Public Health England

UCL Institute of Health Equity

Local action on health inequalities

Reducing social isolation across the lifecourse

Practice resource summary: September 2015

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

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Key messages

1. The quality and quantity of social relationships affect health behaviours, physical and mental health, and risk of mortality.

2. Anyone can experience social isolation and loneliness. While social isolation is more commonly considered in later life, it can occur at all stages of the life course. Particular individuals or groups may be more vulnerable than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.

3. There are links between health and social inequality and social isolation; many factors associated with social isolation are unequally distributed in society.

4. Factors that influence social isolation and loneliness operate at the individual level, the level of the community or local area and at the wider societal level. Individual and community level factors that impact on social isolation are nested in the wider social, economic, political and cultural context.

5. A range of services provided by the public sector, private sector, third sector and community and voluntary services may have the potential to impact on social isolation, even if this is not their primary aim. For example, aspects of the built and natural environment and transport infrastructure can help or hinder efforts to enhance social connections.

6. Learning from specific interventions already in place in local areas can be used to inform work in other local areas to reduce social isolation. Although the context of social isolation across local areas may differ, a recurrent theme is the importance of involving communities in the design of interventions and the way they are managed and implemented.

7. Many community based interventions intended to reduce social isolation will not be identified as such within the community they serve. Instead, they will be focused on activities that can be shared; bringing people together naturally in a way that is appropriate to their particular needs.

8. Successful interventions to tackle social isolation reduce the burden on health and social care services. As such they are typically cost-effective.

Introduction

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

Reducing social isolation is a priority for social care and public health, as reflected in shared indicators across both the Public Health Outcomes Framework[1] and the Adult Social Care Outcomes Framework.[2] The current measures draw on self-reported levels of social isolation (using social contact as a proxy) for both users of social care and carers. These indicators assist local authorities in focusing on some of the more vulnerable people in their community.

This practice resource emphasises that social isolation and the relationship with health and inequalities in health is complex and multi-factorial. Consequently, no single sector can tackle social isolation comprehensively if acting alone: efforts to reduce social isolation require working across organisations and government departments. This provides opportunities for health and wellbeing boards to encourage partnership work between community and voluntary services, the NHS and local authorities to engage in strategies to reduce social isolation and loneliness in the community.

Learning from local areas and organisations already addressing social isolation shows that much can be done to tackle social isolation using existing community assets. This is particularly relevant in view of local spending constraints coupled with increasing demands for health and social care. Readers of this practice resource may also wish to view documents which report on phase 1 of the project ‘Working with communities: empowerment evidence and learning’ initiated jointly by PHE and NHS England to draw together and disseminate research and learning on community-centred approaches for health and wellbeing.[3]

This practice resource provides information and guidance to support bodies in local areas, including local authorities, NHS clinical commissioning groups and their stakeholders to develop effective strategies to prevent and reduce social isolation. In particular the paper focuses on reducing social isolation across the life course. In doing so, the report supports efforts to reduce health inequalities, as part of a broad strategic approach through action on the social determinants of health.[4]

This practice resource is presented in three sections:

1. A summary of the evidence on the link between social isolation, poor health outcomes and health inequalities.

2. Identification of who is at risk of social isolation, at what stage of life, and what impact this has on health inequalities.

3. An outline of interventions to reduce social isolation in the groups identified.

Research was carried out through a combination of desk-based research, including peer-reviewed and ‘grey’ literature, and consultation with experts, including academic researchers and practitioners. The approach was not to carry out a systematic review of the evidence, but rather to provide a broad review of known, new and recommended sources, enabling the authors to draw on the evidence base in highlighting promising areas for local action. Relevant references in the bibliographies of papers and reports were followed up.

Evidence used in this report includes evidence from research studies, systematic reviews, evaluations of interventions and evidence from individuals and organisations with relevant expertise. The authors gathered evidence and insights from stakeholders and experts during the public consultation exercise.

Social isolation, poor health outcomes and health inequalities

The quality and quantity of social relationships affect physical and mental health and risk of mortality.[5] Social isolation describes the state of being deprived of social relationships that provide positive feedback and are meaningful to the individual. Both quantity and quality of social connections are therefore relevant to a discussion on social isolation. In the literature, social isolation is often discussed at the same time as loneliness, in recognition that the two conditions may or may not coexist at the level of the individual. The definitions used in this practice resource document are outlined below:

Social isolation

The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).[6]

Loneliness

An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.[6]

Key questions that arise are whether social isolation and loneliness have independent effects on health or whether social isolation impacts on health via loneliness.[7] Equally important for this report are questions about what kind of interventions are effective at reducing social isolation, and whether these also contribute to improvements in health and wellbeing, or indeed whether they ameliorate loneliness when this is associated with social isolation. More research is necessary to tease out these complex relationships, and in particular to evaluate the effects of interventions. Nevertheless, both social isolation and loneliness are recognised in the UK as issues that should be addressed in the context of improving health and wellbeing. This paper draws on literature that may refer to either or both of the concepts – social isolation and loneliness.

In general, definitions of social isolation are based on the connections and relationships between people, while loneliness is viewed as a distressing subjective experience or feeling and described in the social psychology literature as a cognitive discrepancy between the actual social relations an individual has and their desired social relations.[8]

Social relationships affect physiological and psychological functioning[9 10] and health behaviours, as well as risk of morbidity[5] and mortality.[11] A recent meta-analysis of nine longitudinal studies found that social isolation and loneliness are associated with 50% excess risk of coronary heart disease, which is broadly similar to the excess risk associated with work-related stress.[12]

The cost of social isolation to local government and the NHS is difficult to determine. However, as this report will illustrate, when effective interventions are in place, the return on the investment can be substantial. One of the intervention examples cited in this report, the Family Action Well Family Service, reduced the number of GP consultations, demonstrating a social return on investment of £5.96 for every £1 invested.[13]

Health inequalities

Analysis of the broader concept of social exclusion sheds light on how people can become disconnected from social groups as a result of a range of factors. These include economic factors such as a lack of sufficient income to afford the expenses involved in participating in social networks, and social and cultural factors such as perceived and actual discrimination based on, for example, ethnicity, race, nationality, health status, sexual preferences and age.

Exclusionary processes and the link between social exclusion and health inequalities have been examined in depth for the WHO Commission on Social Determinants of Health[14 14 15] and subsequently by the Marmot Review's Task Force on Social Inclusion and Social Mobility[16] and for the WHO European Review.[17] This analysis positions exclusionary processes as fundamental drivers of health inequalities.

Social exclusion

A complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.[18]

Exclusionary processes

Dynamic multi-dimensional processes embedded in unequal power relationships, interacting across cultural, economic, political and social dimensions and operating at the level of individuals, communities, nation states and global regions.[14 19]

This understanding of social exclusion makes the link between social isolation and health inequalities. Where social isolation results from exclusionary processes it sits within the framework of the causes of health inequalities. These causes are detailed by the WHO Commission on Social Determinants of Health,[20] and further developed in the WHO European Review of Social Determinants and the Health Divide.[17] While social isolation occurs at the level of the individual, interventions to reduce social isolation must act on the structural determinants, including economic disadvantage and discrimination, as well as supporting the immediate needs of socially isolated and/or lonely individuals.

Social isolation is a health inequality issue because many of the associated risk factors are more prevalent among socially disadvantaged groups. Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health,[4] teenage pregnancy,[21] unemployment, and illness in later life.[4] In addition, deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement. Access to transport is also vitally important in building and maintaining social connections.[22-24] These issues are discussed further in the next section.

Anyone can experience social isolation and loneliness. However, the degree of risk depends on a number of factors and thus causes some individuals or groups to be more vulnerable than others. These influencing and often inter-relating factors include physical and mental health, age or life-stage, migrant status, socioeconomic status, ethnicity and gender. These factors, often in various combinations, shape an individual's experience in relation to the nature of the social networks in which they live and the individual's ability to build and sustain adequate social networks.

Factors that influence social isolation operate at the individual level, the level of the community or local area, and at the wider societal level. Figure 1 illustrates how individual factors, including personality, confidence and resilience, which influence relationships, are nested in community factors which may support or inhibit the quantity and quality of social networks. Community factors are in turn shaped by societal factors including the political climate, demographic and family change, the national economic context, and welfare, transport and housing policies.

Resilience

The notion of resilience refers to the process of withstanding the negative effects of risk exposure, demonstrating positive adjustment in the face of adversity or trauma, and beating the odds associated with risks.[25]

Figure 1: Social isolation − a contextual overview

Source: Dave Clarke and Liz McDougall, Bristol City Council.[26] Figure reprinted with permission.

Life course approach

The life course perspective considers the impact on health and health inequalities of conditions experienced throughout life, from before birth to the developmental years in early life and adolescence through adulthood to older ages and end of life. This document examines the experience of social isolation and factors associated with social isolation at different stages of the life course, as well as factors such as transport and the built environment that affect people all stages of the life course.

While the life course perspective can give insights into accumulated risks across life, it is also the case that experiences and living conditions at any stage of life can create or exacerbate social isolation. These may include physical and mental health conditions, caring responsibilities and loss of important close relationships which may happen for a number of reasons. For example, the effects of relocating to a new area or migrating from overseas may reduce the strength of social and familial networks and support.

Social relationships and in particular adequate social networks (in terms of quantity and quality) can promote health through four possible pathways:

- providing individuals with a sense of belonging and identity
- providing material support or increasing knowledge about how to access material needs and services
- influencing the behaviour of individuals, for example through support or influence from family or friends to quit smoking, reduce alcohol intake, or to access health care when needed
- providing social support that enables individuals to cope with stressors such as pressures at school or work, redundancy, retirement or the death of a close relative[27 28]

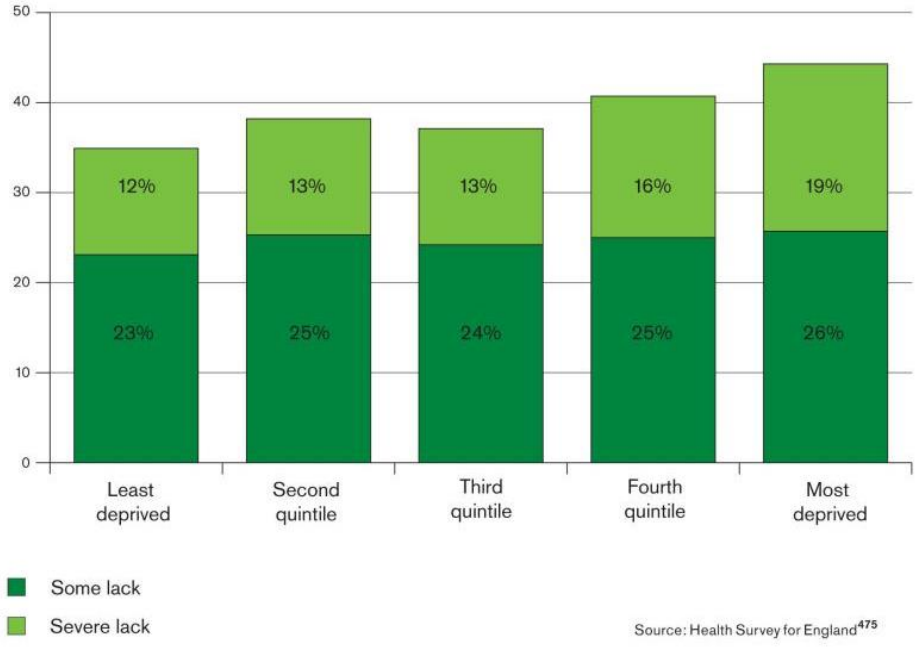
There are circumstances in which social networks have negative aspects that do not promote health, for example gang membership.[29] Research on networks and health behaviours shows that social networks influence the person to person spread of obesity.[30] More positively, they also impact the spread of smoking cessation.[31] More research is needed to evaluate the contribution of positive and negative aspects of social networks to health inequalities.

Stress is central to the mechanisms whereby social isolation can contribute to poor health.[32 33] Physical or psychosocial stressors (such as social isolation) activate adaptive biological systems in the body (the nervous system, cardiovascular, metabolic and immune systems). While there are personality characteristics, behavioural responses (such as smoking) and psychosocial factors (including social support) that can modulate the perception of stress, prolonged exposure to stress is damaging to biological systems in the body.[33] Effects of stress on health can be

direct via physiological mechanisms and indirect via health-damaging behaviour such as smoking.[33]

Social support is a key aspect of social networks for health and wellbeing. Figure 2 illustrates that those living in more deprived areas are more likely to lack adequate social support than those living in more affluent areas. However around one third of those in the least deprived areas also lacked adequate social support. Social support means knowing that there are people who care for you and are willing and able to help you. As outlined in Figure 1, factors associated with social isolation are numerous and complex, operating at the individual, community and societal levels. Living in a more deprived area may impact social support in a number of ways. For example, having a low income may reduce the ability to participate in social networks and as a result contribute to lack of social support.[17]

Figure 2: Percentage of people lacking social support by deprivation of residential area, 2005



Source: Marmot Review[4]

The life course approach is useful in thinking about social isolation as a determinant of health because experiences of social isolation, at any particular stage of the life course, are rooted in both present and past living conditions and experiences. Aspects of the built and natural environment also impact on social isolation and may do so at all stages of the life course, as detailed below.

