Winchester, Basingstoke and Deane, and the Test Valley⁶³.

INTERVENTIONS TO TACKLE SOCIAL ISOLATION AND LONELINESS

There is good evidence that the right actions can reduce social isolation and loneliness and prevent the associated negative health effects. Furthermore, the cost of acting is less than the cost of doing nothing.

The argument for acting to tackle social isolation and loneliness can be made on the individual bases (improving health status and quality of life), the societal basis (enabling ‘harnessing’ of potential community action such as volunteering), and the resource basis (reduced use of health and social care service use)⁶⁴.

This section explores the types of interventions available, with the subsequent sections examining the evidence for their effectiveness and associated costs and savings.

The Campaign to End Loneliness identifies four main categories of interventions which can prevent and support people out of social isolation and loneliness⁶:

- foundation services
- direct interventions
- gateway services
- structural enablers.

Table 4 gives a description of each type of intervention together with examples. Many interventions comprise aspect of more than one category.

The Built and Natural Environment

In addition to the interventions discussed below, the built environment can have a significant impact on whether or not a person becomes socially isolated¹³. The nature of the environment influences physical access to family & friends, public services, shops and community spaces. Evidence suggests that where road traffic inhibits access to goods, services or people, it reduces the opportunity for social interaction in the street. Social interaction is enhanced by safe, attractive and well maintained streets and public places with access to high quality parks and green spaces⁶⁵.

One aspect of this which is particularly relevant in a rural county like Hampshire is access to reliable and affordable transport. Community severance, where road traffic inhibits local access decreases opportunities for social interaction in the street. In

more urban areas social interaction is enhanced by safe, attractive and well maintained streets and public places with access to high quality parks

and green spaces. Another example identified in a report on age friendly cities was the value of providing plentiful, clean public toilet facilities with access for people with disabilities, and benches and bus stops should be placed near to amenities⁶⁶. The 'Age-friendly' cities initiative demonstrates that urban design can deter or facilitate older people going outdoors. Planning of community spaces should include participation of the local residents in order to ensure that they meet community needs and to encourage ownership. Built environments should be designed to encourage walking and active transport.

Table 4. Categories and examples of interventions which can reduce social isolation and loneliness (as described by the Campaign to End Loneliness)⁶.

Type of Intervention	Description	Examples
<p>Foundation Services</p>	<p>Foundation Services are the first steps in finding individuals experiencing loneliness and enabling them to gain support that meets their specific needs.</p> <p>There are three main aims; identifying and establishing contact with lonely individuals (reaching); drawing out the specific circumstances of an individual's loneliness and establishing the most appropriate help (understanding); supporting individuals to make use of available services (supporting). Many services can sit across several of these categories.</p>	<p>Mapping Social Isolation and Loneliness is the first step in identifying vulnerable communities to help target resources.</p> <p>Community Navigators (usually volunteers) provide vulnerable people with emotional, practical and social support. They act as 'navigators', signposting people to the right services and opportunities for them.</p> <p>Village Agents are similar to Community Navigators but often work in more rural areas and have a very in-depth knowledge of services and opportunities in the local area. Many of these local opportunities may not be captured in large-area lists, but may be more ad-hoc groups or events.</p> <p>Family Nurse Partnership is a national home visiting programme for first time young mothers, aged 19 year and under. This group is particularly vulnerable to social isolation and loneliness. Family nurses work with mothers through pregnancy and beyond to support them and their baby. One aspect of this is to help young mothers identify opportunities to build relationships with others.</p> <p>First Contact Schemes utilise services which vulnerable people already come into contact with on a routine basis, to identify and connect them with appropriate services. One specific example of this was the Making Connections trial (see section 7). Another example is work with the fire service who routinely visit older people in their homes.</p>

<p>Direct Services</p> <p>Direct interventions are services that reduce loneliness by directly increasing the quantity and/or quality of a person's relationships. Once an individual experiencing loneliness is identified, commissioners should ensure there is a 'menu' of direct interventions available.</p> <p>Interventions aimed at helping people develop new relationships broadly fall into two categories:</p> <ul style="list-style-type: none"> - group-based approaches, and - one-to-one approaches. 	<p>Group-based approaches offer people the opportunity to meet other people. They often have a 'theme' such as painting or sport. They may be targeted to particular groups, such as older men or young carers. Examples include Men in Sheds, baby groups at Children's Centres, and support groups for women who are victims of domestic abuse.</p> <p>One-to-one approaches include programmes such as befriending schemes where someone is visited in their own home, often by a volunteer, with whom they can chat and build a relationship with. Befriending programmes can be particularly effective during periods of transition such as following bereavement or after discharge from hospital. An alternative is telephone befriending such as Silver Line Friends. Befrienders may also act, in part, as Community Navigators (see above) although their primary focus is building a relationship and providing emotional and social support.</p> <p>An alternative to the above approaches is a psychological intervention where people experiencing isolation and loneliness are helped to change their thinking about loneliness using, for example, mindfulness or cognitive behavioural therapy.</p>
<p>Gateway Services</p> <p>Gateway Services encompass technology and transport provision, which enable individuals to maintain existing relationships and support them in making new social connections. The lack of Gateway Services can have an enormous impact on older peoples ability to engage with services, and on communities' ability to provide them.</p>	<p>Training people to use IT equipment such as computers or tablets, and ensuring they have access to the internet at home can help them maintain relationships with family and friends who they may not see regularly. For some this may be because they live far away from loved ones, for others it may be one solution to mobility problems. An IT programme currently being piloted in Hampshire is described in Section 7. The basic ability to use the internet also opens opportunities for people to find out about services and interventions.</p> <p>Another example is the use of websites to form social groups. One example is the website Mums Net which, as well as providing information for new parents, offers local network groups to enable people to meet others in the local area.</p> <p>The use of Telecare can help people to remain in their own homes and communities for longer, in places where they have built up relationships over a lifetime.</p>

