University of
Reading

TACKLING LONELINESS AND SOCIAL ISOLATION IN READING, ENGLAND

Olivia Bridger and Ruth Evans

Research findings of the Loneliness and Social Isolation in Reading research project funded by the Health and Wellbeing Team, Reading Borough Council and the Participation Lab, University of Reading.

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Participation Lab Reports

Participation Lab Reports are intended to present our research results to as wide an audience as possible and may contain preliminary research findings or highlight results of relevance to policy and practice.

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EXECUTIVE SUMMARY

Introduction

Tackling loneliness has become a key priority for local and central government in England in recent years, with the publication of the Government's Strategy for Tackling Loneliness launched in October 2018, following the appointment of a Minister for Loneliness earlier in the year. Following the establishment of the Reading Loneliness and Social Isolation Multi-Agency Steering Group in 2017, the Health and Wellbeing Team and Steering Group identified a need for more in-depth understanding of the dynamics of loneliness and social isolation in Reading and best practices which may help to prevent and tackle it. The Participation Lab was commissioned to undertake this qualitative study, building on the quantitative survey of Reading residents previously conducted by Reading Voluntary Action (2017) and the Needs Analysis (2018) prepared for the Steering Group.

Research aims

The overarching aim of the study was to provide an in-depth understanding of the dynamics of loneliness and social isolation in Reading and to identify best practices which may prevent and tackle it.

The key research questions guiding the study were:

1 Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?

2 Why are particular groups vulnerable to loneliness and social isolation?

3 How does loneliness and social isolation affect people's health and wellbeing?

4 Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?

5 How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future?

Research methods

This research used a qualitative methodology to explore in depth the perspectives of practitioners and the lived experiences of different groups of service users, volunteers and community members. Semi-structured interviews were conducted with a total of 24 practitioners/service providers from 21 different voluntary and community organisations and statutory providers in Reading. Six focus groups were conducted with a total of 65 participants who were service users, peer support volunteers and members of the community in Reading, comprising groups of Deaf and hearing impaired people, older carers, peer support volunteers with experience of mental illness, people at risk of homelessness, mothers, and refugees and asylum-seekers.

Key findings

The research found a complex interaction between societal, situational and personal risk factors and barriers that prevent people from developing good social connections and networks in Reading, confirming national and international research evidence on the dynamics of loneliness and social isolation. It revealed how, for example, cuts in public services or barriers to statutory service provision may further marginalise people who are already vulnerable to loneliness due to their particular circumstances, such as mental health challenges, disability, ageing and loss of mobility, caring responsibilities, living alone or other significant changes, disruptions or transitions over the lifecourse.

The research identified a number of best practices in alleviating and preventing loneliness and social isolation among statutory and third sector organisations working with vulnerable groups and community members in Reading. These include:

- Specialist support and safe spaces;
- Focused group activities;
- Making services and activities socially, financially and physically accessible;
- Advocacy and assistance 'taking first steps';
- Peer support, befriending and volunteering;
- Signposting to 'someone to talk to';
- Support from healthcare professionals;
- Raising awareness about loneliness, isolation, social anxiety and mental health;
- Befriending, good neighbourliness and faith communities.

Recommendations for action

Best practices for reducing LSI need to be specifically targeted to meet the diverse needs of the people most at risk of loneliness and social isolation according to socio-economic, geographical, gender, age and ethnicity differentials, in addition to situational and personal factors, including immigration status, homelessness, drug and alcohol addiction, mental health, disability, loss of mobility and long term illness, caring responsibilities, living alone, lifecourse transitions and so on.

To ensure that best practices in alleviating and preventing loneliness and social isolation are strengthened, enhanced and developed in the future, this project has identified the following recommendations for action:

- **Raising awareness about loneliness and social isolation (LSI) and its links to health and wellbeing among statutory and voluntary and community sector service providers, employers, schools, members of the public**
- **Greater provision of specialist support services for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends**
- **Fostering more collaborative working 'joined-up' thinking and signposting between organisations, Reading Borough Council and primary healthcare providers**
- **Increasing the affordability and social accessibility of transport, including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives**
- **Developing and supporting peer support initiatives and befriending and volunteering schemes**
- **Fostering good neighbourliness, supportive faith communities and community development**
- **Providing more accessible information, communication and promotion of activities and services in appropriate formats.**

Finally, despite distinctions between the concepts of 'loneliness' and 'social isolation' being widely recognised in the literature, in this research, we often found the two concepts being used interchangeably among practitioners and service users. The government strategy published in 2018 focuses on loneliness, rather than loneliness and social isolation, with accompanying guidance about how to measure loneliness and resources to tackle it. Reading Borough Council's multi-agency steering group may wish to consider having a clearer focus on alleviating and/or preventing 'loneliness', specifically, as the work develops in future.

1. INTRODUCTION

Tackling loneliness has become a key priority for local and central government in England in recent years, with the publication of the Government's Strategy for Tackling Loneliness launched in October 2018, following the appointment of a Minister for Loneliness earlier in the year. The policy focus on loneliness was largely spearheaded by the work of the late Jo Cox, Member of Parliament, and the Commission for Loneliness established after her death that sought to continue the work she started. As the Government Strategy document recognises, loneliness is not new, but there is an increasing body of evidence pointing to the negative effects of loneliness on people's social wellbeing, in addition to their physical and mental health (Department for Digital, Culture, Media and Sport, 2018).

This policy emphasis on loneliness and social isolation, in combination with substantial research considering its relationship with health and wellbeing, led to the identification of 'Reducing loneliness and social isolation' as one of Reading Borough Council's (RBC) eight priorities for Health and Wellbeing for 2017–2020. As part of the plan to address this issue, Reading's Health and Wellbeing Strategy outlined the need to focus on actions that would:

> *Improve our understanding of who in our community is most at risk from loneliness and develop a co-ordinated all-age approach to reach those most in need of support to connect or re-connect with their community; and*

> *Improve the quality of people's community connections as well as the wider services which help these relationships to flourish – such as access to transport and digital inclusion (RBC, 2017).*

Following the establishment of the Reading Loneliness and Social Isolation Steering Group, a multi-agency steering group formed in 2017, the Health and Wellbeing Team and Steering Group identified a need for more in-depth understanding of the dynamics of loneliness and social isolation in Reading and best practices which may help to prevent and tackle it. The Participation Lab was commissioned to undertake this qualitative study, building on the quantitative survey of Reading residents previously conducted by Reading Voluntary Action (RVA, 2017) and the Needs Analysis prepared by and for the Steering Group.

1.1 Aims and objectives

This report seeks to provide qualitative insights into a diverse range of people's experiences of loneliness and social support groups in Reading; to explore how existing third sector organisations and services working with a diverse range of clients aim to prevent and tackle loneliness and build social connections; and to identify best practices and priorities in preventing and tackling loneliness and social isolation in Reading. This report is intended to be used by local partners to develop strategies and plans, and to inform the development, delivery and funding of services that prevent and/or reduce loneliness and social isolation in Reading.

The overarching aim of the study was to provide an in-depth understanding of the dynamics of loneliness and social isolation in Reading and to identify best practices which may prevent and tackle it. The objectives of the Undergraduate Research Opportunities Programme (UROP) placement[1] were:

i   To review and synthesise existing literature.

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1   The fieldwork, analysis and part of the report writing was undertaken by Olivia Bridger, as part of a Participation Lab Undergraduate Research Opportunities Programme (UROP) project, University of Reading, supervised by Ruth Evans and Sally Lloyd-Evans, Participation Lab Leaders. Ruth Evans also analysed the data and co-wrote the report.

ii To use qualitative methods to investigate the views of local stakeholders and practitioners working in health and social care and the third sector in Reading, and to explore the experiences of particular groups of people who may be vulnerable to loneliness and social isolation.

iii To analyse the qualitative data.

iv To present the findings in an open access report.

The key research questions which the study sought to address were:

i Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?

ii Why are particular groups vulnerable to loneliness and social isolation?

iii How does loneliness and social isolation affect people's health and wellbeing?

iv Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?

v How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future?