The built and natural environment

The built environment can have a significant impact on whether or not a person becomes socially isolated. The built environment influences physical access to family

and friends, health services, community centres, shops and all the other places and spaces that enable individuals to build and maintain their social relationships. Poor transport links can create barriers to social inclusion, whereas effective transport links can benefit social cohesion.[22 23] Safe public spaces, with pavements to walk on and lighting, are also part of the physical infrastructure that helps people to maintain social connections. These factors cut across the whole of the life course as part of sustainable communities and places in which people are born, grow, live, work and age.[4]

Transport can help people to stay connected; and accessible and affordable transport links are part of the solution to tackling social isolation.[4 34 24] A 2004 report by the Social Exclusion Unit found transport to have a major impact on exclusion. The report found that two in five job seekers say lack of transport is a barrier to getting a job.[35] Nearly half of 16- to 18-year-old students experienced difficulty with the cost of transportation.[35] Over 1.4 million people say they have missed, turned down, or chosen not to seek medical help over the last 12 months because of transport problems.[35] Older people are particularly affected by transport links; a report by the International Longevity Centre found that 12% of older people would like to visit their family more often and of these 76% cite transport or mobility as an issue.[36]

Designing the built environment to make the streets conducive to walking is also likely to encourage social connectivity.[37 24] Public participation in designing public spaces that meet community needs is important in building a sense of ownership and belonging.[4 38-40] Availability of safe public parks, squares and green spaces also facilitates social contacts and strengthens social ties.

Risk of social isolation across the life course and impact on health inequalities

Influences on social isolation accumulate throughout life.[41] For example, childhood social withdrawal serves as a risk factor for impairment of adolescent interpersonal interactions, which increases the risk of developing depressive symptoms and diagnoses of depression in young adulthood. Depression in turn increases risk of social isolation.[42]

Prolonged social isolation across developmental periods from childhood to young adulthood has a cumulative effect, worsening health outcomes.[41] Social isolation in childhood is associated with isolation in adolescence and adulthood, and social isolation in adulthood is in turn associated with cardiovascular risk factors (such as overweight and elevated blood pressure) at the age of 26.[41] High and increasing levels of social engagement over the life course have the positive effects of lower levels of physical and cognitive limitations at older ages.[43]

Following the life course approach, this practice resource looks at the following life stages: prenatal (factors that affect a mother and baby during pregnancy), pre-school (early childhood), school and training (children and young people), employment (working-age adults), and retirement and later life.

Social isolation can be measured according to assessments of aspects of social networks and diversity, frequency of social contacts, participation in social activities and social engagement. In contrast, loneliness is assessed by questions about experience of feelings, for example: “How often do you feel you lack companionship?”[44]

Table 1: Frequency of loneliness in people aged 25 and above in the UK

Age	How much of the time in the last week did you feel lonely (%)			
	All or almost all of the time	Most of the time	Some of the time	None or almost none of the time
Under 25	2.3	5.7	28.8	63.3
25–34	0.9	3.8	26.6	68.8
35–44	2.3	4.3	22.1	71.4
45–54	2.8	2.5	21.7	73.0
55–64	3.1	6.4	21.1	69.5
65–74	5.3	3.6	19.7	71.4
75+	5.7	6.5	28.3	57.5

UK sample (2,386 respondents aged 15+)

Source: Victor, Data: 2006/07 European Social Survey, UK sample (2,386 respondents aged 15+).[45]

UK based surveys show that people can feel lonely at any stage of life (Table 1), but that the experience is most severe among older people.

By looking at social isolation from the life course perspective, it is possible to study how social isolation during one life stage affects another, and to identify opportunities to intervene to reduce social isolation at stages across the life course.

The causes of social isolation are complex and multifactorial.[46] While social isolation at older ages may have roots in earlier life, current circumstances also play a role. Events including the loss of a loved one, health conditions that precipitate disability and caring responsibilities may contribute to a reduction in social contact. The extent to which these events contribute to social isolation or loneliness depends on individual factors, such as the extent of an individual's previous social connections and the quality of support they provided, as well as community based factors in the built and social environment that may mitigate or worsen the effects of these events.

Pregnancy and early years

Pregnancy can present an opportunity to create new social networks which provide a supportive social environment. However, this is not always the case. A survey conducted on behalf of the charity Family Action found that one in five mothers lack support networks to help them through pregnancy and are unaware of the services available to help with depression.[47] Among mothers in low income households the proportion is greater, at one in three.[47]

There is a well-established link between social disadvantage and poor self-rated health among mothers with newborn infants. There is also an independent link between social isolation and poor self-rated health among new mothers.[48 49]

A mother who is economically deprived, has inadequate social networks or is depressed is also disadvantaged in the degree to which they can provide a good start in life for their child. Depression and help-seeking for depression are also patterned by ethnic group.[50-52] Women from some ethnic minority groups and from deprived areas are more at risk of antenatal depression, which is a risk factor for postnatal depression.[51] For example, perinatal depression among Pakistani women in the UK is associated with social isolation, poor social support, difficulties with housing and income, and marital problems.[53]

A body of evidence shows that maternal depression impairs early child development.[54] Social isolation may therefore contribute to the transmission of disadvantage across generations and to the causes of health inequalities over the life course.

Secure attachment during the earliest years of life underpins the child's development in the interdependent dimensions of social, emotional, cognitive and physical

development. Social and emotional problems emerge even before school age and can be identified as behavioural problems that may create difficulties in developing good friendship groups during the formative years of childhood.

Evidence from longitudinal studies shows that social environments conducive to healthy social and emotional development in early childhood are graded by socioeconomic position. For example, being read to, regular bed times and maternal postnatal depression are all graded by the socioeconomic status of the mother.[4] Other evidence shows a socioeconomic gradient in social and emotional problems among children as young as three years.[55] Development in early childhood has a significant impact on factors such as educational attainment and employment which in turn impact on health.

Children and young people

The risk factors for social isolation among children and young people can be from life events or socially ascribed identities, such as those related to gender, ethnicity, sexuality or physical appearance, the experience of which are shaped by social and cultural attitudes and beliefs. Children who do not conform to local norms of appearance, language or behaviour may face difficulties integrating into peer groups at school, potentially leading to social isolation, which may be associated with an increased risk of being bullied by peers.[56] Children who are socially isolated in school may have low perceived social efficacy (a lack of belief in their ability to control events in their life)[57] and experience anxiety and social withdrawal.[58] Behavioural problems at school can lead to a child missing out on a crucial opportunity to develop social skills which may limit the potential for creating the supportive social networks across the life course that contribute to good health.[59] Children who experience social isolation in childhood tend to have lower educational outcomes and lower adult social class (based on occupation), and higher likelihoods of smoking, obesity and psychological distress in adulthood.[60]

Formative experiences of children and young people

Early years development can be affected by adverse childhood experiences including abuse or neglect, possibly from living in households where there is domestic violence, drug and alcohol misuse, mental ill health, criminality or separation. Social isolation is in itself an adverse childhood experience.[61] Findings suggest that childhood social isolation may have enduring effects on the clustering of metabolic risk markers such as overweight and elevated blood pressure in adult life.[60 61] Witnessing domestic abuse can also damage a child's development.[62] Other adverse childhood experiences such as sexual abuse are also associated with social isolation later in life.[63] A study using the British 1958 birth cohort examined the influence of childhood adversity on social relations and mental health at age 45. In

this study, measures of childhood adversity included neglected appearance, maternal absence, paternal absence, being in care, parental divorce, and physical and sexual abuse by a parent. The study found that childhood adversity was related to negative aspects of close relationships and network size and to poorer mental health at age 45.[64]

Young people who care for others have an increased risk of social isolation. When young people are required to take on too many caring responsibilities or carry out caring roles that are not appropriate, their health, wellbeing, safety and development can be adversely affected.[65] There are a substantial number of young carers: the 2011 Census reports nearly 178,000 carers aged 5–17 in England and Wales.[66] Of these, 54% were girls and 46% were boys.[66] Surveys of young carers have found substantial numbers reporting stress, anxiety, low self-esteem and depression.[65]

Girls most at risk of teenage pregnancy include those who dislike school and those who come from a socially disadvantaged background (both of which are associated with an increased risk of social isolation).[21] Teenage pregnancy in turn can bring stigma and material deprivation;[67] both of these may increase the risk of social isolation for parents and children. Children of teenage mothers with inadequate social networks and living in deprived circumstances face considerable disadvantages from the very start of life, contributing to the intergenerational cycle of disadvantage.

Socially ascribed identities of children and young people

Risks for social isolation among children and young people are also related to social and cultural norms, beliefs and attitudes.

A number of studies show that obesity in childhood and adolescence can result in low self-confidence and can limit the ability to make friends.[68] [69] Analysis of the UK's Millennium Birth Cohort Study (MCS) found that obese children as young as three years for boys, and five years for girls have significantly greater peer relationship problems than healthy weight children of the same age.[69]

In addition, there is evidence that obese children and adolescents are more at risk of being bullied than those of average weight. Findings from the Avon Longitudinal Study of Parents and Children in England show that obese seven-year-old boys are more likely than seven-year-old boys of average weight to be both victims and perpetrators of bullying a year later, and obese seven-year-old girls are more likely to be bullied a year later.[69]

The association between overweight or obesity and bullying is not always consistent between cultures because attitudes to weight differ between cultures and are often gender specific.[68] However the central issue is having a body shape that lies outside

the local cultural norm, which can engender negative attitudes and behaviours such as teasing, bullying and rejection by peers.

Young people are also at greater risk of becoming socially isolated because of sexual identity. A report by the charity Stonewall found substantial evidence of isolation of young homosexual and bisexual people in schools. Two thirds of homosexual and bisexual secondary school children were found to have experienced homophobic bullying.[70] Another Stonewall report found that in secondary schools, homophobic bullying is the second most common type of bullying after bullying because of weight, and is three times as common as racist bullying.[71]

Lesbian, gay, bisexual and transgender (LGBT) people bear a disproportionate burden of mental health problems, including mental disorder, suicidal ideation, substance abuse and deliberate self-harm, compared with heterosexual people.[72] Studies show that peer victimisation based on actual or perceived LGB orientation is associated with poorer mental health, increased substance use, lower sense of school belonging[73] and lower life satisfaction.[74] Transgender people are at particular risk. For example, the 2012 Trans Mental Health Study found that 35% of transgender people had attempted suicide at least once in their lives, 88% had suffered from depression and 53% had self-harmed.[75] These findings were consistent across all age groups, though risk was higher among younger transgender people.[75]

Ethnicity can also be associated with increased risk of social isolation among children and young people. For example, ethnic minority children who start life from an economically disadvantaged position and linguistic barriers are at increased risk of social isolation.[76] [77] A report by the children's charity Barnardo's found that ethnic minority children are subject to racially motivated bullying and harassment at school.[77]

In the UK in 2011–12, around one in eight children (12%) aged 10–15 years reported being frequently bullied physically and/or in other ways.[78] The effects of bullying disrupt many aspects of life and can be long-lasting. Being bullied is particularly harmful at younger ages because it can affect the individual at a time when their social, emotional and cognitive skills are developing, with long-term consequences for health and wellbeing over the life course.

Findings from studies on participants in the 1958 British Birth Cohort followed up at various ages between childhood and middle age show a range of long-term adverse physical, psychological, emotional, cognitive and social consequences of being bullied as a child.[79] Being frequently or occasionally bullied at ages seven and 11 was associated with higher levels of psychological distress at age 23 and 50. Individuals who were frequently bullied as children had an increased risk of

depression, anxiety disorders, and suicidality at age 45. Being bullied in childhood was also associated with poor self-rated health at ages 23 and 50, and with poor cognitive functioning at 50. Adverse social consequences of childhood bullying recorded at age 50 included lower educational attainment, poorer social relationships, including being less likely to live with a partner or spouse, and being less likely to have access to social support when ill.[79]

Long-term conditions and disability

Evidence shows that children living with a disability or a long-term health condition are at increased risk of being bullied at school.[80]

Evidence based on two longitudinal studies in the UK – the Millennium Birth Cohort Study (MCS) and the Longitudinal Study of Young People in England (LSYPE) – found an increased likelihood of being bullied among children with special educational needs (SEN) and among children with a longstanding limited illness (LSLI) compared with their peers without.[81] In the MCS, among children aged seven, 17% of children with SEN (covering conditions or impairments which may inhibit learning such as hearing loss, behavioural difficulties such as ADHD, learning related conditions such as dyslexia, and learning disabilities) and 20% of children with SEN and a Statement of Needs, reported being bullied all the time, compared with 7% of children without SEN. Similarly, 14% of seven-year-olds with LSLI (covering conditions including type 1 diabetes, asthma, mental health problems, and impairments such as a missing limb or partial sight) reported being bullied all of the time, compared with 8% without LSLI.