	<p>Access to safe and affordable transport is key to ensuring people are able to build and maintain relationships, and remain independent for longer. This should guide both local government planning and the organisation of voluntary services. Providing comprehensive public transport in a large rural county such as Hampshire poses particular challenges. Community transport programmes involving volunteers who are trained in driving mini-buses are one example of how communities can help address this issue.</p>
<p>Structural Enablers</p> <p>Structural Enablers aim to create the right environment to reduce loneliness by focusing on ‘how’ rather than ‘what’ is being delivered. When considering strategies that address loneliness and isolation, local authorities should seek to fulfil the following:</p> <ul style="list-style-type: none"> - neighbourhood approaches - asset-based community development - volunteering - positive ageing. 	<p>Breaking down areas at neighbourhood level can be more manageable, allowing effective targeting of initiatives and enabling outreach efforts. Many people, particularly those in older age groups, feel a sense of belonging in their neighbourhood which can mean they are more likely to volunteer for or attend programmes help locally.</p> <p>Asset-based community development and volunteering both utilise resources (people or facilities) to promote inclusion and reduce isolation and loneliness. The benefit of volunteering is that the volunteers benefit as well.</p> <p>Positive ageing recognises the role of local authorities to promote health and active ageing, as demonstrated in Hampshire’s Older People’s Wellbeing Strategy (Ageing Well in Hampshire)¹⁸.</p>

WHAT WORKS?

This review focuses on the evidence base for interventions targeted at older people because there has been a good amount of research in this area. However, interventions targeted at carers and working-age men are also discussed. The interventions reviewed primarily fall within the direct services category described in the previous section. Although social isolation and loneliness are distinct concepts, the evidence for the interventions aimed at addressing them does not consistently differentiate between the two. In reality programmes and services are likely to have an impact of both and therefore they are discussed as one entity in this section.

The four reviews which inform the main body of this briefing all highlight the challenge of reaching a consensus about the effectiveness of interventions because of the variation in participant selection, intervention characteristics and, most importantly, outcome measures^{64,67,68,69}.

One-to-One Interventions

There is evidence that one-to-one interventions are effective in reducing social isolation and loneliness. However, these may not be as effective as group interventions (discussed below). In a large meta-analysis by Dickens *et al*, over half of the one-to-one interventions reviewed resulted in a significantly improved outcome (a range of outcome measures were used but all related to loneliness, isolation or wellbeing)⁶⁷.

In terms of reducing loneliness, there is evidence that people who used 'community navigator' services became less lonely and socially isolated⁶⁴.

One mentoring programme in Devon, in which participants were signposted to community activities for older people, found a significant improvement in social support at 12 months^{68,70}. However, a follow-up of the same cohort at five years did not show any significant difference between those who had received the mentoring and the control group^{68,71}. One explanation for this is that participants did not appear to receive any support in the interim period. This highlights the importance of considering the duration of the intervention as well and evaluating the long-term effects.

There is also evidence that befriending interventions provided companionship and helped to mitigate loneliness, as well as reducing depressive symptoms and improving wellbeing^{64,68}.

Group-based Interventions

There is some evidence to suggest that group interventions are more effective than one-to-one interventions. However, the impact of these appears to vary considerably depending on the nature of the intervention and its duration.

A review by Hagan *et al.*, found that only one of the nine studies identified which looked at group-based interventions resulted in a statistically significant reduction in loneliness⁶⁸. This was a Mindfulness Based Stress Reduction programme. However, the authors argue that the lack of effect seen in the other studies may have been related to their short time-scales (6-12 weeks). One study recommends that group interventions should be a minimum of five months duration⁷².

Another study looked at the impact of gender-segregated social activity groups in a supported living environment⁷³. Greater benefits for males than females were observed including better social identification and reduced depression and anxiety. However, loneliness was not specifically measured.

Group interventions have shown to improve physical health with one study demonstrating improved survival⁷⁴. Studies also demonstrated a reduction in healthcare service use amongst those receiving group interventions compared to the control groups⁶⁴.

There was a general consensus from the reviews that interventions which included an activity, such as painting or exercise, were effective in reducing loneliness whereas those without were not^{64,67}.

Authors discuss the fact that people may be reluctant to talk about loneliness in a group with people they don't know very well due to the stigmatising nature of loneliness and therefore providing an alternative focus through which social relationships can develop is likely to be more successful⁶⁸. However, Masi *et al.* raised concerns that although such interventions may provide opportunities to build friendships and reduce social isolation, they may not be adequate in themselves to reduce loneliness⁶⁹. In this review, the authors argue that the most affective approaches involve activities to address maladaptive social cognition (low/negative self-esteem). This lies slightly at odds with the other papers and demonstrates the complexity of the issues. It may be that groups interventions with a focus on an activity may be beneficial in reducing social isolation and building relationships, but for some people, addressing the underlying reasons for loneliness is required.

New Technologies

Three reviews found that evidence was lacking for the effectiveness of interventions utilising IT and new technologies^{64,67,69}. However, the authors do argue that small sample sizes may have contributed to this and that further work is needed in this area. Conversely, a number of the studies reviewed by Hagan *et al.* which utilised technology were successful in reducing loneliness⁶⁸. One study found a positive impact when participants were encouraged to speak to family members at least once a week on Skype or MSN, whilst another found that loneliness was significantly reduced when couples played together on a Nintendo Wii console compared to those who just watched television⁶⁸. One other study in the review found that giving people either a real or robotic dog significantly reduced loneliness compared to the control group. The authors argue that, as technology changes and our ability to communicate through a variety of routes develops, researchers should be creative and innovative in coming up with new ways to utilise this to reduce isolation and loneliness.