2. WHAT IS MEANT BY LONELINESS AND SOCIAL ISOLATION?

This section gives an overview of the key themes and concepts used in the research and policy literature on loneliness and social isolation. While academic work in psychology has tended to focus on loneliness from the perspective of an individual's emotional state, sociological and social policy literature has focused more on social isolation and drawn attention to structural as well as relational and individual dimensions. There is a rapidly growing policy literature on loneliness and social isolation, with numerous reports published by third sector organisations, some of which focus on 'vulnerable' groups considered to be particularly at risk of loneliness, such as those experiencing mental illness, dementia, carers and so on. Few studies however have examined policies and practices that may help to tackle loneliness and social isolation. We identify existing definitions and concepts that are most relevant to our research questions.

2.1 Defining and measuring loneliness and social isolation

Although it is well documented and widely understood that the terms loneliness and social isolation differ, it is important to briefly define these two terms, and to consider the implications of these distinctions in meaning in the context of reducing loneliness and social isolation in Reading.

Although neither term has a universally accepted definition, loneliness is broadly considered to be a subjective, negative emotional state, whereby the social relationships an individual has are not consistent with the social relationships they desire (Asher & Paquette, 2003). Social isolation, however, is considered to be an objective, physical state whereby an individual has very limited social interactions and connections (Heinrich & Gullone, 2006). These distinctions in meaning underline the point that loneliness and social isolation are not synonymous, although the two concepts are related and are often considered together. An individual may feel lonely when surrounded by people they know. Equally, in some circumstances, an individual may have very few social interactions and be socially isolated, yet not feel lonely.

Social isolation is therefore considered to be quantifiable and more easily measured, as it more directly concerned with the number (opposed to quality) of an individual's encounters. Social isolation is however usually considered a risk factor for loneliness.

Loneliness is generally considered to be a 'gnawing emotional state', and a psychological consequence of social isolation. Weiss' (1973) early work on loneliness categorises two dimensions of loneliness; emotional loneliness, and social loneliness. Emotional loneliness refers to a lack of close, intimate relationships with another person and is associated primarily with issues of attachment. Social loneliness is concerned with a lack of a network of social relations and individuals with whom they share a common interest, and is in many ways more closely linked to the notion of social isolation. Young (1982) suggests that three types of loneliness exist:

i   Transient loneliness: a very brief or short term experience encountered by most people in their everyday lives.

ii Situational loneliness: a medium to longer term experience encountered by individuals who have previously had satisfying relationships that have been affected by life events.

iii Chronic loneliness: an enduring experience of loneliness, whereby an individual has been without a fulfilling social relationship for over two years.

Academic studies specifically focused on loneliness from the 1970s onwards have largely been conducted by psychologists, although studies of people's social networks and connections which are informed by a sociological and social policy perspective have

increased significantly in recent years. The psychological literature generally regards loneliness as a personal and individualised experience, which means that unlike social isolation, it is difficult to quantify. Nonetheless, there are two key measurement scales, developed by psychologists, which have been used to measure loneliness.

The UCLA scale was published in 1978 and has been updated three times since its publication, most recently revised in 1996 (Russell, et al., 2010). The UCLA 3-item scale works by asking respondents how frequently they experience the following statements, with responses of 'hardly ever', 'some of the time' or 'often':

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Similarly, the De Jong Gierveld 6-item loneliness scale, based on the work of Weiss, presents the following statements:

- I experience a general sense of emptiness.
- There are plenty of people I can rely on when I have problems.
- There are many people I trust completely.
- I miss having people around me.
- There are enough people I feel close to.
- I often feel rejected.

Respondents are asked to respond with 'Yes', they feel this, 'No', they don't or 'More or less' (Campaign to End Loneliness, 2015).

At the request of supporting organisations, the Campaign to End Loneliness developed its own loneliness measurement tool (Campaign to End Loneliness, 2015). The tool builds on the UCLA and De Jong Girveld scales and presents the following statements:

- I am content with my friendships and relationships.
- I have enough people I feel comfortable asking for help at any time.
- My relationships are as satisfying as I would want them to be.

Respondents are then asked whether they 'strongly agree', 'disagree', 'neutral', 'agree', 'strongly agree' or 'don't know'.

The more positive statements used in the Campaign to End Loneliness scale focus more on people's social connections and relationships than the earlier scales. They appear to be informed more by a resilience perspective that focuses on strengths rather than adopting a solely individualised, psychological deficit model of loneliness.

As part of the government's Loneliness Strategy, the Office for National Statistics (ONS) (2018a) undertook a programme of scoping work and consultation with experts on existing approaches to loneliness measurement. They suggest that the 'gold standard' is to use both direct and indirect measures of loneliness in national surveys where possible and identified recommended measures of loneliness for adults and children (ONS, 2018a), as seen in Tables 1 and 2.

Table 1:
Recommended measures of loneliness for adults (Office for National Statistics, 2018a, p.4)

Measures	Items	Response categories
The three-item UCLA Loneliness scale	1. How often do you feel that you lack companionship?	Hardly ever or never, Some of the time, Often
	2. How often do you feel left out?	Hardly ever or never, Some of the time, Often
	3. How often do you feel isolated from others?	Hardly ever or never, Some of the time, Often
The direct measure of loneliness	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

The ONS (2018a, p.5) note that there is more robust and extensive data on loneliness in older people, but much less for other age groups including children and young people: "Much less is known about why younger people become lonely and how this compares with factors associated with loneliness in older people. An adapted version of the measures is recommended for use with children and young people aged 10 to 15 years, with the wording changed to a more 'plain English' version, as shown in Table 2.

Table 2:
Recommended measures of loneliness for children (Office for National Statistics, 2018a, p.5)

Measures	Items	Response categories
The three-item UCLA Loneliness scale for children	1. How often do you feel that you have no one to talk to?	Hardly ever or never, Some of the time, Often
	2. How often do you feel left out?	Hardly ever or never, Some of the time, Often
	3. How often do you feel alone?	Hardly ever or never, Some of the time, Often
The direct measure of loneliness	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

All of these measurement tools are primarily focused on an individual's subjective experience, however, and are not very helpful in understanding the relational or wider structural factors that may influence why someone feels lonely or becomes socially isolated. Relational factors may include for example, relationship breakdown, divorce, bereavement, conflict with family members, neighbours or friends, interpersonal violence, isolation, stigmatisation and harassment of particular groups and so on. Structural factors may include financial pressures, unemployment, limited access to healthcare, community

resources and support, limited or inaccessible transport infrastructure, inaccessible public venues and facilities for disabled people, children, older people, hostile public and media environment towards refugees and other migrants and other groups, austerity and cuts to public services and so on.

For the purpose of this report, we adopt the definitions of loneliness and isolation used by Victor, Mansfield, Kay and colleagues (2018, p.8) in their review of the effectiveness of interventions to address loneliness. Social isolation is defined as "having few and infrequent social ties", which is an objective quantifiable construct. This contrasts with loneliness, which is the "outcome of an individual's evaluation of their social relationships as not meeting their expectations". Thus loneliness and isolation are distinct but related concepts and "are not linguistically, empirically or conceptually interchangeable". Despite this, the multi-agency steering group in Reading has a focus on loneliness and social isolation and so the dual term 'loneliness and social isolation' or LSI is used in this research.

2.2 Understanding the factors that influence loneliness and social isolation

The Office for National Statistics (ONS) (2018b) report produced from the 2016–17 CAL survey considered 34 characteristics and circumstances to assess who is most likely to experience loneliness. Of the 34 considered in its analysis, the following 13 characteristics were found to have an impact on loneliness: age; sex; marital status; respondent and partner's (if applicable) gross income; disability status (self-reported); general health (self-reported); number of adults in the household; caring responsibilities; whether chat to neighbours more than to just say hello; feeling as though you belong to a neighbourhood; satisfaction with local area as a place to live; the number of years lived in local neighbourhood; how often meet up in person with family members or friends.