In the LSYPE, 27% of adolescents aged 15–16 with SEN and 34% with SEN and a Statement of Needs reported relational bullying (meaning behaviours such as exclusion and spreading rumours) compared with 19% without SEN. Meanwhile 32% of adolescents with LSLI reported relational bullying compared with 20% without LSLI.[82]

The high prevalence of being bullied reported by children and adolescents with SEN and LSLI is concerning in view of the long-term adverse consequences of bullying across many aspects of life.

Further education and employment

Attending college or university is a major life experience for many young people. The estimated proportion of young people enrolled in higher education for the 2012-13 academic year was 43%.[83] Many students will be living away from home for the first time and as well as acclimatising to their new surroundings and routines, they can often feel isolated.[84] While most students make new friends, others may face difficulties. Beyond the challenges of a new environment, there are also concerns

that students from low socioeconomic status groups and ethnic minority groups are also disadvantaged by institutional cultures, putting them at risk of isolation.[85] Institutional cultures have been traditionally dominated by white middle class males, which can put others at a disadvantage.[85] Similarly, LGBT students experience barriers to social inclusion due to homophobic attitudes.[86] A 2009 survey found that two thirds of LGBT students did not disclose their sexual orientation to their tutors or lecturers out of fear of discrimination.[86]

The transition from education or training to employment is a formative life experience but is one that can be jeopardised by social isolation during adolescence. Wide social networks can provide employment opportunities.[87] Social skills, including the ability to make friends and build social networks, are an asset to individuals and their employers.

Conversely, being a young person not in education, employment or training (known as NEET) has a detrimental effect on the prospect of leading a happy and productive life. More than one in 10 (13%) young people report feeling too anxious to leave the house and this increases to 35% among NEETs. More than a third (36%) often feel anxious about everyday situations, rising to 52% for NEETs. A fifth claim they "fall apart" emotionally on a regular basis. This increases to a third for NEETs.[88]

Being NEET also means missing out on opportunities to develop skills and experience leading to disadvantage in the labour market. In turn this contributes to income deprivation and may adversely affect relationships, increasing the likelihood of social isolation. All of these disadvantages accumulate to increase the risk of experiencing poor health across the life course.[4]

Working-age adults

Adults of working age – 16–64, as defined by the Office for National Statistics – receive less attention than other groups when it comes to studies of social isolation. Table 1 illustrated that adults aged 25-64 are less likely to report being lonely than people over 65. However, as with other age groups, experiences and life transitions occur that can lead to social isolation.

An illustrative example comes from a report on social networks produced by the Royal Society for the Encouragement of Arts, Manufactures and Commerce (RSA). A survey of people aged 18 and over in New Cross, South East London assessed how various aspects of an individual's social networks supported and empowered them.[89] The survey found that having fewer local connections disproportionately affected men, who accounted for 63% of the isolated group. Another significant finding was that 50% of unemployed people were socially isolated, though it was uncertain whether this was due to income deprivation or loss of contacts due to unemployment, or both.[89]

Key aspects of social networks highlighted by the RSA survey relate to the power to influence one's own individual circumstances (for example with respect to employment or housing). A major benefit of social networks is the empowerment of individuals; conversely, disconnection from networks of influence signals disempowerment.

From the perspective of social determinants of health, empowerment is viewed as key to creating health. The WHO Commission on Social Determinants of Health described empowerment in three overlapping dimensions: material empowerment – having the material resources for a healthy life; psychosocial empowerment – having control over one's life, and political empowerment – having a say in decisions that affect one's life.[20] Having adequate social networks can contribute to empowerment in all three of these dimensions, while having inadequate social networks can be disempowering.

A survey conducted 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. The report also noted that the men most likely to be affected were predominantly from disadvantaged backgrounds.[90]

A study of participants in the 1958 British birth cohort at ages 42, 45 and 50 found that for both men and woman, having fewer than five friends at age 45 predicted poorer psychological wellbeing at 50 and having a partner was associated with larger kinship networks. However, contact with larger kinship networks was shown to benefit men's wellbeing but not that of women.[91] This raises the point that there are often negative as well as positive aspects to relationships within kinship networks, which affect men and women differently.

Socially ascribed identities of working-age adults

Among ethnic minority communities, barriers to social inclusion, including those associated with social disadvantage, housing problems, and language barriers, may contribute to increased risk of social isolation.[92] [93] [76] Levels of unemployment are also significantly higher in certain ethnic groups. Data derived from the Labour Force Survey shows that the UK unemployment rate (October 2013 to September 2014) was higher in black (15%) and Asian (10%) ethnic groups compared with white groups (6%).[93]

According to the Mental Health Foundation, ethnic minority people living in the UK are more likely to be diagnosed and admitted to hospital for mental health problems, experience a poor outcome from treatment and to disengage from mainstream mental health services. This signals a circular relationship between social exclusion and deterioration in mental health.[94]

A related issue, reported by Sutton Council, is a lack of good health and community care accommodating local cultural differences, resulting in social isolation and a substantial increase in minority groups suffering from depression.[95]

Formative life experiences

Addiction can be both rooted in, and the cause of, social isolation. Adverse social experiences such as isolation, abandonment and neglect, especially during the early stages of life, increase an individual's risk of developing drug addiction.[96] These adverse social experiences overlap with some of the social isolation risk factors at earlier stages of the life course, for example adverse childhood experiences. This shows that while addiction has been placed in the working-age adult section of this report, it is a life course issue.

Inadequate social networks may contribute to both causes and consequences of alcohol addiction. For example, alcohol use as an effort to establish contact with others and cope with loneliness is widely recognised as a gateway to drinking problems [97] and in turn, addiction can lead to social isolation.[98] Substance abuse may strain social support relationships, leading to social isolation.[99] This can cause particular problems for parents, as family and neighbours may refrain from providing support when child-rearing problems arise.[99] [100]

Addiction can also bring extreme forms of social isolation such as homelessness and criminality. In such cases social isolation manifests itself in withdrawal from people or institutions that represent mainstream society.[101] Social isolation is a common experience for homeless people, which adds further adversity to their lives.[102]

Another formative experience is unemployment. There are a range of negative consequences for working-age adults who are unemployed, one of which is being isolated from networks of influence.[89] The long-term unemployed are at greater risk of becoming socially isolated than those in employment; this in turn negatively impacts upon labour market opportunities.[103] One mechanism by which unemployed people become socially isolated is through the loss of daily contact with colleagues.[104] Another cause is withdrawal from friends and family because of embarrassment and/or the need to cut back on the expenses associated with socialising, the latter being associated with a lower income.[104] Thus the effects of social isolation and long-term unemployment reinforce one another. The RSA report Power Lines found that unemployment doubles the likelihood of men becoming isolated and more than quadruples the likelihood among women.[89]

Retirement and later life

Retirement can be a time of increased wellbeing as the burden of work pressures is reduced and individuals have time to take up a different range of activities, including

socialising, sports, arts and culture, and volunteering.[105] However, some retired and older people are at risk of social isolation,[106] which, when experienced at older ages, increases the risk of mortality.[107] In particular, three life events are associated with social isolation among older people[108]: retirement and losing connection with colleagues; falling ill and becoming less mobile; a spouse dying or going into care.

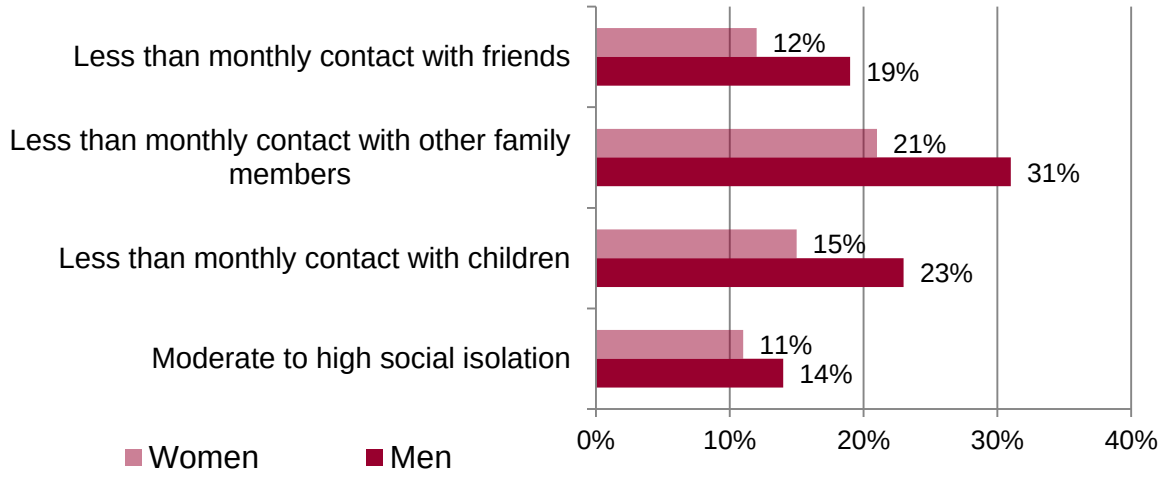
A meta-analysis of 148 studies covering over 300,000 study participants who were on average 63.9 years old at the beginning of the studies, reported that having adequate social relations is associated with a 50% greater likelihood of survival over seven-and-a-half years of follow-up compared with those without adequate social relations. Furthermore, authors of this research reported that the size of the effect of social isolation on survival was comparable to the effect of giving up smoking and greater than the effect of obesity and physical inactivity.[27]

Findings from the English Longitudinal Study of Ageing show that people from disadvantaged socioeconomic groups are less likely to take part in social activities and volunteering than their more advantaged peers and are more likely to face greater limitations in physical and mental functioning.[109]

Socially ascribed identities of older adults

Both men and women can become isolated in older age. However, a recent analysis of data from the English Longitudinal Study of Ageing reported by Independent Age highlighted that older men are more isolated than older women.[110] For older men 14% reported experiencing moderate to high social isolation compared with 11% of women. Of older men 23% in the study reported less than monthly contact with their children, and 31% reported that they were in contact with other family members less than once a month. For women, these figures were 15% and 21% respectively. Older men also had less contact with friends; 19% of men reported less than monthly contact with friends compared with 12% of women (Figure 4).

Figure 4: Isolation among men and women aged fifty and over: England, 2012/13



Note: Source does not provide statistical significance

Source: Beach and Bamford, ILC 2014; analysis of data from the English Longitudinal Study of Ageing[110]

Older people belonging to ethnic minority groups may experience language barriers and experience higher levels of poverty than those from the general population.[111] One study has shown that the levels of loneliness are very much higher among people from ethnic minorities (with the exception of the Indian population) than for the general population but are broadly comparable with rates of loneliness reported for older people in their countries of origin.[112] The social isolation of older ethnic minority people is of further concern as people in this group are less likely to access services for older people.[113]

Health and wellbeing status of older adults

The prevalence of disease is higher in more deprived groups; people in the least affluent socioeconomic group have a 60% higher prevalence of chronic diseases than those in the highest socioeconomic group. The least affluent group also experience 30% greater severity of disease.[114] The isolation of people with long-term health conditions can have further detrimental health effects. For example, because of its physical and psychological effects, cancer can limit mobility,[115] increase loneliness and decrease social support networks.[116 117]

A Macmillan report found that more than half of isolated cancer patients skipped meals or had not eaten properly due to a lack of support at home. More than one in six had not been able to collect a prescription for their medication and more than one

in ten had missed a hospital or GP appointment.[118] Consequently, social isolation lowers the survival rate for cancer.[115 116 119]

The risk of social isolation is greater for people with dementia.[120 121] A 2013 report by the Alzheimer's Society found dementia sufferers at higher risk of social isolation through a loss of social networks and social support.[121] The report found that 70% of people with dementia stop doing things they used to because of lack of confidence, 68% because they were worried they would get confused, 60% because they were worried about getting lost and 60% because of a loss of mobility.[121] Additionally, the survey found that loss of friends due to dementia was a key determinant of social isolation for sufferers: 28% of sufferers had lost friends following their diagnosis.[121] Social isolation itself has been associated with the risk of developing dementia, illustrating a two-way relationship.[122]