Other findings

Service users reported positively on the interventions and felt that they had benefited, although many studies did not include participants' views in their results⁶⁴. Examples of perceived benefits of programmes were improved self-esteem, feeling mentally and physically better, and reduced medication need.

However, some service users reported that interventions were too rigid and that the programmes were too short in duration. One other specific challenge was that some participants found it difficult to travel to activities. This is a particularly relevant consideration when planning interventions in Hampshire.

The review by Dickens *et al.* found that interventions, with a theoretical basis were generally more successful than those without⁶⁷.

Carers Support

One additional review identified in the search looked at interventions to support socially isolated older carers living in rural areas⁷⁵. The authors identified six dimensions which they describe as key in designing interventions aimed at reducing social isolation of rural carers. These are:

- Ability to address individual needs (e.g. availability of carer, transport, respite care)
- Dual carer-care recipient focus (reducing carer concerns about leaving care recipient)
- Provision of an educational component (can build capacity, provide important care-related information and reduce carer's guilt about attending)
- Ability for facilitate informal interaction with other carers (allows friendships to develop more naturally)
- Employment of existing networks and experienced personnel (helps to identify vulnerable carers and ensures they have the necessary support to attend)
- Ability to be sustainable and long-term (builds support for local ownership).

The authors argue that many aspects are likely to overlap with those relating to interventions in urban settings. However, there is evidence that rural carers may be less likely to perceive themselves as isolated, perhaps due to stigma, and therefore provision of interventions in rural areas needs careful consideration. In addition there are added challenges of providing appropriate respite care in rural areas to enable carers to attend events.

Men of Working Age

Evidence for what works in this group comes from a non-peer-reviewed publication written by the Big Lottery Fund , discussed above⁶². The authors make the following recommendations to engage men.

- Specifically target men - – especially in environments that are often considered as female domains such as schools or family centres.
- Consult with the target group – avoid assumptions about what your target group wants or needs
- Go where men 'are' – e.g. pubs, sporting venues
- Have 'hooks' to appeal to motivations and interests
- Build up partnerships with gatekeepers and networks – e.g. community leaders or family members, or formal services or organisations.
- Tailor the service to provide for a range of need
- Be flexible (see example below)
- Build relationships on an individual basis – there should be continuous dialogue with beneficiaries to ensure that their needs are being met.
- Provide effective support
- Encourage beneficiaries to become advocates and volunteers

Some specific examples given in the report which link the barriers to the recommendations are that men are more likely to forgo social activities due to work than women, therefore being flexible in terms of timing is important. Additionally men are far more likely to engage with programmes that have a focus such as sport or DIY, and are generally less happy to attend something just to sit and chat.

RETURN ON INVESTMENT: COSTS AND SAVINGS

We have already looked at the potential costs of social isolation and loneliness to health and social care services. Below we look at some work which had been done to estimate the savings, or the 'return on investment', from services aimed at reducing social isolation and loneliness.

In a review by Knapp *et al*, befriending schemes, at a typical cost of £80, were found to yield a value of around £300 per person per year in terms of reduced need for treatment and improved quality of life⁷⁶. Community navigators, at a total cost of £480 (including costs of increased use of services to which users were referred), yielded benefits of around £900 in the first year due to improved employment, reduced demand on services etc⁷⁶.

Specific case studies on which a Social Return on Investment (SROI) analysis has been done are summarised in the Table below. SROI is a measurement framework that helps organisations understand the social, economic and environmental impact of interventions and programmes. It is a form of cost-benefit analysis which takes into account the full range of social and economic benefits and puts a value on less tangible benefits such as improved well-being or improved family relationships. More detailed information is given in Appendix 3.

When these interventions are reviewed in depth, many of them contain a number of features which the research (discussed above) has shown makes them more likely to be effective. One example is the Lambeth Peer Support Group. This programme provides peer support for people with dementia, and their carers, by providing a facilitated environment for people with dementia to meet and socialise and a variety of dementia-appropriate activities to engage the group members. Carers are also involved and given the opportunity to meet other carers and socialise.

Programme	Intervention	SROI for every £1 spent
Psychosocial group rehabilitation	Psychosocial group rehabilitation of older persons suffering from loneliness. Participants took part in one of the following: therapeutic writing and group psychotherapy, exercise and health-related discussions, art and inspiring activities.	£1.07
The Partnership for Older People Projects	Projects developed ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services.	£1.20
Lambeth Peer Support Group	Weekly sessions for people with dementia and their carers with a variety of group activities provided including: reminiscence and music based activities, group games, a chair-based exercise session and occasional manicure and hair dressing sessions.	£5.18
Southwark Peer Support Group	Fortnightly sessions for people with dementia and their carers with a variety of group activities and games provided including memory specific and advice activities.	£1.71
Croydon Peer Support Group	Monthly sessions for people with dementia and their carers with group activities provided, particularly using reminiscence.	£1.17
Craft Café	Offers older people a range of creative activities supported by a professional artist. At the Craft Café participants learn new art and craft skills (such as silk painting, photography, ceramics, drawing/painting, and textiles) and are given the space and encouragement to build on existing skills.	£8.27
BT Digital Inclusion Programme	Five and ten week courses for older people, job-seekers, disabled people and people living in rural areas. Aims to tackle the issues of digital exclusion, to make sure that the internet is available to everybody, and to help individuals and communities gain the benefits of being online.	£1.04
Hackney WellFamily	Recovery-focused and holistic interventions including a mix of individually targeted and flexible practical and emotional support to promote health and social wellbeing. The service provides advice and information, including in the areas of employment and housing support, counselling and welfare benefits support. It also encourages and helps facilitate activities such as physical activity, advocacy, volunteering, signposting to other services, carer support and peer support.	£5.96
Stay Well at Home Service	The Service targets people at risk of losing their independence and supports them to stay well and remain living at home. Referrals come mainly from health and social care agencies and sometimes from individuals themselves. They are followed up with a holistic assessment to establish the level of need.	£11
Community Agents	The Project was primarily designed as a signposting service but also to solve practical challenges experienced by people in the community and those being discharged from hospital. It was established to build relationships across the sectors, to provide up-to-date information and link clients to existing services and activities in order to better meet the needs of these clients.	£7.38
Gloucester Community Village Agents	Gloucestershire Village and Community Agents are trusted members of the community who provide information and support to people aged 50 and over across the county.	£1.90