The ONS (2018b) report identified biographical profiles of those who may be the loneliest:

- widowed older homeowners living alone with long-term health conditions.
- unmarried, middle-agers with long-term health conditions.
- younger renters with little trust and sense of belonging to their area.

Additionally, the multi-agency Campaign to end Loneliness (CEL, 2019a) considers there to be two broad categories of risk factors, that is 'personal' and those pertaining to 'wider society'. The 'personal' risk factors include: Poor health; Sensory loss; Loss of mobility; Lower income; Bereavement; Retirement; Becoming a carer; Other changes (for example, giving up driving). The factors relating to 'wider society' include: Lack of public transport; Physical environment (no public toilets or benches); Housing; Fear of crime; High population turnover; Demographics; Technological changes.

The risk factors identified in the national policy reports discussed above are broadly aligned to those outlined in RBC's (2018) Loneliness and Social Isolation Needs Analysis, which identified the following themes as risk factors: Age; Living alone; Life events; Income; Transport; Health.

Due to the implications LSI has on health and wellbeing there is a significant body of research that attempts to unpack the risk factors and causes of LSI. However, academic work on this is limited, with the majority of research being undertaken by local and central government, and NGOs. One of the most substantive piece of social science academic research that considers risk factors for LSI is Victor and colleagues' (2005) report, which identified 5 sets of risk factors: 1. Socio-demographic; 2. Material Circumstances; 3. Health Resources; 4. Social Resources; 5. Life Events. This study however, only considers the experience of loneliness amongst older people, therefore, although potentially cross cutting, the findings of this study cannot be used to consider loneliness across the lifecourse.

A key point raised by Victor and others (2005) is that within existing literature, there is limited consideration of protective factors, characteristics, and circumstances that prevent individuals from becoming lonely. Victor and others (2005) argue that this oversight is detrimental to efforts made to reduce loneliness, and that supporting individuals so that they do not become lonely or isolated is more effective than tackling loneliness once it has taken hold. This suggests that a resilience perspective may be helpful in understanding the protective mechanisms that enable people to thrive and achieve positive outcomes despite experiencing difficult circumstances.

Within the sociological and social policy literature, the concept of social capital has been widely used to examine people's social connections and networks, levels of trust and so on which act as resources within communities. As Lovell (2009, p.781) observes, social capital has been proposed as a "cure-all for society" as researchers emphasise positive relationships between social capital and variables such as health, socio-economic status and confidence in government. Robert Putnam (2000), one of the best known proponents of social capital, refers to social capital as connections among individuals and the social networks and norms of reciprocity and trustworthiness that arise from them (Franklin, 2003). A distinction is often drawn between 'bonding' (within group) social capital, which tends to be selective, excluding those who differ from an individual or group; and 'bridging' (between group) social capital, which crosses social divisions to encourage societal inclusiveness (Lovell, 2009).

In the context of loneliness and isolation, the focus would therefore be on how people may be unable to develop beneficial social networks, reciprocity and relationships of trust within their group (bonding social capital) and/or between groups (bridging social capital) within communities. In a study in western Finland, Nyqvist and others (2016) found that frequent loneliness (defined as experienced often or sometimes) was higher among younger people (39.5%) compared to older people (27.3%) and that low levels of trust were linked to loneliness across four age groups. They conclude that low social capital, especially in terms of low trust, may be a risk factor for loneliness.

The concept of social capital has, however, been widely critiqued by social scientists. There is a lack of consensus on how to define and measure 'social capital', and related notions, such as 'social networks' (Clark, 2009; Lovell, 2009). Commentators have argued that the concept "barely touches the complex reality and the diversity of people's lives" (Franklin, 2003, p.351). A broader, more liberal approach might focus on a range of social processes, recognising how individuals in contemporary societies adapt to, and live with, the insecurities that come with social change (Beck and Beck-Gernsheim, 2002). The community development literature, with its established themes of community capacity building and empowerment, may be more appropriate in practical work to tackle loneliness, marginalisation and the isolation of particular groups and individuals at the grassroots level (Lovell, 2009).

From a psychological perspective, Heinrich and Gullone (2005) draw on Jones' (1982) 'cycle of loneliness' and concluded that lonely people consider more things to be of a threat than non-lonely people, with links to paranoia and negative social behaviours. Jones (1982) argues that the behaviour patterns of those who are lonely can be detrimental to social communications, making forming relationships difficult and perpetuating the cycle of loneliness and isolation. However, as more recent research has demonstrated, the negative effects of loneliness are not due to unusual features or behaviours of those who are lonely, but rather the effect that loneliness has on normal people (Cacioppo & Cacioppo, 2018). This suggests that loneliness is a normal part of life. Furthermore, recent reports and media broadcasts have pointed out that loneliness is not necessarily always negative; there can be positive benefits associated with loneliness. This suggests that a resilience approach that emphasises strengths may also be helpful when considering loneliness and social isolation.

Recent neurological research has begun to consider how loneliness may be more than a risk factor for physical and mental ill health, and could itself be considered a heritable trait due to differing brain structures (Kanai and others, 2012). Cacioppo and others (2014) hypothesised that some people are genetically more susceptible to loneliness, and that loneliness can be considered to be a trait that arises due to the expression of a specific gene. It is however important to note neurological and biological studies are only just starting to examine these potential risk factors. Such studies often conflict with the broad consensus of policymakers and social scientists that loneliness and isolation need to be considered as linked to personal, relational and societal factors rather than regarding these as simply biologically determined (Cacioppo and Boomsma, 2013).

2.3 The effects of loneliness and social isolation on health and wellbeing

The effects that loneliness and social isolation may have on health and wellbeing are extensive and well documented in the medical and psychological literature. Numerous studies identify a causal relationship between heightened levels of loneliness and social isolation, and poorer mental and physical health and wellbeing.

Holt-Lunstad and others' 2010 study suggest loneliness is as detrimental to health as smoking 15 cigarettes per day (Holt-Lunstad and others, 2010), and their 2015 study suggests loneliness increases mortality by up to 26% (Holt-Lunstad and others, 2015). Additionally, loneliness is considered a risk factor for cardiovascular disease (Valtorta and others, 2016) and high blood pressure (Hawkley and others, 2010). The onset of disability (Lund and others, 2010), frailty (Gale & Cooper, 2018) and clinical dementia (Holwerda and others, 2014) occurs quickest for the loneliest individuals, and the loneliest are more likely to use emergency services unnecessarily (Geller and others, 1999).

In addition to the effects on physical health, loneliness has significant implications for mental wellbeing. Heightened levels of loneliness are linked to depression across age groups (Bhagchandani, 2017) (Cacioppo and others, 2006), and specifically in the elderly cognitive decline (James, and others, 2011), and completed suicide (O'Connell and others, 2004). Equally, loneliness in young people is linked to poor emotional development (Besevegis & Galanaki, 2010) and lower academic achievement (Margalit, 2010).

Good social networks have long been identified as a key determinant of health (Whitehead & Dahlgren, 1991), and the findings of these, and many other studies clearly demonstrate that an absence of good social networks is more than undesirable. Loneliness and social isolation are now regarded a public health issue, which warrant research that identifies risk factors for its progression and best practices which reduce its occurrence.

Although understanding causal mechanisms or how loneliness and social isolation progress over a period of time are not within the scope of this study, this research seeks to understand which factors may contribute to feelings of loneliness and social isolation, with reference to particular vulnerable groups in Reading.

2.4 Vulnerabilities of particular groups to loneliness and social isolation

As numerous policy reports across a range of social groups have argued, loneliness occurs across the lifecourse and affects different people in different ways, depending on their particular circumstances, characteristics and barriers to social inclusion. Carers who support people who are older disabled or seriously ill have been identified as particularly vulnerable to loneliness and isolation. Carers UK's (n.d.) State of Caring 2017 survey, for example, found that 81% of carers felt lonely or socially isolated as a result of their caring role, with this figure rising to nearly 86% for carers providing 50 hours a week. Almost half

of carers surveyed (48%) said not having time to spend on social activities had made them feel lonely or isolated, and almost half (49%) identified the difficulty of not being able to get out of the house much, as causes of their loneliness and social isolation. Over half (54%) of carers reported that regular breaks from their caring role would help to make them feel less lonely, and 52% identified a need for more understanding from society. A third (30%) of those in work and care said that more understanding at work would help while a third (31%) said support with paying for social activities would help.