Carers

The effect of caring responsibilities on social isolation for young people was highlighted in an earlier section. When older people become infirm, there is an increased responsibility of care, often for partners. As the population is ageing, an increasing number of older caregivers will be providing care over a long period, during which time they will be burdened both by care-giving and by the physiological effects of their own ageing.[123] Low resistance to stressors, lowering of the immune system, fatigue, anorexia, non-intentional weight loss and physical inactivity are frequently associated with care-giving; these in turn increase the risk of social isolation.[123] There is evidence to suggest men and women cope very differently to the pressures of care-giving. Females are notably more likely to be unpaid carers than males: in 2011 57.7% of unpaid carers were females and 42.3% were males in England and Wales.[124] However, a 2009 study found that male care-givers were four times more likely to experience social isolation than their female counterparts.[125]

The home environment and housing

The home environment is also an important factor in social isolation for older people. An increasing proportion of older people stay in their own homes as opposed to moving into relatives' homes or care homes.[22] As people age, they develop strong cognitive and emotional ties to their home.[22] However, given the increased frailty of elderly people, the home can become detrimental to health[22] – for example from risk of accidents and falls. Living alone also correlates with social isolation.[126] Meanwhile architectural and urban planning can either deter or encourage social interaction for older people, consequently reducing or increasing the risk of social isolation.[127]

Housing conditions, such as cold homes, may contribute to social isolation. In England, over half of households in fuel poverty comprise people aged over 60.[128] The home environment is important for the wellbeing of older people and although

the majority of households in fuel poverty comprise older people, people of all ages living in fuel poverty may become more socially isolated due to not being able to afford to participate in social activities outside the home and not feeling comfortable inviting friends into a cold home.[129]

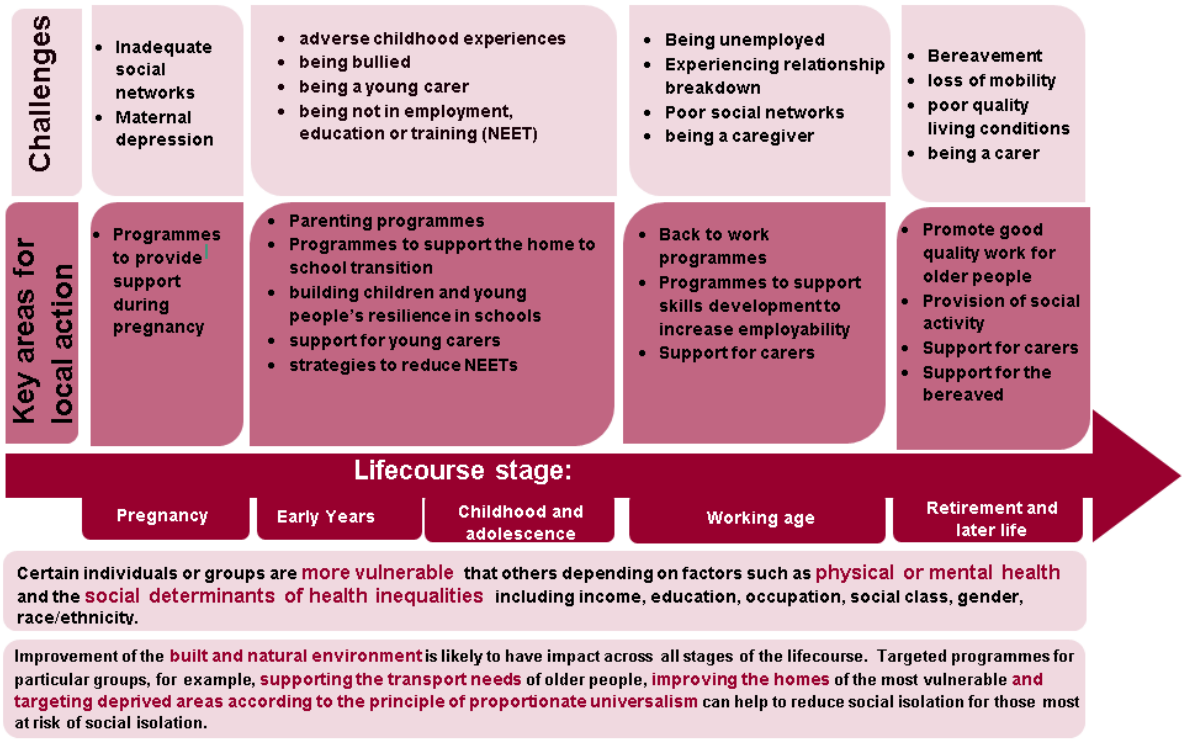
Given that social isolation relates to network size and diversity, and frequency of contact,[108] it is easy to see how retirement and older age increase the risk of social isolation. Social networks shrink with retirement and loss of working colleagues, friends and relations,[106] and the reduction of income associated with retirement may limit social activities, especially for those on lower incomes. Social networks become less accessible with decreased mobility: it becomes more difficult to participate.[130] When some or all of these events happen and result in social isolation, the consequences can include unmet healthcare needs and premature death.[108] Well documented epidemiological evidence charts a social gradient in premature death.[4]

Interventions to reduce social isolation at different stages of the life course

The previous section summarised who is at risk of social isolation, at what stage of life, and what impact this has on health and health inequalities. This section discusses a range of interventions that may impact on social isolation, directly and indirectly. It provides examples of interventions at different stages of the life course, and for particular at-risk groups, as well as interventions that act across all stages of the life course.

Figure 5 summarises opportunities for interventions across key stages of the life course.

Figure 5 – impact of social isolation across the lifecourse



In the example interventions that follow, information on the cost and cost effectiveness is included where available. Where cost effectiveness evidence was not available, commentary on where costs and benefits could potentially lie, based on our understanding of the potential impacts of social determinants across the life course, is provided. Further research on short- and long-term benefits is needed to provide evidence on these.

Pregnancy and early years

Interventions to support women and couples during pregnancy can help to strengthen or build supportive networks. Effective social support networks can reduce the risk of emotional distress and mediate the effects of stress, anxiety and depression among pregnant women.[131] Programmes and interventions to support parents can deliver benefits to parents and enable them to support their child's social and emotional development and reduce behavioural problems, with potentially lifelong benefits for the child, including creating and maintaining relationships. A separate report by IHE describes good quality parenting programmes and the home to school transition.[132]

One example of an intervention to improve children's outcomes in the early years is the Incredible Years Basic Programme.[133 134] This pre-school programme is designed to strengthen parent–child interactions and attachment and to support parents in promoting their child's social, emotional and language development.[133] Parents attend 18 to 20 weekly group sessions where they learn techniques to improve their relationship with their child, communicate effectively, establish rules and routines and manage anger and conflict.[134] The Early Intervention Foundation describes further examples of effective early years interventions.[134]

Interventions in local areas also include schemes led by trained professionals who coordinate volunteer befrienders who offer support to pregnant women before and after birth. An example is the Family Action perinatal support service, described in the box. The service supports mothers, babies and volunteers.

Example intervention: Family Action perinatal support service

Description: The aims are fourfold: to improve the mental health of participants, to improve attachment between mothers and infants, to reduce social isolation and to improve self-confidence of participants and volunteers.

In this service, Family Action volunteer befrienders visit women in the perinatal pregnancy stage, offering social, emotional and practical help. The service is led by a professional co-ordinator with a health and social care background. All the volunteer befrienders have experience of parenthood and some have received help from the service themselves.

Volunteers:

- offer the mother regular emotional support – this leads to the mother becoming more emotionally available for her baby and other family members, and reduces her social isolation
- observe how the mother responds to her baby and offer guidance on how

she can better relate to and parent her baby
- help the mother take the baby and other children outside the home, so they can make use of things like health services, shops, parks and children's centres
- give the mother support with issues, such as benefits and housing, that concern them

Target groups: Perinatal mothers who are deemed vulnerable or who have mild to moderate mental health problems.

Delivery partners/roles: The project was funded by the Big Lottery, the Monument Fund and the Henry Smith Charity. The project works with the Family Nurse Partnership (FNP) pathway as a complementary service.

Type of intervention: Voluntary befrienders assist a target group of at-risk mothers.

Impact: An external evaluation found that of the participants, 88% had reduced anxiety, 59% reduced depression, and 47% reported higher support on the Maternal Social Support Index scale. The evaluation also found a significant improvement in warmth of the mother–baby relationship.

One service user said: "To have somewhere to go once a week, meet other people and offload your problems to. Somebody to get you to understand that it's not you that's a bad person. It's support. Without having the project co-ordinator and the other girls there to understand, I don't know where I'd be now."

The external evaluation also noted that befrienders report a gain in confidence from volunteering. At one service site, on leaving the project 100% of volunteers had moved into education, employment or training, including social work and teaching degrees.

Evidence on costs: The independent evaluation found that the average cost per mother was £2,230. The quantified financial benefit is estimated to be £2,429 for each woman who receives support and could rise to £4,383 under the wider economic measure when monetisation of wellbeing is included. The costs came from expenses on buildings, staff and utilities and are based on information provided by Family Action.

The economic benefits came from increased chances of employment and higher earnings of mothers as a result of this service (£2,262), and increased wellbeing (£1,954). A more modest benefit came from decreased use of health and social care services (£137). The evaluation also noted that there are likely to be added benefits from the increased wellbeing of the service users' children across their lifespan.

Source: Family Action Impact Report[13]

The Family Action case is an example of effective one-to-one support. Some target groups can be more difficult to reach than others. Women facing detention need support during pregnancy, yet their access to traditional support from families and friends is limited. Birth Companions is an example of an intervention to reduce the isolation and distress of women who are pregnant and giving birth during or following detention (next box).

Example intervention: Birth Companions

Description: Birth Companions is an organisation which aims to reduce the isolation and distress of women who are pregnant and giving birth during or following detention. The Birth Companions coordinator, paid post holders, and volunteers work to support women before, during and after the birth of their babies.

The specific services provided include:

- basic outreach
- antenatal classes
- birth plans
- prison visits
- support by a Birth Companions visitor during labour and birth
- hospital visits
- practical assistance
- breastfeeding support
- community visits

Target groups: Detained women, both those convicted of criminal activity and detained migrants.

Delivery partners/roles: Prisons and detention centres.

Type of intervention: Volunteer-based, one-to-one meetings with pregnant women.

Impact: An evaluation found the women taking part in the antenatal class had mostly positive experiences. Birth Companions' service was seen as compassionate and non-judgemental, according to the women themselves, prison authorities and other agencies that came into contact with Birth Companions.

From the evaluation Birth Companions appears to make an essential positive difference to pregnant women in detention. Loss of individuality and dignity can be key issues for all people in prison and particularly for women who are pregnant, giving birth or caring for young babies in detention – and those separated from their babies.

The evaluation concluded that Birth Companions added an element of respect,

individuality and dignity in addition to providing very practical support.

Comments from those interviewed for the evaluation included:

“Everyone should have a Birth Companion – not just women in prison!”

“I can breast-feed proudly, not shyly”

“Their patience, the time they are prepared to give and the experience of being seen as an individual… I was made to feel special”

“They make a huge difference to how women in detention cope at a time of very great anxiety”

Evidence on costs: No review completed, but costs will come from running the service and reimbursing volunteers for expenses. Potential cost savings include lower health service use by mother and child. There may also be longer-term benefits to mothers and children if mothers are enabled to cope better: for example, if they subsequently end criminal activity there would be reduced costs to the criminal justice system and potentially improved outcomes for children. Further studies would be needed to evaluate longer-term effects.

Source: Birth Companions Evaluation[135]

Birth Companions is one example of an effective intervention targeting vulnerable women during the perinatal stage. What both the Birth Companions and the Family Action cases illustrate is that one-to-one meetings can make a significant difference for the wellbeing of women in the perinatal stage. These interventions also have the potential, through supporting mothers, to support newborn babies in developing resilience.

Children and young people

A separate report prepared by IHE on local action, ‘Building children and young people’s resilience in schools’, describes interventions that support children and young people’s “capacity to bounce back from adverse experience and succeed despite adversity”.[136] Such interventions support children and families in building good quality relationships within the family, peer groups, school and wider community. For example, in school settings, Families and Schools Together (FAST) is an intervention programme aimed at families with children aged 3–11, delivered in a number of areas of high deprivation, which aims to strengthen relationships within families and build supportive family and community environments.[137] The programme reduces child emotional problems and improves child social behaviour,[138] all of which supports children’s social skills in interacting with others.

Bullying in school causes distress and isolation. Efforts by families and schools and the wider community to generate positive and inclusive attitudes to all, regardless of disability/ability, support social inclusion and help counter any social difficulties.[139] Schools in England have a legal obligation to prevent all forms of bullying.[140] There are six major intervention methods available to schools for tackling bullying, namely, the traditional disciplinary approach, strengthening the victim, mediation, restorative practice, the support group method, and the method of shared concern.[141] Schools decide on their own measures to prevent and tackle bullying.[140]

The Anti-Bullying Alliance works to stop bullying and create safe environments for children and young people.[138] Its members run a range of anti-bullying training around the country, including training for peer supporters and assertiveness training for bullied children.