WHAT ARE WE ALREADY DOING IN HAMPSHIRE?

Hampshire has a large number of services and facilities which both directly and indirectly reduce social isolation and loneliness. A fully exhaustive list of these is beyond the scope of this report and would quickly become out of date. To set the context, one of the resources used in gathering together information to populate the table overleaf was a 264-page document listing all the programmes, just in Test Valley alone⁷⁷. Clearly there a lot is already being offered. The table below lists a small selection of the projects currently in operation in Hampshire which, as part of their activities, aim to prevent social isolation and loneliness or provide support for people affected.

Encouragingly, many of these projects represent partnerships between the voluntary and public sector. Not only do these projects serve their communities and help to prevent isolation and loneliness directly through their work, but many also provide opportunities for community members to get involved in volunteering, the benefits of which are far reaching.

Projects which involve participation of local community members help to foster a sense of ownership and provide co-benefits for the volunteers such as the opportunity to meet new people and make friends, as well as providing a sense of purpose. However, whilst having a local focus to programmes is associated with good outcomes, it does mean that finding out what is available can present a real challenge. Many of the smaller voluntary organisations which provide an invaluable service for their community are reluctant to be included in official lists because their small size means they may be unable to guarantee the service indefinitely.

There are over 100 ‘Good Neighbour’ groups running in Hampshire⁷⁸.

This is why organisation such at AgeConcern Hampshire are so important. Their trained volunteers (for example AgeConcern Hampshire’s OPAL and Village Agents programmes) hold the most up-to-date knowledge of what is available in areas locally, and what surrounding support is on offer, such as transport.

AgeConcern Hampshire not only provides ‘foundation services’ but also run a number of ‘direct services’. They have 15 Wellbeing Centres across Hampshire which Hampshire County Council commission to provide day care and offer the opportunity for older people to stay connected to their local communities and expand their interests and social networks⁷⁹.

There are also several national and local organisations which offer support for vulnerable groups either locally or via telephone or internet-based services. For example Age UK, Brendoncare, Alzheimer’s Society, Calm, Women’s Institutes, University of the Third Age and Contact the Elderly.

Baby and toddler groups have not been included in the table below due to their large number. However, we recognise their importance in providing support for parents of young children and recommend that comprehensive lists of local groups with timings, cost and 'age focus' should be made available to parents on a regular basis.

What is missing in Hampshire?

What is clear is that people need to be able to find out about what is happening in their area. Navigation is key. For people who are actively looking to get involved in projects and groups, there are a number of very helpful local directories which can be accessed via the internet or at local volunteering hubs. However for many people, particularly the older age group, the internet may not be an appropriate forum. Furthermore, the 'first step' may need to be taken by someone else. People who are at risk of, or already experiencing, isolation and loneliness may not recognise this to be the case or may lack the motivation to actively seek solutions. It is vital to make this first step as easy as possible. Whether this is initiated by the individual themselves, a friend, family member or professional with whom the person comes into contact, there should be an easy way to find out what is available locally. Community Navigators have a vital role here, and they must be knowledgeable, visible and accessible throughout Hampshire.

This work has demonstrated that there are a large number of opportunities for older people, carers and people with long term conditions already available. However, there is an apparent lack of opportunities for the following groups:

- People who are lesbian, gay, bisexual or transgender
- Men of working age
- People in ethnic minority groups

There is an additional group which are hard to identify but are likely to experience difficulty in accessing services due to living in rural areas. These hard-to-reach groups may be hidden from population-level statistics but need consideration.

The focus for the first three of these groups seems to be provision of emotional and psychological support such as counselling and telephone helplines, rather than opportunities to have positive social interactions, build relationships and prevent loneliness. However, challenges exist in terms of how all of these groups can be reached and how to engage them in activities. It is likely that a different approach is needed with these groups, with projects which are 'activity focused' rather than simply aimed at introducing people who may feel they have little in common with each other.

Type of Intervention	Examples	Target Group	Location
Foundation Services	OPAL Village Agents AgeConcern Hampshire Helpline Carers HUBB Dementia Friendly Drop in Surgery Signposters Community Access Project Basingstoke NeighbourCare Carers Together in Hampshire No Limits The Junction Youth Options Romsey and District Carers Forum	Older people Older people Older people People caring for others People caring for others Everyone People with depression, anxiety, loneliness, other mental health condition Vulnerable adults People caring for others Young people under 26 Young people aged 13 – 25 Young people People caring for others	Hampshire-wide Hampshire-wide (rural) Hampshire-wide Gosport Fareham Gosport Aldershot, Farnborough & Fleet Basingstoke Hampshire-wide Hampshire-wide Test Valley Hampshire-wide Romsey
Direct Services	Saturday clubs Men in Sheds Gosport Voluntary Action Befriending Gosport Memory Café Memory Café Kitbags & Berets Carers Support Group Fareham Activity Support Group Fareham Library Memory Group Hart Health Walks Minding the Garden North Hampshire Young Carers Andover Young Carers Romsey Young Carers Sunshine and Showers 121 Youth Counselling Open Sight Greater Rushmoor Nepali Community	Older people Older men Adults People with dementia. People caring for others People with dementia. People caring for others People with dementia. People caring for others People caring for others People with dementia. People caring for others People with dementia. People caring for others Everyone People with mental health problems Young people caring for others Young people caring for others Young people caring for others People with depression and/or anxiety Young people People with sight loss People of Nepali origin	Fareham, Farnborough, Winchester Gosport, Havant, Colden Common, Romsey Gosport Gosport Lee on the Solent Gosport Gosport Fareham Fareham Hart (multiple locations) Hart Andover, Basingstoke, East Hampshire, Eastleigh, Fareham & Gosport, Hart & Rushmoor, Havant, New Forest, Romsey, Winchester Andover Romsey Odiham Yateley Hampshire-wide Rushmoor