Disability charity Sense's (n.d) report for the Jo Cox Commission on Loneliness suggests that disabled people are more likely to be chronically lonely. Having one or more impairment increases the risk of loneliness and social isolation, with over half of disabled people (53%) reporting that they feel lonely, while the figure rises to 77% for young disabled people. Furthermore, almost a quarter of disabled people (23%) say they feel lonely on a typical day. The report discusses the particular dynamics of loneliness for people with a wide range of impairments and identifies the causes of loneliness for disabled people in terms of practical barriers to establishing social connections such as physical activity transport premises or issues related to the nature of conditions themselves. Stigma and poor public attitudes were also directly related to feelings of isolation among disabled people, a finding that Olivia Bridger (2019) also explored in her research with physically disabled people in Reading. The following areas are identified as crucial in reducing LSI among disabled people:

- **increasing awareness** through improving social attitudes and increasing professional awareness and support
- **improving access to services** by enabling independence through access to social care and provide access to services that respond to loneliness
- **tackling poor accessibility** by ensuring physical access to communities, providing accessible transport and addressing the digital divide
- **addressing financial barriers** by providing fair and adequate financial support and the increasing access to employment and work experience.

A Mental Health Foundation survey in 2010 found that 42% of adults in the UK have felt depressed because they felt alone, demonstrating that loneliness is closely related to people's mental health. The figures were higher among women (47%, compared to 36% men) and higher among those aged 18 to 34 (45%, compared to 31% of those over 55). If Sense (n.d) also recognise the two-way relationship between mental health and loneliness: LSI can have a significant impact on a person's mental health, and mental health problems often lead to feelings of isolation. In particular, mental health problems can lead to low self-esteem and poor self-image. For people who experience conditions such as phobias, social contact or leaving the house may be especially difficult. Some people find the medication they take for their condition can affect the way they see themselves or the way they communicate, leading to people worrying about others judging them. People with mental health conditions are less likely to be in work which reduces the availability of support networks people have access to. The Sense (n.d) report also suggests 9 out of 10 people with mental health problems experience social stigma and discrimination impacts on their level of social connectedness.

In terms of children's and young people's vulnerability to loneliness, an ONS (2018c) report found that 11.3% of children aged 10–15 said that they were "often" lonely, while 9.8% of young people aged 16–24 said that they were "often" lonely. Children in lower socio-economic groups and those who had difficult social relationships with family and friends were more vulnerable to loneliness. For example, children who reported "low" satisfaction with their relationships with family and friends were also more likely to say they were "often" lonely (34.8% and 41.1%, respectively), while 27.5% of children who received free school meals said they were "often" lonely, compared with only 5.5% of those who did not (ONS,

2018c). Action for Children's (n.d.) report on the impact of loneliness in children and young people and families identifies those most at risk, including children who experience neglect, children in care, disabled children, young parents and parents with mental health problems. The report recommends:

- central and local government recognise that loneliness is a problem that affects children and young people and families and measures to address loneliness must not be restricted to provision for the older generation

- central and local government support to extend the provision of services that reduce isolation for children and young people and families, particularly for those most at risk. Examples cited include the continued funding of young carers support services, services for disabled children, children's centres and young parents support groups

- further research to measure loneliness and its impact on children and young people and families

- organisations providing social support services to children and young people and families to develop an understanding of loneliness and evaluate the impact of their services in reducing loneliness.

While much less attention has been paid to loneliness among Black, Asian and Minority Ethnic groups, research suggests a real problem of 'hidden loneliness' among BME older people (Khan, n.d.). Acting Director of Runnymead, Khan's essay in the report on Loneliness and Diversity suggests the causes of this are related to the fact that the vast majority of the current UK BME population aged over 65 were born overseas and their experiences of ageing – and of loneliness – are affected by their migration history. They do not necessarily share this history with other members of their household and family, who are much more likely to have been born and raised in the UK. Older BME people are also much more likely to live in poverty, as with minority ethnic groups generally, this is explained both by their lower wages and their higher likelihood of unemployment, meaning they are less able to save for retirement. Khan identifies that language issues may also be important factors, since older BME people may be more likely to have poor English and research suggests that those experiencing dementia often lose whatever second-language ability they had.

Khan (n.d.) identifies several areas that need to be strengthened including: language provision, including translation services and better support for English for Speakers of Other Language programmes; care provision, where services are not always suitably developed to meet the needs of older minority ethnic groups, in terms of language needs, but also wider cultural needs and preferences; and activities that bring people together, such as lunch clubs or exercise groups for older people, with programmes tailored to people from particular ethnic backgrounds and events supporting mixed interactions. The accessibility of services aimed towards the general population is also highlighted to ensure that they are sensitive to the needs of older BME people and are affordable.

Reading Borough Council's (2018) Needs Analysis concluded that individuals may be at greater risk of loneliness or social isolation in Reading if they: are single (have no current spouse or life partner); have recently experienced a significant change to their life, particularly a bereavement; are impeded by practical barriers including physical mobility or another limiting health condition or physical or learning disability, geographical or transport barriers, or lack of funds, time, energy and confidence; and lack social and economic resources. Local survey information also suggests that a recent move to the area (meeting the criteria for a significant change) may be a particular risk in Reading.

2.5 Best practices to prevent and reduce loneliness and social isolation

The UK Government's Strategy for Loneliness (Department for Digital, Culture, Media and Sport, 2018, p.67) has three overarching goals: "to catalyse a national conversation on loneliness; to build the evidence base on loneliness; and to drive a lasting shift in government so that relationships and loneliness are considered as a matter of course in policy-making". It identifies preliminary measurement areas for each of the goals.

The following Loneliness Framework (CEL, 2019b) is the strategic approach used by the Campaign to End Loneliness which sets out the interventions needed to tackle loneliness, and their strategic implementation.

Figure 1. **Campaign to End Loneliness' (2019) Loneliness Framework**
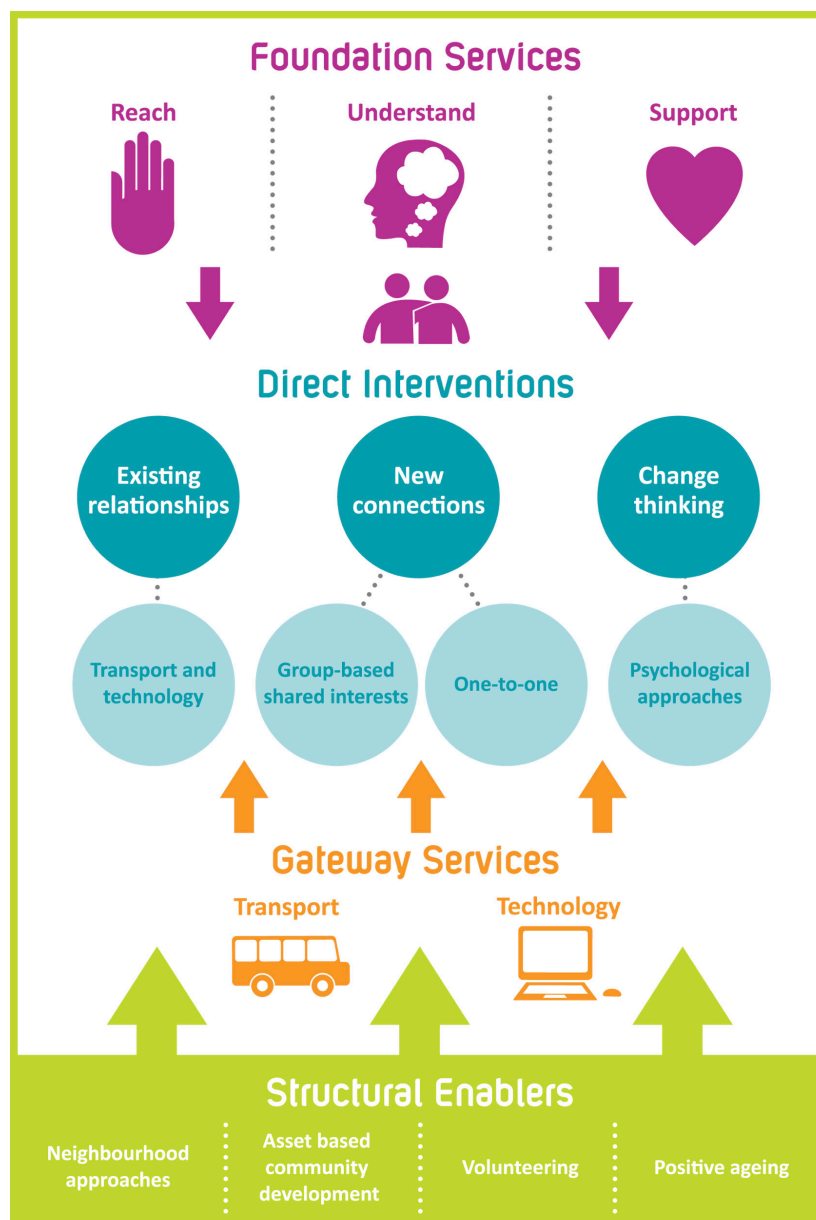
1 **Foundation services**
   Focus on reaching, understanding, and supporting.