Interventions that focus on individual cases of bullying in schools sit in the wider context of community and societal norms and values that shape attitudes to minorities. Therefore interventions that seek to change social norms and values, such as attitudes to ethnic minorities, underpin interventions at the community and individual level.

Below two examples of interventions to tackle bullying are described. Show Racism the Red Card is an example of an intervention to reduce racism among school aged children through educational and creative activities supported by popular role models who stand up against racism. It is included here because promoting the rights of others and respecting others is fundamental to building cohesive societies and improving social connections. Teaching children to respect others is an essential part of education, and one that is recognised and applied in successful school bullying prevention policies.[140] The second example illustrates how a strategy to tackle bullying can be developed and implemented at the local level.

Example intervention: Show Racism the Red Card – Scotland schools competition

Description: Show Racism the Red Card (SRtRC) aims to combat racism in schools through enabling role models, who are predominantly, but not exclusively, footballers, to present an anti-racist message to young people and others. In the intervention described here, Scottish schools are invited to submit entries of art, poetry or multimedia on a relevant anti-racist theme. For example, in 2008 submissions were invited on the theme of 'welcoming new Scots and celebrating diversity'.

The competition is open to both primary and secondary schools. Art (mainly posters) is by far the most popular category, attracting a sizeable majority of entries.

Target group: School children in Scotland.

Delivery partners/roles: Partners include schools, the Scottish government, professional football clubs and football players.

Type of intervention: A nationwide student art and poetry competition to challenge racist attitudes.

Impact: A 2009 evaluation found the competition to have a large uptake, and feedback was overwhelmingly positive. As of 2008, one in five Scottish schools and 80,000 children had taken part in the competition. In a 2008 survey of 19 schools, there was unanimous agreement that the scheme had helped tackle racism in their school – a key indicator of the scheme's success.

The evaluation concluded that the structure of the competition, together with the accompanying materials, enables teachers to convey (and children to absorb) an appropriate anti-racist message. It also stated that poll results suggest the competition is making a difference in terms of the attitude of pupils towards racism.

There was concern in this evaluation that the competition would wind down; however, the competition is still being held, indicating continued success.

Evidence on costs: The 2009 evaluation calculated that there was a £3.57 net cost per participant. Although cost effectiveness was not reported in the evaluation, the authors concluded that the programme demonstrated good value for money.

Source: SRtRC (2009) Scottish Schools Competition evaluation[142]

Bracknell Forest Council (see box below) has taken a strategic approach to bullying through Taking Action Together, a local strategy which aims to tackle bullying in schools through a range of interventions.

Example intervention: Taking Action Together, tackling bullying in Bracknell Forest

Description: Bracknell Forest Council set up the Anti-Bullying Group (ABG) several years ago as a multi-agency forum to bring together representatives from all who are involved in dealing with bullying, whether working with victims or perpetrators and their families and schools. To tackle and prevent bullying, the ABG undertakes a varied programme of activities and initiatives aimed at raising awareness and reducing bullying, while supporting schools and other professionals with training, resources and by providing short-term support to individuals.

Target group: School children in the Bracknell Forest area.

Delivery partners/roles: The Bracknell Forest ABG brings together the following partnerships: The Bracknell Forest Partnership, which consists of agencies that deliver public services (local councils, police, fire and rescue service and local health services), businesses and people that reflect voluntary organisations and the community; the Children and Young People's Partnership; and the Local Safeguarding Children Board (LSCB), which is a statutory partnership responsible for securing the effectiveness of local safeguarding arrangements for children and young people in Bracknell Forest.

Type of intervention: The variety of interventions and activities associated with this scheme include surveys, mentoring, information provision and more creative initiatives such as drama.

Impact: A number of surveys were developed and carried out to further understanding of bullying in Bracknell Forest. These included a survey investigating the transition to secondary school and Year9online, a survey aimed at Year 9 pupils, with a particular emphasis on cyber bullying.

Peer mentoring: The 'safe to learn' peer mentoring scheme was embedded in all Bracknell Forest secondary schools. Peer mentors at Easthampstead Park Community School have been awarded the Princess Diana Award twice in three years for their work in supporting young people in their school.

Cyber mentoring: As well as continuously training peer mentors in secondary schools, a group of 50 young people were trained to become cyber mentors by the charity Beat Bullying.

Information for parents: Tackling Bullying: A Guide for Parents & Carers was produced and anti-bullying workshops for parents and carers were held throughout the borough.

Effective communication with schools: In addition to existing strong links with schools, a named anti-bullying lead contact was established in all Bracknell Forest schools in order to develop an effective network for the sharing of good practice, guidance and information.

Bullying and domestic abuse: A four-session PSHCE (personal, social, health, citizenship and economic) programme to explore links between domestic abuse and bullying was piloted in a secondary school. The pilot aimed to raise awareness of a sensitive subject in a safe and constructive environment. The course included the production of a play called The Lobster, which was performed by young people at a showcase event.

Drama production/workshops: Using drama as a means of engaging children and young people, a powerful anti-bullying monologue was performed in schools,

reaching over 2,500 young people. Building on the effectiveness of this approach, a variety of drama projects and self-esteem workshops were organised in schools to raise awareness and help tackle bullying. An event showcasing winning entries from a monologue-writing competition on the theme of 'Girls and Bullying' was held in a secondary school.

Rights, respect and responsibility: Bracknell Forest Schools have embarked on the programme of Rights Respecting Schools (RRS) Award in conjunction with Unicef, learning about the United Nations Charter for the Rights of the Child and its implications. Head teachers report greater respect and responsibility among the children and fewer incidents of bullying.

Research indicates that involvement in the RRS Award reduces bullying in schools nationally. All Bracknell Forest primary schools are engaged in the award with 15 achieving level one and two schools achieving level two (the highest). Of the six secondary schools, one has achieved level one, with three more schools working towards the award.

Evidence on costs: None reported. Researching and administrating these projects will undoubtedly incur costs. Potential benefits include improved GCSE results, and therefore employability and earnings. Another potential benefit is reduced use of counselling services due to a reduction in bullying.

Source: Bracknell Forest Anti Bullying Strategy[143]

Young carers are a group at increased risk of social isolation whose needs are unlikely to be met. Young carers often remain hidden and their needs therefore not met due to: the fear of being identified, not realising they are a young carer, or through professionals not acknowledging their role and failing to identify and support them.[144] Schools and school nursing teams are well placed within the community to identify and support young carers. The school nursing model, outlined in Getting it Right for Children, Young People and Families[145] provides a framework through which to plan and structure service delivery and tailored support to ensure young carers' needs are supported through partnership and effective approaches.

A briefing document, 'Supporting the health and wellbeing of young carers',[144] pulls together core principles to assist local areas to develop their own framework and presents a number of local examples.

An earlier section of this report discussed the potential of the built environment to impact on social isolation. Active travel and street play are the most sustainable approaches for delivering out of school activity for all children – whatever their age, gender or level of deprivation. Regular street closures for street play including resident involvement also lead to wider benefits including improved social cohesion and community connectedness.

The Street Play project is led by Play England in partnership with Playing Out, London Play and the University of Bristol and is a national project which aims to activate street play in communities. Evidence has shown that children are three to five times more active outdoors than indoors – when outdoors, more time is spent with friends which increases opportunities for greater levels of social interaction for children and families.[146]

Local authorities have an important role to play in enabling street play; it is important to provide support for children being able to play out in the street, based on an understanding of the benefits, and to ensure this support is communicated throughout the council, to all departments and officers. A clear, simple and free procedure for residents to regularly open their street for play will encourage people to take action – some examples of good practice, are Bristol, Hackney and Adur & Worthing councils.[147]

An evaluation of the Play Streets programme in the London Borough of Hackney reported that the intervention had reached a significant number of local children and families and was directly responsible for 8,100 hours of physical activity, the equivalent of 14 additional term-time PE lessons. Reported benefits of the programme in the evaluation report included, “a strong consensus among organisers about the perceived benefits of the scheme for children, families and communities – especially in terms of social interaction”.[148]

Working-age adults

While opportunities to develop social networks present themselves through work, leisure activities and interests such as sport and the arts, there is a significant problem of social isolation and loneliness among working-age adults, as described previously. Unemployed people may be particularly at risk. A previous IHE report, commissioned by Public Health England discussed evidence on local action to increase employment opportunities and improve workplace health.[149] This report describes interventions to increase employment opportunities and retention in employment of people with long-term health conditions and disabilities, people with mental health disorders and older people. While these programmes and interventions do not directly set out to tackle social isolation, they are likely to have an impact on it, and may contribute to alleviating the problem in some cases.

This section presents several examples of interventions aimed at particular at-risk groups. The first, St Giles Trust’s SOS project, is included here because it aims to re-integrate into social networks isolated individuals who are ex-offenders or who are at risk of offending, through provision of personalised, holistic support across areas such as housing, education and training according to the particular needs and aspirations of the individuals.

Example intervention: St Giles Trust's SOS project

Description: St Giles Trust's SOS project aims to break the cycle of offending. It works with young people both in prison and in the community, offering a tailored package of support for each individual to help them identify and realise alternative aspirations and goals away from a life of crime. It also works with young people who are at risk of getting involved in the criminal justice system.

SOS can help an individual across a wide range of practical areas including accessing housing, education and training, as well as in the more emotional realm of re-establishing positive ties with family and siblings.

The majority of caseworkers are trained, reformed ex-offenders who have first-hand experience of the issues their clients are working through.

Target groups: Ex-offenders and those at risk of offending. A project evaluation found that 96% of the service users were male, 59% black British (40% African, 19% Caribbean), and 27% white British. The SOS Project's client group spans a number of different age groups, including children (aged 10–17), young adults (typically 18–20, but also 18–24 where highlighted) and small numbers of adults (25-plus). The average age at the start of the engagement is 19.

Delivery partners/roles: The project has a range of partners to ensure that a holistic service is provided. They work with Jobcentre Plus to help find employment opportunities, along with specialist training organisations such as Drop the Tag, which works specifically with offenders. The project works with local authorities and housing associations to help with housing needs. It also co-ordinates with the Metropolitan Police and prison authorities on various initiatives, for example for referrals of young offenders.

Type of intervention: The majority of SOS projects follow a similar process: referral and engagement followed by regular reviews of both client needs and progress to date.

Impact: The Social Innovation Partnership (TSIP) evaluated the service in 2006. It found that 73% of those who undertook education, training and employment activities successfully achieved an outcome, for example securing part-time work or an apprenticeship. The SOS project helped 76% of the clients that were identified as having housing needs to find temporary or permanent housing, 43% of clients were assisted in claiming benefits and 23% of clients were recorded as receiving mentoring and/or information, advice or guidance support.

The importance, quality and effectiveness of the caseworkers are also reflected in the evaluation. The interview process of the evaluation found:

- 87% of client interviewees said that engaging with the SOS project had changed their attitude to offending
- 73% said that it was important that their caseworkers were ex-offenders themselves, as they could relate to them and felt inspired that they too could turn their lives around
- when client interviewees were asked what the worst thing about the SOS project was, most said “nothing” (and most other responses related to issues outside SOS’s control, such as long waits for housing)
- 86% of partner organisation interviewees said that their experience of working with the SOS project was either good or very good
- 100% agreed or strongly agreed that the SOS project helps clients to stop re-offending or reduces it
- 100% said that the relationship between SOS project staff and clients was either good or very good

Evidence on costs: No cost–benefit analysis was carried out. As with other services, there will be running costs to the scheme. Benefits could include a smaller burden on prison services, lower policing costs and increased employability and earnings.

Source: St Giles Trust Website[149] and SOS project evaluation[150]

The SOS project is an example of an intervention that supports people into a virtuous cycle. However, continuous support is needed to have the best chance of reducing the risk of becoming socially isolated. TimeBanks is an approach that is increasingly being used in local areas, targeted at low income communities, with the aim of building strong and mutually supportive social networks (see below).

Example intervention: TimeBanks

Description: TimeBanks builds social networks of people who give and receive support from each other through contributing skills and practical help. Examples include ensuring older people receive nutritious food and are able to eat regularly, and providing a ‘circle of support’ for young people to keep them out of trouble. The scheme enables people from different backgrounds, who may not otherwise meet, to form connections and friendships. TimeBanks aims to build social capital in low income communities.

Target groups: Low income communities.