Type of Intervention	Examples	Target Group	Location
Direct Services	Thorngate Village Care Group	People who lack social support	Tytherleys, East Dean, Lockerley
	1 Community's Carers Centre	People caring for others (>18 years)	Eastleigh Borough
	NeighbourCare Group	People who lack social support	Amport, Monxton, Grateley, Quarley
	Awbridge NeighbourCare	People who lack social support	Awbridge
	North Baddesley Friends	People who lack social support	North Baddesley, Knightwood, Chilworth
	Bridge Community Building	Everyone	Andover
	Andover VIPs	People with sight loss	Andover
	Hurstbourne Tarrant Over 60s Social Club	Older people	Hurstbourne Tarrant
	North Baddesley Over 60s Club	Older people	North Baddesley
	Wellow Happy Go Lucky Club	Older people	Wellow
	Home-Start - Andover and District	Parents of young children	Andover
	ARK Eastleigh	Families	Eastleigh
	Hedge End Retirement Club	Older people	Hedge End
	Time for Older People (TOP)	Older people	Bishopstoke
	Happy Brunch Over 60s Club	Older people	Chandler's Ford
	Bursledon Silver Club	Older people	Bursledon
	No Labels - No Limits	Parents and carers of children and young people with learning disabilities	Eastleigh
	Parent Support Group	Parents who have children with additional needs	Eastleigh
	Open Sight	People with sight loss	Netley
	Multi-Arts Group	Children with disabilities	Eastleigh
	Jubilee Singers	Everyone	New Milton
	Hordle pop in coffee morning	Older people	Hordle
	Knit and Natter	Older people	Lymington
	Brendoncare Friendship Clubs	Older people	Milford Green, New Milton, Lymington
	Bingo	Older people	Hounslow
	Carers Café	Older people	West Totton, Lyndhurst
Singing Group	People caring for others	Fenwick	
Visually Impaired Group	Older people and their carers	Romsey	
Widows Club	People with sight loss	Totton	
SOS Polonia	People who have been widowed	Eastleigh	
Asian Elders	People from Poland	Eastleigh	
Breakout Youth	People of Asian ethnicity	Basingstoke, Eastleigh, IOW	
Y Services for young people	Young people who are LGBT	Fareham and Gosport	
		Young people who are LGBT	

Type of Intervention	Examples	Target Group	Location
Gateway Services	Gosport Voluntary Action Transport Services Dial a Ride Basingstoke Community Transport Test Valley Community Transport	Older People. People with disabilities. Older People. People with disabilities. Older People. People with disabilities. Older People. People with disabilities.	Gosport Rushmoor Basingstoke Test Valley
Structural Enablers	Gosport Voluntary Action Give, Gain & Grow Volunteer Group Loud and Proud Volunteer Group Hart Voluntary Action Rushmoor Voluntary Services Basingstoke Dementia Action Group Test Valley Community Services	Everyone People with mental health issues, learning or physical disabilities 16-25 year olds Everyone Everyone Community Everyone	Gosport Gosport Gosport Hart Rushmoor Basingstoke Andover, Romsey

APPENDIX 1: DRIVERS FOR CHANGE

The profile of loneliness

The scale and health impacts of social isolation and loneliness in England are receiving increasing attention from health and social care professionals as well as central government⁶. Public health and social care policies are reflecting this, with social isolation and loneliness explicitly identified as key areas of importance.

The Care Act

The Care Act 2014 came into effect in April 2015 and sets out the legal framework for delivery of care and support services in England⁹. The Act establishes the “wellbeing principle”, making this a key focus of Local Authorities’ care and support function⁶. Loneliness and Social isolation are directly addressed in the Act which says that through their commissioning, Local Authorities should “emphasise prevention, enablement, ways of reducing loneliness and social isolation, and promotion of independence as ways of achieving and exceeding desired outcomes, as well as choice in how people’s needs are met”.

Public Health Outcomes Framework

As well as linking directly into outcomes such as mortality and healthcare usage, social isolation is specifically listed in the Public Health Outcomes Framework (outcome 1.18)¹¹. The Campaign to End Loneliness has identified three key areas of the NHS Outcomes Framework which loneliness has a direct impact on: preventing people dying prematurely, enhancing quality of life for people with long-term conditions, and helping people recover from episodes of ill health or following injury⁶.

In Hampshire

The Hampshire Older People’s Wellbeing Strategy (April 2014 – March 2018) sets reducing social isolation and loneliness as one of its key objectives¹⁰. The strategy recognises the need to work with voluntary and community sectors to “support access to, and increase the range of, social and community activities available to older people, in order to help tackle social isolation and loneliness” as well as “proactively reach out into communities to engage with older people who may be excluded, hard to reach or isolated”. The Supportive Communities programme within Hampshire County Council has identified social isolation as one of six key areas of focus.