2 **Direct Interventions**
   Directly improve the quantity/quality of an individual's interactions. Focuses on three areas: Supporting and maintaining existing relationships, which is supported by transport and technology; supporting new connections, through group-based shared interests (identified as best when they focus on specific groups or when additional benefits are tagged on) or one to one approaches; and changing thinking through psychological approaches (such as mindfulness and Cognitive Behavioural Therapy).

3 **Gateway services**
   Technology and transport provisions improve an individual's ability to connect to services and the community's ability to provide them.

4 **Structural enablers** underpin the above three levels, since they create the right conditions and arrangements to reduce loneliness and emphasise how services are delivered. These range from neighbourhood approaches, asset-based community development, volunteering and positive ageing.

The Jo Cox Commission on Loneliness, made the following calls to action in 2017:

1 National Leadership, with a UK wide strategy, a lead minster and a family relationships test for new policy;

2 Measureable Progress, with a national indicator; and

3 Catalysing Action to stimulate solutions innovatively.

A point reiterated in the 2017 report is that action across all parts of the community is required and that everyone has their part to play to tackle loneliness and social isolation. The work of RVA, and Reading's Champions to End Loneliness are promising in this respect.

Victor and colleagues' (2018) review highlights the limited evidence from published literature about the effectiveness of interventions to address loneliness at all stages of the lifecourse, with the majority of published literature focusing on the 55 years and older age group. Nevertheless, their review of available literature suggests that programmes tailored to the circumstances and needs of individuals, specific groups or type of loneliness experience would be more likely to result in reductions in loneliness. They identify a number of mediating factors which are central to the development of successful loneliness interventions including: the development of companionship, supporting meaningful relationships and tailoring interventions to the needs of those for whom interventions are designed. In particular, the authors comment on the complexities of befriending (offering supportive reliable relationships usually in person and by volunteers), emphasising the need for appropriate promotion of interventions emphasising the development of meaningful relationships, rather than as 'loneliness' interventions, which may be both unappealing and stigmatising.

In terms of policy, Victor and colleagues (2018, p.6) call for a focus on person-centred and tailored loneliness interventions, which are designed for the specific needs of a targeted population defined in terms of sociodemographic, vulnerability or types of loneliness. They suggest the need to develop programmes to alleviate loneliness across the life course and with due attention to diverse population groups, social contexts and change over the life course. They also highlight the importance of promoting programs to alleviate loneliness which pay attention to the avoidance of stigma or the reinforcement of marginalisation and isolation. Programs are needed which emphasise meaningful relationships and improved social connections for those who are lonely or at risk of loneliness.

Victor and colleagues (2018, p.6) also raise broader points about the need for conceptual clarity in loneliness work; for policy support to develop social impact models of the processes and mechanisms by which loneliness interventions work; and for policy support for better evaluations and primary research in this field, including measures of costs.

2.6 Summary

This section has reviewed the academic and policy literature on the factors which appear to increase the risk of loneliness and social isolation, the vulnerabilities of particular social groups in the UK, the relationship between LSI and health and wellbeing, and policies and practices to address LSI. The complex and intersecting nature of many of the societal, situational and personal factors that lead to loneliness and social isolation suggests a need for a diverse range of services, community infrastructure and support that is tailored to the needs of people experiencing loneliness in Reading and to reduce isolation and prevent loneliness at an early stage, as we explore in Section 6. The next section gives an overview of the research methods used in this study.

3. RESEARCH METHODS

3.1 Introduction

This section gives an overview of the research methods used in this study. Given the quantitative data gathered in the Reading Voluntary Action (2017) survey, this research sought to use a qualitative methodology to explore in more depth the perspectives of practitioners and the lived experiences of different groups of service users, volunteers and community members.

3.2 Research methods

Semi-structured interviews were conducted with a total of 24 practitioners/service providers from 21 different voluntary and community organisations and statutory providers in Reading (a small number of interviews were with two practitioners). Six focus groups were conducted with a total of 65 participants who were service users, peer support volunteers and members of the community in Reading, comprising groups of Deaf and hearing impaired people, older carers, peer support volunteers with experience of mental illness, people at risk of homelessness, mothers and refugees and asylum-seekers.

Table 3:

Research methods used with different groups and numbers of participants in focus groups and interviews

Characteristics of group	Number of focus groups	Number of focus group participants	Number of practitioner interviews	Number of practitioner interviewees
Black, Asian & Minority Ethnicities			3	3
Refugees and asylum-seekers	1	25	1	1
Bereavement			1	1
Homelessness	1	5	1	1
Drug/Alcohol addiction & recovery			1	1
Mental health	1	3	3	3
Physical impairment			2	2
Sensory impairment	1	20	2	2
Learning disability and Autism			2	4
Dementia and life-limiting illness			2	2
Adult carers	1	7		
Young carers			1	1
Parents/mothers	1	5		
University students			1	1
Other third sector organisations			1	2
Total:	**6**	**65**	**21**	**24**

Table 3 above shows the diverse range of social groups who participated in focus groups or with whom practitioners worked. The selection of these groups for the sample was

informed by the literature review and existing contacts suggested by Reading Borough Council's Health and Wellbeing Team and the researchers. The purposive sample does not seek to be representative, but does provide depth of insight into a diverse range of perspectives and experiences of different social groups at risk of loneliness and social isolation in Reading.

As shown in Table 3, the number of focus group participants ranged from 3 peer support volunteers with experience of mental illness, to 20 Deaf and hearing impaired people and 25 refugees and asylum-seekers. However, in these larger focus groups, many participants observed rather than spoke themselves. A British Sign language interpreter was used in the focus group with Deaf people.

All interviews and most of the focus group audio recordings were transcribed in full. In the two large focus groups where the audio-recording was difficult to transcribe, 'notes and quotes' were written up by the researcher.

Thematic analysis of the interview and focus group transcription was undertaken using a sifting and sorting approach to identify the key themes. A summary document was produced for each interview and focus group to capture the key points, including examples and potential quotations to be used in the report.

Ethical approval for the project was obtained from the University of Reading Research Ethics Committee prior to the fieldwork and participants' views have been anonymized throughout this report.

3.3 Conclusion

This section has given an overview of the qualitative research methods used with participants in Reading. The following sections 4, 5 and 6 discuss and identify the key findings emerging from the data gathered for this project.