Delivery partners/roles: TimeBanks has a number of partners providing a range of roles to help develop infrastructure and provide funds:

- the Tudor Trust supports the creation and development of regional networks

across the UK and encourages the sharing of best practice
- the City Bridge Trust supports the strengthening and development of TimeBanks over three years within the City of London
- the London Borough of Barnet supports TimeBanks as part of the Coproduction and Ageing Well programme
- the London Borough of Harrow supports a three-year multi-partnership project to implement and develop a mutual support network using TimeBanks as a tool
- Hour World forms a partnership between countries to share resources, skills and knowledge to the benefit of time banks in the UK and the USA
- Big Assist supports TimeBanks UK as an infrastructure organisation
- Town Teams encourages its projects across the UK to incorporate time banks as a way to reward and motivate local people to get involved
- the Big Lottery Fund awards lottery money to community groups and projects that improve health, education and the environment

Type of intervention: TimeBanks works to improve social capital and networks in deprived areas

Impact: The scheme currently has 200 members and has developed 60 TimeBanks. The scheme has been most impactful on low income communities, as was the ambition. Significantly, there is a high proportion of low income volunteers: 58% have a salary below £10,000 compared with 16% for the volunteering community as a whole. Nearly double the number of TimeBank participants are not in formal employment (72%) compared with of general volunteers (40%).

Evidence on costs: TimeBank interventions cost £450 per member per year, but cost savings could exceed £1,300 per member. This is a conservative estimate of the net economic benefit, since time banks can achieve a wider range of impacts than those that have been quantified and valued to date. Costs incurred are from running the time banks: the savings come from the immediate effects of the volunteering, and the added benefits of increased skills development and employability.

Source: TimeBanks website and Knapp[151]

Taking an holistic approach to people's needs naturally serves to connect health, social care, education, lifelong learning, employment, housing, transport and the environment. This principle is seen in action in community-based services, including the Bromley by Bow Centre[151] and the Hackney Migrants Centre, which provides advice and space to connect for asylum seekers, refugees and recent migrants.[152]

Some primary care providers are moving towards greater emphasis on supporting users holistically. This is demonstrated in the Hackney WellFamily Service example, described below.

Example intervention: Hackney WellFamily Service

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

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

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

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

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

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

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

Source: Family Action Impact Report[13]

These three interventions for working-age adults are all examples of cost- effective services that have demonstrable impact. All three examples illustrate how volunteers, local authorities and others can work together in combining resources to create effective services to reduce social isolation in the community.

Retirement and later life

As already discussed, social isolation and loneliness are not the same. Age UK has recognised that social isolation and loneliness require different interventions, and in terms of the former: "Older people experiencing isolation may require practical support, or the provision of transport."[153]

Big Lottery funding is supporting interventions to reduce social isolation among older people through its £82m Fulfilling Lives, Ageing Better programme in 16 local areas across England[154]. Evaluations of these interventions will provide information to inform work in other local areas to reduce social isolation. Presented below are some additional interventions focused at tackling social isolation in later life.

Service providers can bring effective interventions, even when social isolation is not their primary objective. One example, the West Midlands Fire Service, uses its services and status as a trusted and respected organisation to reach isolated individuals – see box below.

Example intervention: West Midlands Fire Service (WMFS)

Description: In its fire prevention work with the community, WMFS applies the principle of "making every contact count" (128) − a strategy used by the NHS to encourage people to make healthier choices to achieve positive long-term behaviour change. Organisations use everyday interactions with service users to help individuals make continuous health improvements.[155]

Target groups: People of all ages who are socially isolated and as a consequence are at greater risk of being involved in a fire.

Delivery partners/roles: The service is funded and conducted by the West Midlands Fire Service.

Type of intervention: One-to-one engagement, which can lead to further actions (see Impact).

Impact: A range of impacts are reported by the WMFS. While its primary aim is to reduce the risk of fires, which occur disproportionately in deprived areas, the interventions also act to reduce social disadvantage, including social isolation.

The frail elderly living alone are especially vulnerable to dwelling fire and consequent harm or death. Mental ill health, including dementia, and disability are factors in the heightened risk of home fires for elderly people living alone. [156] One elderly man's interaction with the making every contact count strategy shows the impact of a fire officer's visit to his home and illustrates the importance of meaningful

contacts:

Bill, 86 years old, was a former merchant navy officer who had lived the life of a recluse for 28 years following the death of his brother. Bill revealed his life story to a visiting fire officer. The fire officer then made contact with a former merchant navy commander also living locally who had not known what had become of Bill since leaving the merchant navy, and described how Bill had achieved the height of respect and seniority during his employment. With the help of the former commander, the fire officer put Bill in contact with former colleagues and friends. Bill died around 18 months later but those months were filled with joy, support and friendships.

Evidence on costs: None reported, however this service requires the time of fire service staff. Benefits include lower risk of fires as well as potential improvements in wellbeing.

Source: WMFS[156 157]

The example of WMFS shows the positive impact 'making every contact count' can have, and emphasises the importance of relationships between service providers and users. The problem of social isolation needs to be tackled by a range of services collectively, not just by organisations that exist to tackle social isolation.

Retirement and later life is a stage in which people often become carers. Being a carer can place stress on people's relationships. The relationship counselling service organisation, Relate, found that carers were at risk of depression because of care-giving. Consequently, Relate provides services for carers: for example, in Wales cancer specialists are able to make referrals to Relate and in Doncaster dementia services signpost service users to Relate.[158]

A Department of Health analysis showed that 41% of Relate clients said that they were completely satisfied, while 38% were mostly satisfied with the support they had received. For every £1 invested in Relate couple counselling, £11.40 of benefits accrue. These benefits include improved income for service users and decreased burden on state services.[159]

People's lives can be enhanced by sharing experiences and activities, which can maintain existing networks and create new ones. Shared experiences and activities can have more than one positive effect. For instance, engagement with the creative arts can help individuals build and maintain social connections and can be beneficial for health and wellbeing.[160-162]

Improved social connectedness can go hand in hand with increased physical activity, as described in the LinkAge programme below.

Example intervention: LinkAge, Bristol

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

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

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

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

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

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

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

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

Service users' comments included:

"LinkAge is a saviour. I gave up work six months ago and it was incredibly important

in helping me make the transition" – participant in Tai Chi class

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

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

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

Source: Centre for Social Justice Evaluation[163]

Older people may be inhibited from accessing services and social activities because they cannot access means of transport, for a variety of reasons. Various interventions are in place to support the transport needs of older people. The Leicester community transport scheme is an example of a service where volunteers drive people to hospital for treatment.

Example intervention: Leicester community transport scheme

Description: This service provides two-way transport between home and hospital for a group of hospital users. Users are primarily regular hospital visitors, mostly chemotherapy or radiotherapy patients. Volunteers use their own cars to provide this service. The scheme provides the user a form of social interaction, as well as transport.

Target group: Elderly hospital users.

Type of intervention: One-to-one volunteering.

Impact: The evaluation of the scheme nationwide looked at social return on investment alone. Nationwide, the scheme facilitates 90,000 journeys per year but the breakdown for Leicester was not available. The evaluation acknowledged that the community transport scheme might make its users "feel more involved in their community".[164]

There are also possible benefits for the volunteers. The evaluation noted that:

"We spoke to one of the community transport scheme volunteer drivers, who works three days each week but helps on other days if needed. He started volunteering because he felt a bit lonely at home after taking early retirement."[164]

Evidence on costs: The social return on investment was £0.93 for every £1, or put differently: £0.07 was lost for every £1 invested. Over half the costs were volunteer expenses (£63,367) from drivers' mileage; staff costs were estimated to be £20,000. The major cost benefit was on cheaper transportation through avoiding spending on taxis and ambulances.

The evaluation noted that it was difficult to determine the wider benefits, meaning that this figure is likely to be an underestimate. The evaluation also pointed out potential non-financial benefits including giving friends and family spare time, and less time spent waiting for a hospital ambulance.

Source: RVS SROI evaluation[164]

These two very different interventions illustrate the varying needs of older people in efforts to reduce social isolation. They highlight the importance of intervention strategies or approaches that address the specific issues that put certain groups at risk of social isolation.

Conclusion

Social isolation is a complex social issue with roots at the societal, community and individual level. While social isolation is more commonly considered in the context of later life than it is at earlier stages of the life course, people can be affected by social isolation at any stage. Reducing social isolation will contribute to improved overall health and wellbeing and to reduced health inequalities in communities.

Social isolation and loneliness may affect anyone, but some groups are more at risk at particular stages of life. A number of factors including socioeconomic status, age, gender, ethnicity, physical and mental disability and long-term health conditions may create conditions that reduce an individual's ability to create and maintain supportive social networks. This practice resource document has provided examples of interventions to support people at different stages of the life course. The report supports efforts to reduce health inequalities as part of a broad strategic approach to action on the social determinants of health. As risk factors are greatest for some of the more vulnerable groups in society, there is a strong case for action based on the interests of equality and social justice.

The examples of interventions outlined in this report provide insights into how to tackle social isolation in an integrated way that will support individuals in many aspects of their lives, including those managing long-term health conditions. Interventions such as these should form part of a comprehensive strategy to improve health and reduce health inequalities by taking action across the whole of society, with more intense and targeted action for those at greater risk – proportionate universalism.[4]

The costs of interventions to reduce social isolation are inevitably at the forefront of local planning concerns. Examples given in this report show costs associated with staffing, reimbursing volunteers and the administration of the services. Volunteering may bring valuable co-benefits in local areas, including reducing social isolation and improving social capital while reducing health service expenditure. However, it should be noted that volunteers may only be available temporarily, and at times of their own choosing, and have their own needs. Where the involvement of volunteers appears to be used as a way of delivering services that would otherwise be paid for financially, there may be ethical, political and sustainability concerns to address.

Economic benefits of reducing social isolation arise from the reduced burden on other, more costly, services (such as GPs), and the increased productive capacity and potentially increased incomes of service users. In considering estimates of the net economic benefit it should be noted that interventions may achieve a wider range of impacts than those that have been measured and quantified. More economic

evaluation is needed with analyses taking into account the direct and indirect benefits across multiple dimensions.

There are circumstances where social networks have negative aspects which do not promote health, for example gang membership, and in influencing the spread of obesity.[29 30] Virtual mobility whereby opportunities, services and social networks are accessed via the Internet[165] is also discussed in the literature as a potentially useful tool in supplementing access to social networks. However, it is also possible that the use of online social media may have a negative influence, reducing time for actual 'offline' social interaction and leading to a more isolated lifestyle. In addition, concern has been raised about cyber bullying among children and young people.[166] More research is needed to evaluate the contribution of positive and negative aspects of social networks to health inequalities.

Maintaining good quality social relationships and integrating people into enabling and supportive social networks are central actions to preventing social isolation. Organisations in local areas are well placed to work with individuals and communities to identify who is at risk and to engage them in finding solutions. A range of services provided by the public, private and charitable sectors, and community and voluntary services, may have the potential to impact on social isolation, even if this is not their primary aim. For example, public transport and street design can promote social interactions that build social connectivity. Broader interventions in areas such as transport, housing and the built and natural environment will support the creation of conditions that forge and foster good relationships within society. To give another example, the fire service acts to prevent fires by engaging with individuals and communities; such interventions may impact directly and indirectly on social isolation.

There is an opportunity for local areas to assess and evaluate existing services' potential impact on social connectivity and social isolation of at-risk groups. This would provide the evidence base for local areas to put in place measures that build synergies across existing services and maximise co-benefits across sectors to reduce social isolation.

Interventions that build community based social networks and promote shared values and trust within the community have been shown to benefit individuals, communities and service providers.[167] For example, the Hackney WellFamily Service evaluation showed that there was a social return on investment of £5.96 for every £1 invested because the burden had been shifted from a more to less expensive service: the WellFamily service typically costs £55 per hour, compared with GP costs of up to £300 per hour.[13]

Individual and community level factors that impact on social isolation are nested in the wider social, economic, political and cultural context. While community based

action contributes to reducing social isolation,[168] the extent to which such action is scalable and sustainable depends on factors including local area budgets for health and social care, economic policies, taxation and social welfare policies, public health and social care policies, as well as societal norms and values with respect to groups including older people, ethnic minority groups and people with disabilities.

A strategic approach to preventing and reducing social isolation is required, which includes all local public services (social services, police, fire, health, education, welfare, transport and housing sectors) and local society (individuals, community and voluntary organisations, local businesses and enterprises). Practitioners from all these sectors can examine together how to effectively contribute to reduce and prevent social isolation.

Organisations in local areas are well placed to work in partnership and with individuals and communities to identify who is at risk of social isolation and to engage them in finding solutions. The importance of local people's participation in planning, managing and implementing interventions is a recurrent theme.[169] [170] However, the context of social isolation across local areas may differ and programmes and interventions identified as successful elsewhere may need to be adapted according to the local context and needs of local citizens.