APPENDIX 2: DATA FOR SOCIAL ISOLATION MAP

Area	% all households: one person household aged 65 and over	% People over 65 providing unpaid care	% People over 65 widowed or surviving partner from civil partnership	Older people in deprivation (IDAOPI) score	% of people 65+ resident in households with long term health problem or disability	% age 65 and over: no cars in household	% aged 65 and over
Basingstoke and Deane	9.9	12.8	26.8	Only available at small area level	43.9	22.3	15.7
East Hampshire	12.9	13.2	26.6		41.0	16.2	21.0
Eastleigh	11.9	13.7	27.7		46.5	21.8	17.8
Fareham	13.3	13.6	26.8		45.1	20.0	21.8
Gosport	12.9	12.9	29.6		48.9	29.5	18.3
Hart	10.5	12.8	24.4		39.2	14.2	18.1
Havant	14.6	13.6	27.9		47.9	24.0	22.3
New Forest	16.2	14.4	26.7		45.2	17.8	26.7
Rushmoor	9.4	11.7	28.6		46.4	27.2	13.2
Test Valley	12.0	14	25.4		43.0	18.7	20.1
Winchester	13.4	12.9	26.9		41.6	20.2	20.0
HAMPSHIRE	12.6	13.4	26.9		44.4	20.5	19.9

For social isolation, scoring was done at LSOA level with a score of either zero or one given for each of the indicators above. A social isolation index score comprising scores from all seven indicators was given to each LSOA. Whilst scores between zero and seven were possible, they actually ranged from zero to six.

Loneliness in Hampshire was mapped at LSOA level using data supplied by ONS and Age UK. In order to facilitate comparison with the map of social isolation, LSOAs were divided into seven groups according to their loneliness score, those in group six having the highest prevalence of loneliness.

APPENDIX 3: SOCIAL RETURN ON INVESTMENT OF INTERVENTIONS

*Return on investment rather than SROI (therefore true SROI figure likely to be higher).

Programme	Loc.	Target Group	Intervention	Aims	Outcomes measured for SROI	SROI per £1 spent	Quality of Evidence
Psychosocial group rehabilitation ⁷⁴	Finland	Older people suffering from loneliness.	Psychosocial group rehabilitation of older persons suffering from loneliness. Participants took part in one of the following: therapeutic writing and group psychotherapy, exercise and health-related discussions, art and inspiring activities. Each participant attended one session per week over three months (12 sessions in total). Each group consisted of seven to eight elderly participants and two professional group leaders. Meetings lasted for 5 – 6 hours having objective-oriented and a predetermined program that the participants could modify.	Improved subjective health Reduced use and costs of health services Reduced mortality.	Use of healthcare services - days in primary hospitals - days in secondary hospitals - physician visits - ambulatory visits in specialist hospitals	€1.07* (euros)	Peer reviewed. RCT study. Intervention was for 3 months. Follow-up period: 1 year.

<p>The Partnership for Older People Projects (POPP)⁸⁰</p>	<p>UK – multiple LAs</p>	<p>Older people.</p>	<p>Twenty-nine local authorities were involved as pilot sites, working with health and voluntary sector partners to develop services. Those projects developed ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services</p>	<p>Provide improved health and well-being for older people via a series of individual projects providing local services. To promote independence and prevent or delay the need for higher intensity or institutional care</p>	<p>Reduction in hospital emergency bed days.</p>	<p>£1.20*</p>	<p>Large-scale project. Report not peer-reviewed. UK-based. This finding has been questioned subsequently (Dorset POPP evaluation)</p>
<p>Lambeth Peer Support Group⁸¹</p>	<p>London</p>	<p>People with dementia and their carers</p>	<p>Weekly sessions with a group facilitator, paid staff and 10 volunteers. Average number of attendees: 23. A variety of group activities provided including: reminiscence and music based activities, group games, a chair-based exercise session and occasional manicure and hair dressing sessions. Lunch provided for free.</p>	<p>Provide peer support for people with dementia for providing a facilitated environment for people with dementia to meet and socialise and a variety of dementia-appropriate activities to engage the group members.</p>	<p>Members experience a reduction in loneliness and isolation. Members are mentally stimulated (including memory stimulation) more so than if they remained at home. The members' personhood and sense of identity is promoted which increases their wellbeing. Members feel part of a welcoming community which gives them a sense of trust, belonging and social wellbeing. Members are fitter as a result of taking part in the weekly exercise session. Carers experience a reduction in stress and burden of care. Carers have an increased sense of wellbeing through being involved with the group. Carers experience a reduce feeling of loneliness and isolation. Volunteers have an increased sense of wellbeing through feeling engaged and fulfilled in their role at the group. Volunteers have an increased level of knowledge by interacting with people with dementia and dementia care. Volunteers have more transferable skills. Volunteers feel part of a community.</p>	<p>£5.18</p>	<p>Not peer-reviewed. Highly detailed methodology given with validated values used to calculate the ROI.</p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Southwark Peer Support Group⁸¹</p> <p style="text-align: center;">London</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">People with dementia and their carers</p>	<p>Fortnightly sessions with a group facilitator and one paid staff. Average number of attendees: 5. A variety of group activities and games provided including memory specific and advice activities.</p>	<p>Provide peer support for people with dementia for providing a facilitated environment for people with dementia to meet and socialise and a variety of dementia-appropriate activities to engage the group members.</p>	<p>Members experience a reduction in loneliness and isolation. Members are mentally stimulated (including memory stimulation) more so than if they remained at home. Members wellbeing is increased from having a sense of purpose and enjoying their time at the group. Carers experience a reduction in stress and burden of care.</p>	<p>£1.71</p>	<p>Not peer reviewed. Highly detailed methodology given with validated values used to calculate the ROI.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Croydon Peer Support Group⁸¹</p> <p style="text-align: center;">London</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">People with dementia and their carers</p>	<p>Monthly sessions with a group facilitator, one paid staff and 2 volunteers. Average number of attendees: 9. Group activities provided, particularly using reminiscence. Lunch provided for paid members.</p>	<p>Provide peer support for people with dementia for providing a facilitated environment for people with dementia to meet and socialise and a variety of dementia-appropriate activities to engage the group members.</p>	<p>Members experience a reduction in loneliness and isolation. Members are mentally stimulated (including memory stimulation) more so than if they remained at home. Members wellbeing is increased from having a sense of purpose and enjoying their time at the group. Carers experience a reduction in stress and burden of care. Volunteers have an increased sense of wellbeing through feeling engaged and fulfilled in their role at the group. Volunteers have an increased level of knowledge by interacting with people with dementia and dementia care.</p>	<p>£1.17</p>	<p>Not peer reviewed. Highly detailed methodology given with validated values used to calculate the ROI.</p>