4. DYNAMICS OF LONELINESS AND SOCIAL ISOLATION IN READING

4.1 Introduction

This section discusses the dynamics of loneliness and social isolation in Reading, based on the experiences of community members, service users and volunteers from marginalised groups who received support from statutory and/or third sector organisations, in addition to the professional experiences of practitioners working with those who may be vulnerable to LSI in Reading. It focuses on the first research questions guiding the study: Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?

The analysis is structured according to understandings of the factors leading to LSI discussed in the research literature (see Section 2), focusing on societal factors, situational factors and personal factors.

4.2 Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections?

As expected, the research confirmed that the risk factors for LSI, and barriers which prevent people developing meaningful social connections, are complex and multifaceted. In an attempt to simplify what is a very complex topic, the factors mentioned and discussed during interviews and focus groups have been analysed according to the following spatial scales: societal, situational and personal. It is, however, important to note that these factors are interlinked and should not be viewed in isolation.

4.2.1 Societal factors

Societal factors encompass societal attitudes, changes or wider issues that were perceived to increase an individual's risk of loneliness or restrict their ability to develop meaningful social connections. Table 4 summarises the factors identified and the numbers of interviews or focus groups where these issues were mentioned, with an indication of which social group of focus group participants raised the issue given in brackets.

Table 4:

Perceptions of societal factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of interviews with practitioners where mentioned (n=21 interviews)	Focus groups where mentioned (n=6 focus groups)
Stigmatisation of particular groups	9	2 (homelessness; mental health)
Access to transport	4	2 (refugees; carers)
Cuts to public services & infrastructure	2	3 (homelessness; parents; carers)
Barriers in accessing statutory services	3	2 (homelessness; parents)
Internet and technological changes	3	2 (carers; parents)
Unsupportive workplace	1	2 (homelessness; parents)
Exclusion from job market	3	2 (refugees; homelessness)

Stigmatisation of particular 'vulnerable groups'

Lack of understanding and stigmatisation of particular 'vulnerable groups' was perceived by many practitioners and service users as a key issue which could result in significant loneliness and isolation. The effects of national policy and attitudes toward refugees, asylum seekers and other migrants was said to be key factors in these groups' isolation. For example, the 2016 Immigration Act was regarded as having *"really reinforced the hostile environment for asylum seekers"* (practitioner working with refugees). Equally, negative media coverage and public prejudice were perceived to be a key factor for loneliness because asylum seekers and refugees are:

> *a part of the population that are lambasted on the front of the Daily Mail every chance they get. Every crime that's committed in the area someone will blame on all the asylum seekers over here. They're very much pilloried by the state and by a lot of the press. So they're going to feel isolated and slightly paranoid.*

A hostile environment was also in evidence more broadly against Black, Asian and Minority Ethnic (BAME) groups, such as *"being asked to show your passport when you go to get medical service or when you call the police out"* (practitioner working with BAME groups). This led to minority ethnic groups who had previously been quite well integrated in Reading becoming *"more segregated and inward looking"* due to feeling more unsafe. As this practitioner commented:

> *[there are] women who now feel like they don't want to walk their children to school in the morning because they're at fear.. [of] a lot of verbal racism and hate crimes.[...] really low level but continuous bias and discrimination....[results in many BAME people becoming] more socially isolated and starting to only mix then more with their own communities".*

Negative public perceptions and racist, Islamophobic attitudes have major consequences for a sense of belonging, security and isolation of particular minority ethnic communities. Nonetheless a practitioner working with refugees and asylum seekers felt that Reading is a welcoming place, based on their positive experiences of working with a group of footballers who are refugees and asylum seekers within the mainstream local football league.

A lack of understanding and stigma was identified as affecting many vulnerable groups, not just migrants and BAME communities, such as people with learning disabilities, autism, mental illness and drug and alcohol addiction. One practitioner commented on the lack of understanding of autism behaviours: *"Everybody else will tut-tut because they're behaving differently"*.

Participants at risk of homelessness and those with mental health conditions highlighted the significant stigma surrounding mental health and fear associated with particular behaviours deemed problematic, such as hearing voices or experiencing anxiety in public spaces, which could lead to a loss of social relationships.

Women related their experiences of anxiety in public spaces:

Female participant: *I used to be terrified of people, particularly groups of people, and, yes, one of the hardest things I ever did when trying to get better was to go and sit in Broad Street. I wasn't alone, I had someone I trusted [...] I was an absolute ball of terror, [...] it was horrific....*

Female participant: *Then you're blamed for it. Generally, society would point you out, "Oh, she's a weirdo, look at her. Oh, she's behaving very oddly. We'd best stay clear of her."*

Participants found themselves being blamed by others (and also sometimes blaming themselves) for "isolating themselves" rather than a loss of social connections being seen as part of their mental illness.

A related research project conducted by Olivia Bridger (2019) explored the role that attitudinal barriers towards disability may play in contributing to feelings of LSI among physically disabled people in Reading. It concludes that attitudinal barriers to disability consolidate the exclusion of disabled people and inhibit their ability to develop and maintain meaningful social relationships that are essential for wellbeing and the prevention of loneliness. Attitudinal barriers impacted on some disabled people's self-confidence and mood to the point where they did not want to go out and engage in activities in the community.

Access to transport

The government's Loneliness Strategy identifies the importance of accessible and inclusive transport that "supports people's social connections and helps people be connected to their community" (Department for Digital, Culture, Media and Sport, 2018, p.36). RVA's (2017) survey in Reading identified transport as the third most important barrier that prevents people being more socially active (reported by 29% of respondents). Groups identified as most affected by transport issues included those in unstable/ temporary accommodation (50%), those who were 85 and older (48%), those who were unemployed (42%), those who lived alone (33%) and full time parents (32%).

In this research, refugees and asylum seekers highlighted the cost of transport as a barrier to their mobility and social participation, which could lead to being isolated and feeling lonely at home. They expressed a need for cheaper bus services, since they had to prioritise food and meeting their children's needs with the little income support they received. The travel expenses they received when attending refugee support group sessions were highly appreciated and enabled them to access English language classes and social activities, especially for children.

In the focus group with carers of older people with a range of long term conditions, many highlighted how helpful Readibus transport services were for older people with mobility impairments, particularly those living alone. However, there was a perception by one man caring for his wife with dementia that the service would not meet their needs because his wife was no longer able to be independent in town and remember where to meet to be picked up at a specific place. This perception is at odds with the service ReadiBus provides, which enables carers to travel on the bus with people with dementia and other impairments who need to be accompanied by a carer.

Cuts to public services and infrastructure

The impacts of austerity and cuts to public services, seen at both the national and local levels, were widely commented upon across the interviews and focus groups. A Syrian male refugee emphasised the crucial importance of national policy and provision of English language learning for migrants: *"Role of government is key. Five hours a week is not enough to learn English"*.

Spending cuts to local councils and voluntary and community services such as support groups were regarded as a key risk factor that increased people's loneliness and social isolation. For example, due to financial constraints, a practitioner working with blind and partially sighted people explained they *"recently had to restrict"* [attendance]....*the only way we can get these people in is to limit people* [attending] *to once a week"*.

Mothers commented on cuts to support groups and services that might help new mothers experiencing post-natal depression: "*I know we've got a lot of cuts that have taken place in Reading, support groups and whatever, but if we just tried to support each other more of*

sticking the boot in…"; "Or even if your doctor signposted it and gave you a number". They also highlighted the reduction in community centres in recent years: *"you used to have proper community centres, didn't you? But, again, cutbacks, they've taken a lot of them away"*.

Practitioners commented on how financial constraints had led to very limited knowledge about the specific needs of people with learning disabilities among social workers and a lack of awareness or joined up thinking about specialist support services that they could signpost people on to:

> *"They [Social workers] don't know anything about learning disability, they don't know the families, they don't know the person, and they don't know that there's Reading Mencap and Autism Berkshire out there, and CommuniCare, they just don't know what's out there. So, there is a huge lack of connectedness which, to me, has been caused by money".*

Carers of older people with disability or long term health conditions were particularly concerned about cuts to respite day care services:

Male participant: *I think an awful lot of things have been cut back.*

Female participant: *That's why it's always worrying about day care because that isn't mandatory. They can cut any service whether it's children or adults.*

Older carers also commented on cuts to Age UK's exercise classes, such as Zumba and Tai Chi, which they used to volunteer for.