References

1. Public Health England. Public Health Outcomes Framework. Secondary Public Health Outcomes Framework 2014. http://www.phoutcomes.info/.
2. PHE. Adult and Social Care Outcomes Framework. 2014.
3. South J. A guide to community-centred approaches for health and wellbeing. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing__full_report_.pdf, 2015.
4. The Marmot Review Team. Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010. London: Marmot Review Team, 2010.
5. Umberson D, Montez J K. Social Relationships and Health: A Flashpoint for Health Policy. J Health Soc Behav 2010;**51**:12.
6. Zavaleta D, Samuel K, Mills C. Social isolation: a conceptual and measurement proposal. POPHI Working Paper No 67, Oxford Poverty and Human Development Initiative, 2014.
7. Cornwell EY, Waite LJ. Social disconnectedness, perceived isolation and health among older adults. J Health Soc Behav 2009;**50**(1):17.
8. Perlman D, Peplau LA. Toward a social psychology of loneliness. In S. W. Duck & R. Gilmour (Eds.), Personal relationships in disorder London: Academic Press, 1981.
9. Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. Psychol Bull 1996;119:43.
10. Cacioppo JT, Hawkley LC. Social Isolation and Health, with an Emphasis on Underlying Mechanisms. Perspectives in Biology and Medicine 2003;**46**(3).
11. House JS, Landis KR, Umberson D. Social Relationships and Health. Science 1988;**241**(5).
12. Steptoe A, Kivimaki M. Stress and cardiovascular disease. Nature reviews Cardiology 2012;**9**(6):10.
13. Family Action. Family Action Impact Report Family Action 2014.
14. Popay J, Escorel S, Hernández M, et al. Understanding and Tackling Social Exclusion: Final Report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network 2008.
15. Mathieson J, Popay J, Enoch E, et al. Social Exclusion: Meaning, measurement and experience and links to health inequalities, a review of literature. WHO Commission on Social Determinants of Health, WHO Social Exclusion Knowledge Network Background Paper 1 2008.
16. Piachaud D, Bennett F, Nazroo J, et al. Report of task group 9: social inclusion and social mobility. Task group submission to the Marmot Review, 2009.
17. The Institute of Health Equity. Review of the Social Determinants and the Health Divide in the WHO European Region. Copenhagen: WHO Europe, 2013.
18. Levitas R, Pantazis C, Fahmy E, et al. The Multi-Dimensional Analysis of Social Exclusion. In: Department for Communities and Local Government DoSaSfSPTCftISoP, and Bristol Institute for Public Affairs, University of Bristol. , ed., 2007.
19. Popay J ES, Hernández M, Johnston H, Mathieson J, Rispel L Understanding and Tackling Social Exclusion: Final Report to the WHO Commission on Social Determinants of Health From the Social Exclusion Knowledge Network, . WHO Social Exclusion Knowledge Network 2008.
20. CSDH Social Exclusion Knowledge Network. Understanding and tackling social exclusion: Final report of the Social Exclusion Knowledge Network of the Commission on Social Determinants of Health. Geneva: World Health Organisation, 2007.
21. Bonell C. P., Strange V. J., M Stephenson JM, et al. Effect of social exclusion on the risk of teenage pregnancy: development of hypotheses using baseline data from a randomised trial of sex education. J Epidemiol Community Health 2003;**57**:5.
22. Iwarsson S, Wahl H-W, Nygren C, et al. Importance of the Home Environment for Healthy Aging: Conceptual and Methodological Background of the European ENABLE–AGE Project. The Gerontologist 2007;**47**(1):78-84.
23. Anciaes P, Jones P, Mindell JS. Quantifying community severance - A literature review, Street Mobility and Network Accessibility Series Working Paper 02 November 2014
24. Boniface S, Scantlebury R, Watkins SJ, et al. Health implications of transport: evidence of effects of transport on social interactions. Transport and Health Study Group 2014.
25. Bartley M, editor. *Capability and Resilience: Beating the odds*. London: ESRC Human Capability and Resilience Research Network, 2006.
26. Clarke D, McDougall E. Social Isolation in Bristol: Risks, Interventions and Recommendations Report 2014.

27. Holt-Lunstad J, Smith TB, Layton JB. Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Medicine 2010;**7**(7).
28. Cohen S, Gottlieb BH, Underwood LG. Social Relationships and Health. In: Cohen S, Underwood LG, Gottlieb BH, eds. Measuring and intervening in social support. Oxford University Press 2000.
29. Pyrooz DC, Sweeten G. Gang Membership Between Ages 5 and 17 Years in the United States. Journal of Adolescent Health 2015(56):5.
30. Christakis NA, Fowler JH. The Spread of Obesity in a Large Social Network over 32 Years. N Engl J Med 2007(357):9.
31. Christakis NA, Fowler JH. The Collective Dynamics of Smoking in a Large Social Network. N Engl J Med 2008;**358**(21).
32. Cacioppo JT HL. Social Isolation and Health, with an Emphasis on Underlying Mechanisms Perspectives in Biology and Medicine 2003;**46**(3):13.
33. McEwen BS. Protective and damaging effects of stress mediators: central role of the brain Dialogues in Clinical Neuroscience 2006;**8**(4).
34. First Steps. Improving social isolation and loneliness, version 3: NHS, 2013.
35. Social Exclusion Unit. Making the Connections: The Final Report on Transport and Social Exclusion. In: Minister OotP, ed., 2004.
36. Steptoe A, Shankar A, Rafnsson S. The Links Between Social Connections and Wellbeing in Later Life. ILC-UK 2015.
37. Boyce C. Walkability, Social Inclusion and Social Isolation and Street Redesign. Built Environment 2010;**36**(5):12.
38. Bambra C, Joyce K, Maryon-Davis A. Strategic Review of Health Inequalities in England post-2010. Marmot Review. Task Group 8: Priority public health conditions. Final report. England, 2009.
39. Kweon BS, Sullivan, W.C., Wiley, A.R., Green. Common Spaces and the Social Integration of Inner-City Older Adults. Environment and Behavior 1988;**30**(6):26.
40. Lee ACK, Maheswaran R. The health benefits of urban green spaces: a review of the evidence. Journal of Public Health 2011;**33**(2):212-22.
41. Caspi A, Harrington H, Moffitt TE, et al. Socially Isolated Children 20 Years Later: Risk of Cardiovascular Disease. Arch Pediatr Adolesc Med 2006;**160**:6.
42. Katz SJ, Conway CC, Hammen CL, et al. Childhood social withdrawal, interpersonal impairment, and young adult depression: a mediational model. Journal of abnormal child psychology 2011;**39**(8):1227-38.
43. Thomas PA. Trajectories of Social Engagement and Limitations in Late Life. Journal of Health and Social Behavior 2011;**52** (4):13.
44. Shankar A, McMunn A, Banks J, et al. Loneliness, social isolation, and behavioral and biological health indicators in older adults. Health Psychology 2011;**30**(4):8.
45. Victor C, Scambler S, Bond J. The social world of older people. Understanding loneliness and social isolation in later life. New York: Open University Publishing, 2009.
46. Victor C. Loneliness, Social Isolation and Living Alone in Later Life: ESRC Full Research Report. ESRC 2005.
47. Mahadevan J. New mums lack support to cope with isolation and depression
- See more at: http://www.cypnow.co.uk/cyp/news/1073793/new-mums-lack-support-cope-isolation-depression#sthash.TCFokvsx.dpuf. 2012.
48. Morgan K, J., , Eastwood JG. Social determinants of maternal self-rated health in South Western Sydney, Australia. BMC Research Notes 2014;**7**(51):7.
49. Eastwood JG, Jalaludin BB, Kemp LA, et al. Relationship of postnatal depressive symptoms to infant temperament, maternal expectations, social support and other potential risk factors: findings from a large Australian cross-sectional study. BMC pregnancy and childbirth 2012;**12**:148.
50. Gater R., Tomenson B., Percival C., et al. Persistent depressive disorders and social stress in people of Pakistani origin and White Europeans in UK. Social Psychiatry and Psychiatric Epidemiology 2009;**44**(3):9.
51. Redshaw M, Henderson J. From antenatal to postnatal depression: associated factors and mitigating influences. J Womens Health 2013;**22**(6):518-25.
52. Byatt N, Biebel K, Friedman L, et al. Patient's views on depression care in obstetric settings: how do they compare to the views of perinatal health care professionals?(). General hospital psychiatry 2013;**35**(6):598-604.
53. Husain N, Cruickshank K, Husain M, et al. Social stress and depression during pregnancy and in the postnatal period in British Pakistani mothers: a cohort study. J Affect Disord 2012;**140**(3):268-76.
54. Center on the Developing Child at Harvard University. Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8. 2009
55. Kelly Y, Sacker A, Del BE, et al. What role for the home learning environment and parenting in reducing the socioeconomic gradient in child development? Findings from the Millennium Cohort Study. ArchDisChild 2011;**96**(9):832-37.

56. Levinson CA, Langer, J. K., & Rodebaugh, T. L. Reactivity to Exclusion Prospectively Predicts Social Anxiety Symptoms in Young Adults. Behavior Therapy 2013;**44**(3):8.
57. Bandura A. Personal and Collective Efficacy in Human Adaptation and Change, in J.G. Adair, D. Belanger, & K.L. Dion (eds), Advances in Psychological Science: Vol 1, Personal, Social, and Cultural Aspects. Psychology Press 1998:592.
58. Kvarme et al. The effect of a solutional-focused approach to improve self-efficacy in socially withdrawn school children: A non-randomized controlled trial. International Journal of Nursing Studies 2010;**47**:7.
59. Kvarme L, Helakorpi S. The effect of a solution-focused approach to improve self-efficacy in socially withdrawn school children: A non-randomized controlled trail. International Journal of Nursing Studies 2010;**47**:1389-96.
60. Lacey R, Kumari M, Bartley M. Social isolation in childhood and adult inflammation: Evidence from the National Development Study. Psychoneuroendocrinology 2014.;**50**:9.
61. Danese A, Moffitt TE, Harrington H, et al. Adverse childhood experiences and adult risk factors for age-related disease: depression, inflammation, and clustering of metabolic risk markers. Arch Pediatr Adolesc Med 2009;**163**(12):1135-43.
62. Levendosky A, Graham-Bermann S. Parenting in Battered Women: The Effects of Domestic Violence on Women and Their Children. Journal of Family Violence 2001;**16**(2):171-92.
63. Fleming J, Mullen PE, Sibthorpe B, et al. The long-term impact of childhood sexual abuse in Australian women. Child Abuse and Neglect 1999;**23**(2).
64. Ford E, Clark C, SA S. The influence of childhood adversity on social relations and mental health at mid-life. J Affect Disord 2011.
65. Jackson M. The power of procurement -Towards progressive procurement: the policy and practice of Manchester City Council. Manchester, 2010.
66. Best Value Statutory Guidance: Department for Communities and Local Government, 2011.
67. Harden A, Brunton G, Fletcher A, et al. Young people, pregnancy and social exclusion: A systematic synthesis of research evidence to identify effective, appropriate and promising approaches for prevention and support. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London 2006:124.
68. Sikorski C, Luppa M, Luck T, et al. Weight Stigma "Gets Under the Skin"—Evidence for an Adapted Psychological Mediation Framework—A Systematic Review Obesity Review 2015:11.
69. Griffiths LJ, Wolke D, al. PAe. Obesity and bullying: different effects for boys and girls. Arch Dis Child 2006;**91**(2):4.
70. Hunt R, Jensen J. The School Report. Stonewall 2012:24.
71. Guasp A. The Teachers Report: Homophobic bullying in Britain's schools. Stonewall 2012:32.
72. Crisis. Homelessness: A Silent Killer - A research briefing on mortality amongst homeless people. Secondary Homelessness: A Silent Killer - A research briefing on mortality amongst homeless people 2011. http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf.
73. Russell ST, Sinclair KO, Poteat VP, et al. Adolescent health and harassment based on discriminatory bias. American Journal of Public Health 2012;**102**(3):2.
74. Kerr JC, Valois RF, Huebner ES, et al. Life satisfaction and peer victimization among USA public high school adolescents. Child Indicators Research 2011;**4**(1):17.
75. McNeil J, Bailey L, Ellis S, et al. Trans Mental Health Study 2012, 2012.
76. Bedford M. BME Small Grant Funding, Project Report. 2011:11.
77. Barnardos Northern Ireland. Response by Barnardo's Northern Ireland to Children and Young People's Stratic Partnership: BME Children and Young People Draft Action Plan. 2012., 2012.
78. ONS. Measuring National Well-being – Exploring the Well-being of Children in the UK. 2014.
79. Takizawa R, Maughan B, Arseneault L. Adult health outcomes of childhood bullying victimization: evidence from a five-decade longitudinal British birth cohort. The American journal of psychiatry 2014;**171**(7):777-84.
80. Sentenac M, Gavin A, Gabhainn SN, et al. Peer victimization and subjective health among students reporting disability or chronic illness in 11 Western countries. The European Journal of Public Health 2013;**23**(3):5.
81. Chatzitheochari S, Parsons S, Platt L. Bullying experiences among disabled children and young people in England: Evidence from two longitudinal studies (Working Paper No. 14-11), 2014.
82. Platt L et al. Research summary four: Are disabled children and young people at a higher risk of being bullied? . Briefing paper London: Centre for Longitudinal Studies 2014.
83. BIS. Participation Rates In Higher Education: Academic Years 2006/2007 – 2012/2013 (Provisional). In: BIS, ed., 2014.
84. NUS. Student Experience Research 2012, Part 4: First Year Student Experience, Student experience research to gain insight into the quality of the learning experience. NUS 2012.
85. Read B, Archer L, Leathwood C. Challenging Cultures? Student Conceptions of 'Belonging' and 'Isolation' at a Post-1992 University Studies in Higher Education 2003;**28**(3).
86. Ellis SJ. Diversity and Inclusivity at University: A Survey of the Experiences of Lesbian, Gay, Bisexual and Trans (LGBT) Students in the UK. Higher Education 2009;**57**(6):723-39.