<p>Craft Café⁸²</p>	<p>Glasgow</p>	<p>Older people</p>	<p>Craft Café is open from 10am to 4pm, 3 days per week and offers a range of creative activities supported by a professional artist. At the Craft Café participants learn new art and craft skills (such as silk painting, photography, ceramics, drawing/painting, and textiles) and are given the space and encouragement to build on existing skills. Craft Café members attend for free and are encouraged to take the lead on their own learning with a constant supply of materials and access to expertise. Activities are intended to foster the intrinsic joys of creativity, artistic expression, and learning.</p>	<p>Support older people to reduce isolation and loneliness, to make positive lifestyle changes associated with ageing, and to achieve a better quality of life. Ultimately it is intended to enable older people to live independently for longer in their community. Provide a safe, social and creative environment where older people can learn new skills, renew social networks, and reconnect with their communities.</p>	<p>Through the activities participants feel stimulated and inspired, leading to a sense of self-worth and fulfilment Participants make new friends, form better and stronger relationships, and are therefore less lonely Regular attendance brings mental stimulation, a more positive outlook, and reduced levels of anxiety and depression Over time participants become more confident, more independent, more active in their community, leading to a better quality of life Participants start to take more regular and more vigorous exercise from attending Participants take greater notice of their health and reduce harmful behaviours (e.g. smoking, drinking, and poor diet) In order to attend the Craft Café, participants reduce their level of community and voluntary activity to make more time for themselves The new interests and motivation of the older person leads to more conversation and a better relationship for family members The companionship and interests provided through the Craft Café means that family members worry less about their loved one The group support offered by the Craft Café means that the older person requires less attention by the family The creative output of the older person leads to increased appreciation and interest in art among family members The publicity gained from the programme and association with Impact Arts leads to improved Housing Association profile and reputation A more settled, satisfied, and involved group of older tenants enables the Housing Association to provide a more efficient service The catalyst of the Craft Café leads to a more vibrant programme of activities for older people and greater demand for tenancies The stimulation, interaction and wellbeing derived by older people enables them to sustain an unassisted tenancy for longer The therapeutic value of attendance of the Craft Café brings about a reduction in the symptoms of anxiety and depression The companionship and positive outlook brought about means that participants reduce or stop smoking completely The improved physical and mental health of Craft Café participants leads to a reduced frequency of GP attendance</p>	<p>£8.27</p>	<p>Not peer reviewed. Very thorough report with detailed explanation of what data was used to evaluate the SROI and how this data was collected.</p>
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BT Digital Inclusion Programme (Get IT Together) ⁸³	UK	Older people, job-seekers, disabled people and people living in rural areas	<p>The Get IT Together projects operate in 15 locations around the UK. They run five and ten week courses for older people, job-seekers, disabled people and people living in rural areas. They cover all four countries and are particularly focussed in the most disadvantaged regions in England. These projects are primarily delivered by Citizens Online.</p>	<p>Tackle the issues of digital exclusion, to make sure that the internet is available to everybody, and to help individuals and communities gain the benefits of being online.</p>	<p>Older people:</p> <ul style="list-style-type: none"> • Confidence • Reduced social isolation • Independence • Meaningful use of time • Cost savings <p>The State:</p> <ul style="list-style-type: none"> • Savings from digitisation • Health • Employment <p>Job-seekers:</p> <ul style="list-style-type: none"> • Employment (short-term) • Employment (long-term) • Employment (under-employed) • Confidence • Economic savings • Convenience <p>Volunteers:</p> <ul style="list-style-type: none"> • Employment (short-term) • Employment (long-term) <p>Paid tutor:</p> <ul style="list-style-type: none"> • Extra hours 	<p>£1.04 in first year</p> <p>£3.7 projected in year 2</p>	<p>Not peer reviewed. In-depth report by Just Economics commissioned by BT.</p>
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Hackney WellFamily ⁶⁴	Hackney, London	Families	<p>The Hackney WellFamily Service is a primary care service aimed at addressing complex psychosocial needs. The service provides recovery-focused and holistic interventions including a mix of individually targeted and flexible practical and emotional support to promote health and social wellbeing.</p> <p>The service provides advice and information, including in the areas of employment and housing support, counselling and welfare benefits support. It also encourages and helps facilitate activities such as physical activity, advocacy, volunteering, signposting to other services, carer support and peer support.</p>	<p>The aim is to improve clients' wellbeing in terms of anxiety and depressive symptoms and improved social adjustment and recovery in terms of mental health, financial status, self-care and physical health, social networks, work, education and training, relationships, independent living and addictive behaviour.</p>	<p>Reduction in:</p> <ul style="list-style-type: none"> • GP consultation • CMHT consultation • Consultant Psychiatrist • A&E attendance • Social Worker assessment • Referral to IAPT high intensity service 	<p>£5.96</p>	<p>Independent review however, unable to access original report by Bristol University (with details of SROI methodology). Therefore detail lacking.</p>