Participants at risk of homelessness expressed concern about the sustainability of third sector support services they were currently receiving and emphasised the importance of consistency of support provided in a regular routine over time. As one woman commented: *"I'm a bit worried about the changes that are coming here, because my support worker is not going to be here anymore. It's scary that it's changing because you get into routine and you don't really know what to expect"*. Others also echoed these concerns in the light of negative experiences of NHS mental health services:

> *We're scared about when our time here comes to an end, what we'll be doing. It's a worry when it stops, because it's so good. It's the first thing that's really stuck with me. Most of the NHS and stuff, I've found they just write you off and they don't really give you the support. You just feel really hopeless and negative there (female participant at risk of homelessness).*

Similarly, local decisions around infrastructure and leisure facilities were regarded as being just as detrimental as national policy measures in terms of contributing to social isolation. For example, the removal of the St Mary's Butts pedestrian crossing was mentioned by two practitioners, because this decision reduced the mobility of visually impaired people and *"how they navigate the town"*. Equally, the significant reduction in public swimming facilities and other sports and leisure activities in the town and cuts to concessionary rates for accessing activities in recent years was mentioned in several interviews.

One practitioner highlighted the apparent contradiction in cuts to local services and the council's efforts to tackle loneliness and social isolation: "*The council… is rightly targeting tackling loneliness and isolation, but at the same time its doing other stuff that is the opposite to that, which you can't help because of budget restraints*". There was a recognition among many practitioners that reducing services to vulnerable groups was counter-productive, in terms of the long term impact on people's loneliness and social isolation. As one practitioner working with BAME groups commented: *"If we, as a society, do not look after our most vulnerable…. and we cut all of those services, then we are creating for ourselves a chronic problem of isolation and loneliness".*

Barriers to accessing statutory services

Several practitioners and service users pointed to barriers in accessing statutory services. For example, practitioners supporting people with learning disabilities commented on the difficulties service users faced in accessing doctor's appointments with a support worker:

> the doctor will only offer you an appointment at a certain time, on a certain day, and their support worker doesn't work then, so they're just going without appointments at the doctors or they're going to appointments not being able to say what's wrong with them and not being able to give a history, so the doctor can't diagnose them and they go untreated.

Indeed, healthcare services were regarded by many practitioners and service users as inflexible and unresponsive to people's diverse needs.

Mothers commented on the situation of a new mother they knew who had committed suicide and emphasised the need for NHS doctors to spend more time listening to new mothers experiencing postnatal depression rather than "*just dismissing it*":

> It's also the fact that if you do go to the doctors – I know they're hard-pushed for time or whatever, but just to sit and listen to someone. If they're a new mum and they're really down in the dumps, don't just dismiss it and say, 'You'll be alright, it's just the baby blues'. Find out why they're feeling so down and see if you can help.

They felt doctors should play a key role in signposting mothers onto services which may help to reduce isolation.

Black and Minority Ethnic women were recognised as experiencing particular barriers in accessing healthcare. One practitioner supporting BAME communities commented that FGM is not understood by the services that should be there to provide care for women:

> We just have one uniform system and if that doesn't work, then you kind of just slipped through the net. I feel that a lot of BAME women, a lot of most vulnerable women in our society, slip through that net very easily. That leads to their isolation and loneliness, which then leads to depression and anxiety which then compounds the issue to be even more isolated and lonely.

Refugees also highlighted the language barriers they faced and inadequate provision of interpreters which meant that statutory services were inaccessible. For example, "*Many things make someone feel numb. [...] There is no trust with this refugee group, no interpreter to help access services. How can I been happy if I am strange here, and if no one helps me?*" (male participant).

A practitioner supporting drug and alcohol users also commented on the stigma many of their clients faced when trying to access statutory service provision:

> I think wider services do need to look at how they work with us. Sometimes they're seen as trouble to be gotten rid of, rather than part of the community to be worked with.....We do get reports sometimes from our service users that they feel that they're judged and stigmatised. So, therefore, they will disengage, and out of choice, because they don't want to be in those environments.

Participants at risk of homelessness who had mental health conditions also highlighted their negative experiences of seeking NHS support: "*In the NHS, I've been made to feel like a burden a lot. They minimise your problems, don't they? [...] I just feel like I'm a pain all the time, because I can't cope with things that lots of other people can do. I feel like I need more support than I maybe should at my age*" (female participant).

Some participants suggested that the thresholds for obtaining support could mean that people with Asperger's Syndrome were unable to access the support they needed.

Practitioners also highlighted a widespread lack of understanding about autism among statutory providers.

Some participants at risk of homelessness explained that they fell between different mental health services and were deemed too complex for a short-term Cognitive Behavioural Therapy (CBT) intervention, with no service wanting to provide support:

> *I think there's a massive breakdown between services because I, a couple of weeks ago, was assessed for... I was offered CBT in the NHS, then that service got in contact with me and said I was too complex for them, they wouldn't meet my needs. […] Another service got in contact with me and they were like, "Well, we're not really sure what we can offer you." They were just, like, fobbing me off. I was told I was going to get something, really excited, and then they said I was too complex. Then the other service said they didn't know what to offer. I'm really not that complex. It just makes you feel like they've decided that you're not going to get better. So, it's, like, breakdown of service. You get one team that might be good, then you're just being passed to another person. I just wish there was, I don't know, more consistency.*

Carers of older people with a disability or long term health conditions highlighted difficulties in finding good respite care homes and the cost of respite care, which were major barriers that increased carers' isolation and loneliness. They also pointed to the difficulty of meeting thresholds for care support for older people with a disability or long-term health condition and lack of transparency about the assessment criteria: *"The council assesses you. They took a year to offer my husband a place because they kept saying, 'We don't think he fits the criteria'. I said, 'Tell me what the criteria are'. They never did."* Carers also expressed considerable frustration about the lack of availability of respite care at weekends and limited hours of council-run respite services during the week:

> *My wife goes to the care home one day a week which is really good, but they don't run Saturdays or Sundays. So if I want to do something at the weekends then there's nothing. [The hours are] 9:30 to 4:30. It's not even 9:00 to 5:00 […] What's worse about the care home is that really it's 9:45 to 4:15. You get there at 9:30 the place is empty (male participant).*

The internet and technological changes

The pervasive role of the internet and other technological changes in recent years were regarded by some practitioners, service users and community members as an important factor that could either increase or reduce people's isolation.

Participants who were peer support volunteers for people with mental health conditions highlighted the importance of online support networks, particularly for people experiencing agoraphobia:

> *I have an online support network, online group. We actually play a game, World of Warcraft. So, I have a group of friends that I've made through there. So, they're from all over the world, and we get together at least three times a week for a couple of hours in the evening and do stuff together. Yes, that was my first experience, really, of any kind of proper support network, and it was really good. Considering I didn't leave the house, it had to be online...(female participant)*

Another female participant also highlighted the importance of socialising with friends online for people with mental health conditions:

> *My friends are all online as well, because I don't know anyone in Reading. So, that's why this is a little awkward for me, because loneliness is a really serious issue for me.[…] So, speaking to people online, that's mainly how I socialise. They're all over the country and all over the world, but I used to be, before I became unwell, a very sociable person.*

A male participant however felt that increasing reliance on online, rather than face-to-face interactions could lead to people becoming *"lonelier and lonelier": "although it's good, technology has moved us farther away from each other".*

Some parents, carers of people with long-term conditions and people with mental health conditions perceived there to be much less contact with neighbours today than in previous decades. Mobile phones were perceived by parents to be causing less social interaction in public spaces, which inhibited communication between generations. There was a perception that if people did speak to anyone they did not know in public, they would be thought of as *"a nutter", "a bit weird"* or *"they're frightened to interact with anybody in case someone sees it the wrong way".* Similarly a male older carer observed that women used mobile phones as a *"protective device"* when going for a walk in public. He highlighted the fact that, *"everyone will talk to you if you have a dog"*, but going for a walk alone could be stigmatised.