87. Thompson R. Individualisation and social exclusion: the case of young people not in education, employment or training. Oxford Review of Education 2011
37(6):17.
88. The Prince's Trust. The Prince's Trust McQuire: Youth Index 2015. 2015.
89. Marcus G, Neumark T, Broome S. *Power Lines*. London: RSA, 2011.
90. The Samaritans. Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide., 2012.
91. Cable N, Bartley M, Chandola T, et al. Friends are equally important to men and women, but family matters more for men's well-being. J Epidemiol Community Health 2013(67):5.
92. BAWSO. Domestic abuse from a BME perspective, 2015.
93. Dar A, Mirza-Davies J. Unemployment by ethnic background. House of Commons Library 2015.
94. Mental Health Foundation. Black and Minority Ethnic Communities. Secondary Black and Minority Ethnic Communities Accessed Jan 2015 2015. http://www.mentalhealth.org.uk/help-information/mental-health-a-z/b/bme-communities/.
95. Sutton Council. Involving Black Minority Ethnic groups in Planning Sutton's Future: Additional evidence for 'Working Together - Sutton Council's Statement of Community Involvement' Final Stage 1 and 2 Report, 2006.
96. Whitaker LR, Degoulet M, Morikawa H. Social Deprivation Enhances VTA Synaptic Plasticity and Drug-Induced Contextual Learning. Neuron 2014;**77**(2):10.
97. Akerlind I, Hornquist JO. Loneliness and alcohol abuse: a review of evidences of an interplay. Social science & medicine (1982) 1992;**34**(4):405-14.
98. Mowbray O, Quinn A, Cranford JA. Social networks and alcohol use disorders: findings from a nationally representative sample. The American journal of drug and alcohol abuse 2014;**40**(3):181-6.
99. Testa MF, Smith B. Prevention and Drug Treatment. The Future of Children 2009;**19**(2).
100. Wolock I, Magura S. Parental substance abuse as a predictor of child maltreatment re-reports. Child abuse & neglect 1996;**20**(12):1183-93.
101. Harrell A, Peterson GE. *Drugs, Crime, and Social Isolation: Barriers to Urban Opportunity*. Washington DC.: The Urban Institute Press, 1992.
102. Corazon RL, Lane PL. The Lived Experiences of Homeless Men. Journal of Community Health Nursing 1995;**12**(4):211-19.
103. Lindsay C. In a Lonely Place? Social Networks, Job Seeking and the Experience of
Long-Term Unemployment. Social Policy and Society 2010;**9**:12.
104. Manni J.L. Some Thoughts for the Unemployed on Avoiding the Trap of Social Isolation. Psychology Today 2012.
105. van der Heide I, van Rijn RM, Robroek SJW, et al. Is retirement good for your health? A systematic review of longitudinal studies. BMC Public Health 2013;**13**.
106. Kirkevold M, Moyle W, Wilkinson C, et al. Facing the challenge of adapting to a life 'alone' in old age: the influence of losses. J Adv Nurs 2013;**69**(2):9.
107. Coyle CE, Dugan E. Social Isolation, Loneliness and Health Among Older Adults
J Aging Health 2012;**24**:17.
108. Wilson D.M., Harris A., V. H, et al. Upstream thinking and health promotion planning for older adults at risk of social isolation. International Journal of Older People Nursing 2011;**6**:6.
109. Banks J, Nazroo J, Steptoe A. The dynamics of ageing: Evidence from the English Longitudinal Study of Ageing 2002-10 (Wave 5). ESLA 2012.
110. Beach B, Bamford S-M. Isolation: the emerging crisis for older men. ILC-UK 2014:60.
111. Khan O. Loneliness and older people from BME groups: challenging misconceptions and stereotypes. Campaign to End Loneliness 2014.
112. Victor CR, Burholt V, Martin W. Loneliness and Ethnic Minority Elders in Great Britain: An Exploratory Study. Journal of Cross-Cultural Gerontology 2012;**27**(1).
113. Sachragda A. Dementia Care in London. IPPR 2011:25.
114. Department of Health. Long-term conditions compendium of Information: 3rd edition. In: Health Do, ed., 2012.
115. Hewitt M, Rowland JH, Yancik R. Cancer survivors in the United States: Age, health, and disability. Journals of Gerontology - Series A Biological Sciences and Medical Sciences 2003;**58**(1):82-91.
116. Deckx L, van den Akker M, Buntinx F. Risk factors for loneliness in patients with cancer: a systematic literature review and meta-analysis. European journal of oncology nursing : the official journal of European Oncology Nursing Society 2014;**18**(5):466-77.
117. Wells M, Kelly D. The loneliness of cancer. European Journal of Oncology Nursing 2008;**12**(5):410-11.
118. MacMillian Cancer Support. Facing the Fight Alone: Isolation among cancer patients. 2013.
119. Tomaka J, Thompson S, Palacios R. The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. J Aging Health 2006;**18**(3):359-84.

120. Harris PB, Caporella CA. An intergenerational choir formed to lessen Alzheimer's disease stigma in college students and decrease the social isolation of people with Alzheimer's disease and their family members: a pilot study. Am J Alzheimers Dis Other Demen 2014;**29**(3):270-81.
121. Kane M, Cook L. Dementia 2013: The hidden voice of loneliness. Alzheimer's Society 2013:78.
122. Lyketsos C, Steinberg M, J. T. Mental and behavioral disturbances in dementia: findings from the Cache County Study on Memory in Aging. The American journal of psychiatry 2000;**157**(5):6.
123. Neri AL, Yassuda MS, Fortes-Burgos AC, et al. Relationships between gender, age, family conditions, physical and mental health, and social isolation of elderly caregivers. International psychogeriatrics / IPA 2012;**24**(3):472-83.
124. ONS. Full story: The gender gap in unpaid care provision: is there an impact on health and economic position?, 2013.
125. Robison J, Fortinsky R, Kleppinger A, et al. A broader view of family caregiving: effects of caregiving and caregiver conditions on depressive symptoms, health, work, and social isolation. The journals of gerontology Series B, Psychological sciences and social sciences 2009;**64**(6):788-98.
126. Hawthorne G. Measuring Social Isolation in Older Adults: Development and Initial Validation of the Friendship Scale. Social Indicators Research 2006;**77**(3):521-48.
127. Gouda K, Okamoto R. Current status of and factors associated with social isolation in the elderly living in a rapidly aging housing estate community. Environmental health and preventive medicine 2012;**17**(6):500-11.
128. Press V. Fuel Poverty and Health: A guide for primary care organisations, and public health and primary care professionals. National Heart Forum, the Eaga Partnership Charitable Trust, the Faculty of Public Health Medicine, Help the Aged and the Met Office, 2003.
129. UCL Institute of Health Equity. The health impacts of cold homes and fuel poverty. Secondary The health impacts of cold homes and fuel poverty 2011. www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty.
130. Dickens et al. Interventions targeting social isolation in older people: a systematic review. BMC Public Health 2011;**11**.
131. Glazier R, Elgar F, Goel V, et al. Stress, social support, and emotional distress in a community sample of pregnant women. Journal of Psychosomatic Obstetrics & Gynecology 2004;**25**(3-4):247-55.
132. The Institute of Health Equity. Good quality parenting programmes and the home to school transition, 2014.
133. Incredible Years. Pre-school basic curriculum. Secondary Pre-school basic curriculum. http://incredibleyears.com/programs/parent/preschool-basic-curriculum/
134. Foundation EI. Incredible Years Basic Pre-School Program. 2014.
135. Birth Companions. Birth Companions External Evaluation. Birth Companions 2007.
136. Institute of Health Equity. Local action on health inequalities: Building children and young people's resilience in schools. PHE and UCL IHE, 2014
137. Family and Schools Together Family and Schools Together home page.
138. The Anti-Bullying Alliance. http://www.anti-bullyingalliance.org.uk/.
139. Schools for All: Including disabled children in education. Save the Children 2002.
140. Department for Education. Preventing and tackling bullying: Advice for headteachers, staff and governing bodies. 2014
141. Rigby K. Bullying Interventions in schools: Six major approaches. 2012.
142. Wright S, Lister J. Evaluation of EIS and Show Racism the Red Card Schools' Competition 2003 to 2008. Glasgow: Fair Pley, 2009.
143. Bracknell Forest Council. Taking Action Together: Bracknell Forest Anti-Bullying Strategy. Bracknell Forest Council, 2014.
144. Department of Health. Supporting the health and wellbeing of young carers. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299270/Young_Carers_pathway_Interactive_FINAL.pdf.
145. Department of Health. Getting it right for children, young people and families. https://www.gov.uk/government/publications/getting-it-right-for-children-young-people-and-families, 2012.
146. Bristol Uo. Outdoors and Active. http://playingout.net/wp-content/uploads/2015/04/Bristol-University-Outdoors-And-Active-Evidence-Briefing.pdf.
147. http://playingout.net/. Secondary http://playingout.net/.
148. Gill T. Hackney Play Streets Evaluation Report. http://www.hackney.gov.uk/Assets/Documents/play-streets-evaluation-report.pdf, 2015.
149. Bloomer E. Local action on health inequalities: Increasing employment opportunities and improve workplace health IHE and PHE 2014.
150. The Social Innovation Project. SOS Project Evaluation. Secondary SOS Project Evaluation 2006. http://site.stgilestrust.org.uk/stats-and-info/p217898-reformed-gang-members-are-the-key-to-the-sos-project-s-success.html.

151. Martin Knapp, Annette Bauer, Margaret Perkins, et al. Building community capacity: making an economic case PRSSI 2010.
152. Bromley by Bow Centre: http://www.bbbc.org.uk/.
153. Age UK. Loneliness and Isolation Evidence Review. 2010:30.
154. Fund BL. Fulfilling Lives: Ageing Better Reducing social isolation among older people in England. 2015.
155. Varley E, Murfin M. An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing. In: NHS, ed., 2014.
156. West Midlands Fire Service. Accidental Fire Deaths in the Black Country North: Analysis of Fire and Casualty data to identify geographical areas and groups of the population most at risk of accidental dwelling fires in the Black Country North Command Area, 2014.
157. West Midlands Fire Service. Improving Lives to Save Lives: WMFS, 2014.
158. Relate. From notes taken at a meeting with a Relate policy officer 2015.
159. Spielhofer T, Corlyon J, Durbin B, et al. Relationship Support Interventions Evaluation, 2014.
160. Clift S. Creative arts as a public health resource: moving from practice-based research to evidence-based practice. Perspectives in Public Health 2012;**132**(3):7.
161. Hallam S, Creech A, Gaunt H, et al. Music for Life Project: The Role of Participation in Community Music Activities in Promoting Social Engagement and Well-Being in Older People. Sheffield: New Dynamics of Aging, . 2011.
162. Murcia CQ, Kreutz G, Clift S, et al. Shall we dance? An exploration of the perceived benefits of dancing on well-being. Arts & Health: An International Journal for Research, Policy and Practice 2010;**2**:14.
163. Centre for Social Justice. Linkage Evaluation, 2013.
164. Royal Volunteer Society. Royal Volunteer Society: Social Return of Investment Evaluation, 2011.
165. Susan Kenyon, Glenn Lyons, Rafferty J. Transport and social exclusion: investigating the possibility of promoting inclusion through virtual mobility. Journal of Transport Geography 2002;**10**(3):12.
166. NSPCC. Can I Tell You Something: What's Affecting Children in 2013. NSPCC 2013.
167. Knapp M, Bauer A, Perkins M, et al. Building community capacity: Making an economic case. Personal Social Services Research Unit (PSSRU) Discussion Paper 2772. Secondary Building community capacity: Making an economic case. Personal Social Services Research Unit (PSSRU) Discussion Paper 2772 2010. http://www.pssru.ac.uk/pdf/dp2772.pdf
168. South J. A guide to community-centred approaches for health and wellbeing. Public Health England 2015.
169. Cattan M. Supporting Older People to Overcome Social Isolation and Loneliness: Help the Aged, 2002.
170. Popay J, Attree P, Hornby D, et al. Community engagement in initiatives addressing the wider social determinants of health: A rapid review of evidence on impact, experience and process. NICE 2007.