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Stay Well at Home Service ⁸⁵	Kingston upon Thames	Older people	<p>The Service targets people at risk of losing their independence and supports them to stay well and remain living at home. Referrals come mainly from health and social care agencies and sometimes from individuals themselves. They are followed up with a holistic assessment to establish the level of need. A dedicated team of part-time employees and trained volunteers provides the service.</p>	<p>To reduce Accident & Emergency attendance and unplanned hospital and residential admissions and improve the quality of life and safety of older people living in their own homes.</p>	<p>Older People:</p> <ul style="list-style-type: none"> • Increased independence • Reduced worry and isolation • More use of appropriate help • Being able to stay at home for longer • Improved QoL and greater sense of wellbeing <p>Public Sector:</p> <ul style="list-style-type: none"> • Creating capacity in intermediate care services • Prompter discharge and admission avoidance 	<p>£11</p>	<p>Not peer reviewed independent evaluative, but unclear who did the report. Full report awaited.</p>
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Community Agents ⁸⁶	Tees Valley	Older people	<p>The Community Agents Project is an innovative approach to meeting the social needs of the elderly and vulnerable population in the area. The Project was primarily designed as a signposting service but also to solve practical challenges experienced by people in the community and those being discharged from hospital. It was established to build relationships across the sectors, to provide up-to-date information and link clients to existing services and activities in order to better meet the needs of these clients.</p> <p>Initially, one community agent was placed in each of the three areas. The idea behind this was for each of them to establish networks with relevant services and agencies within each of the localities. Due to staff changes in July 2014, the two remaining Community Agents began to cover all three areas. The Community Agents are now recognised as a first point of contact for any person presenting with low level social needs across the area. Such interventions include shopping, cleaning, gardening, form filling, accessing social activities.</p> <p>Community Agents assess the needs of clients referred into the service, discuss options and then refer to relevant activities or services. Community Agents also offer some practical support themselves although this tends to be one-off, or emergency support rather than ongoing.</p>	<ul style="list-style-type: none"> • Help older and vulnerable people live independently and safely in their own homes • Help older and vulnerable people return home from hospital as quickly as possible • Reduce admissions to hospitals and residential care homes • Reduce social isolation and loneliness • Improve the financial status of older and vulnerable people by supporting appropriate access to benefits • Engineer a more appropriate use of health and social care services • Encourage cost savings in health and social care • Increase community capacity. 	<p>Community Health Professionals:</p> <ul style="list-style-type: none"> • Reduction in anxiety and depression • Patients are more actively engaging with health professionals and medication requirements • Reduction in DNAs at GP and hospital appointments • Reduction in frequent flier bed days • Community health professionals time saved sourcing relevant low level interventions. <p>Redcar & Cleveland Council:</p> <ul style="list-style-type: none"> • People are staying in their own homes for longer • Delaying need for increased care packages • Improved access to wider local authority services • ASC time saved sourcing relevant low level interventions. <p>Voluntary Sector:</p> <ul style="list-style-type: none"> • New project established to increase capacity within local communities • An increase in the numbers of volunteers. <p>Elderly and Vulnerable Adults:</p> <ul style="list-style-type: none"> • Improved health and wellbeing • Improved financial status • Less isolated – improved social networks • Increased self-confidence • Retaining independence – able to stay in own home for longer. 	<p>£7.38</p>	<p>Not peer reviewed. Very thorough report undertaken by Teeside University.</p>
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<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Gloucester Community Village Agents⁸⁷</p> <p style="text-align: center;">Gloucester</p> <p style="text-align: center;">Older People</p>	<p>Gloucestershire Village and Community Agents are trusted members of the community who provide information and support to people aged 50 and over across the county. There are 38 Village & Community Agent areas or communities covering the whole of Gloucestershire. Each Village Agent has a geographic area in which they work. The majority of Agents live within their areas. Five Community Agents work with the Black and Minority Ethnic (BME) communities across the county. Two Polish-speaking Agents work with the largely Eastern European Migrant Community; one Agent each works with the African Caribbean, Bengali, and Gujarati Communities. Four Agents work specifically in Cheltenham and Gloucester, with two in each locality. They are supported by the Village Agents working on the borders of the urban centres, and the Community Agents working with the BME communities.</p>	<ul style="list-style-type: none"> • To help older people in Gloucestershire to feel more independent, secure, cared for, and have a better quality of life. • To promote local services and groups, enabling the Agent to provide a client with a community-based solution where appropriate. • To give older people easy access to a wide range of information that will enable them to make informed choices about their present and future needs. • To engage older people to enable them to influence future service planning and provision. • To provide support to people aged 18 and over who are affected by cancer. 	<p>Falls Prevention:</p> <ul style="list-style-type: none"> • Grab rails • Mobility aids • Small repairs • Wet rooms • Stair lifts <p>Retaining Independence:</p> <ul style="list-style-type: none"> • Gloucester telecare • Community alarms • OT assessments • Social care assessments • Carer's needs assessments • Re-enablement • Support in the homes • Home safety checks <p>Loneliness and Social Isolation:</p> <ul style="list-style-type: none"> • Befriending services • Social groups and activities • Transport • Volunteering <p>Fuel Poverty Specialist Cancer Agents</p>	<p>£1.90</p>	<p>Not peer reviewed. Not an independent analysis. Thorough report with cost savings to both public services and financial savings for clients (not included here). Detailed report of analysis.</p>
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