Unsupportive work environments

Participants at risk of homelessness who were unemployed thought that work could be a good way to make social connections and reduce isolation if the environment was supportive:

> I see it like working would be amazing because then that would alleviate a lot of the isolation, but I'm guessing it depends what kind of company you work for and how supportive the environment is. Probably some people do feel really lonely at work, but if you're in a good environment then they wouldn't (female participant).

People with mental health and/or neurological conditions who had experienced long-term sickness absence, however, talked about the stress they faced in returning to work and the impacts of a lack of understanding from line-managers and colleagues in unsupportive work environments. Some participants who had asked for adjustments to their workload due to their disability felt their line-managers responded by putting more pressure on them and blaming them for not coping. Such experiences could lead to long-term unemployment and accompanying risks of homelessness and a downward spiral of mental illness.

Exclusion from the job market

Refugees and asylum seekers regarded unemployment and not having the right to work as leading directly to social isolation and loneliness. As one older woman commented, *"If you can't work you don't meet anyone, and aren't leaving the house, so you feel lonely. Voluntary or other work would be good".* Refugees and asylum seekers also pointed to the crucial importance of learning English in order to obtain work and thereby reduce the loneliness they experienced. For example, one male refugee commented: *"If I don't learn English I will be lonely…if my language [is] not good I can't get a good job, so I stay at home".*

Practitioners supporting people with drug and alcohol addiction also pointed out how some service users were excluded from the job market because they were on certain medications and were not permitted to do certain jobs as a result.

4.2.2 Situational factors

Situational factors refer to social relations, circumstances or life events that were perceived to influence an individual's risk of loneliness and ability to develop meaningful social connections. This includes financial pressures, language barriers, mental health, disability and caring responsibilities.

The table below shows the key factors mentioned in interviews and focus groups.

Table 5:

Perceptions of situational factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of practitioner interviews where mentioned (n=21)	Focus groups where mentioned (n=6)
Limited support networks	9	3 (refugees; homelessness; mental health)
Financial pressures	8	2 (refugees; parents)
Language & communication	6	3 (refugees; deaf people; homelessness)
Mental illness	7	2 (homelessness; refugees)
Physical disability, ageing & loss of mobility	6	2 (carers; parents)
Significant life event or change	5	2 (homelessness; parents)
Negative coping strategies	4	1 (mental health)
Caring responsibilities	2	2 (parents; carers)
Living alone	0	3 (carers; homelessness; mental health)

Limited support networks

Perhaps unsurprisingly, many practitioners regarded limited support networks as increasing the risk of loneliness and social isolation among the groups they worked with. This could result from family members being spread further apart than in previous generations or people being newcomers to the area due to being a student or starting a new job or because they were newly arrived refugees and asylum seekers. Focus group participants who were refugees and asylum seekers highlighted their limited support networks and the fact that recently arrived refugees who did not know the area often stayed at home and became isolated.

A practitioner from an integrated treatment service supporting drug and alcohol users explained that when their clients try to change their drug and alcohol use, they often have to change their support group, their family group, their friendship group, which could be difficult. This could lead to isolation, fear and restrictions on their mobility in the neighbourhood:

> *A lot of our clients when they start to look at steps towards reducing and stopping their drug and alcohol use, they will stay indoors because they don't want to be out and be bumping into dealers or bumping into previous associates. So, then you start to isolate yourself.*

Participants at risk of homelessness and those with mental health conditions also highlighted the difficulties caused by being isolated from family members. They commented on how hearing about others' holiday plans could be particularly difficult when they were estranged from family members and were alone, for example, at Christmas:

...for Christmas I went training, but I went training because I didn't have anyone to spend it with. When people say, you know, talk about loneliness, that's a hard thing to do when you spend a month listening to people planning their Christmas breaks (male participant).

Groups of carers and parents commented on the importance of good neighbours in reducing social isolation, giving examples of how they or their neighbours 'looked in' on older people and sought conversations with parents, carers and people living alone. Some participants with experience of mental illness said that they did not want to talk to their neighbours, as they felt they were being judged by them, while others just felt that society was becoming lonelier and *"no-one knows who lives next to them"* anymore. As one participant with experience of mental illness commented:

I live on the same road that I've lived on since I was two years old. I couldn't tell you the name of more than three people on it, and that's simply because I knew their kids when we went to school together. I have no contact with them.

Financial pressures

Many practitioners pointed out how financial constraints limited the leisure and social activities people were able to do, leading to further isolation.

Refugees and asylum seekers highlighted the cost of transport as a barrier to accessing services. Furthermore, not being able to get a job due to limited English language learning opportunities led to significant financial pressures on refugee families and barriers to achieving their aspirations for the future.

The group of parents pointed to the low incomes that many parents had to cope with, resulting in long working hours and little time to care for their children or to have time for themselves to socialise or participate in the community. As one mother commented: *"I used to work 60 hours a week. I had two jobs. I never saw my boys grow up [...] I wouldn't get home sometimes until 1 o'clock or 2 o'clock in the morning. Up again to take them to school the following morning at 7 o'clock again. Six days, seven days a week."* Such pressures could lead to isolation, loneliness and potentially mental illness. Job precarity could also lead to unemployment, with all the accompanying risks for individuals' and families' health and wellbeing.

Language and communication

Deaf and hearing impaired focus group participants highlighted the communication barriers deaf people may face, including not being able to use the phone, some deaf people not having learned to read or write English and problems if carers of deaf people did not use sign language. As one participant explained, lack of understanding and communication could lead to loneliness and mental health problems: *"Feeling lonely and depressed is not uncommon. People coming to visit helps. But a lot of people don't understand, many elderly people have carers who don't sign which contributes to isolation and loneliness."*

Furthermore, accessing mainstream (hearing group) activities on their own without peer support could be particularly challenging for deaf people. For example one participant attended a craft group which was hearing, but with another deaf person since, *"going to a hearing group by yourself is difficult"*.

In another focus group, one participant with epilepsy explained how having more seizures could make it hard for her to explain to service providers and members of the public about her needs.

Refugees and asylum seekers highlighted how isolation resulted from inadequate provision of English language learning and insufficient opportunities to improve their English by interacting with first language speakers of English. While this impacted on their access to

statutory services in the short to medium term, it also had major long-term consequences such as unemployment, which led to people staying at home and having reduced social contact.

Mental illness

Participants with experience of mental illness raised several points about how loneliness and social isolation were often key part of their experiences of mental illness, since it often triggered a loss of social networks and sometimes unemployment. One woman explained:

> Mine [mental health story] literally kicked off when I lost all the friends that I had and then lost my job. So, I went from filling every single hour with people, living with someone, to losing it all, being completely isolated. To the extent that I couldn't open my front door when my mum called around. It was my birthday, she wanted to give me a birthday present, and I couldn't open the front door to her, because that outside, I did not want to do it, but I was so isolated (female participant).

A female participant at risk of homelessness highlighted how isolation could worsen mental health, leading to self-harm or suicidal thoughts:

> …at the worst extreme, if you're completely isolated, personally speaking, it can lead to a lot of very negative thoughts about either self-harm or suicide and stuff like that. Even though you don't act on them, because you feel like you have a responsibility to the people in your life who would be upset, feeling isolated is probably one of the biggest things that can make you feel like, "Well, what's the point of me being here?"

Another female participant highlighted the particular issues faced by those with social anxiety such as finding large groups of people difficult in public spaces and facing challenges taking public transport which could lead to isolation. Other participants discussed the stigma and difficulties they faced in dealing with people's expectations and responses to their behaviour, such as hearing voices. Some talked about difficult relationships at work and stress they experienced in the workplace which impacted on their mental health and made them not want to go into work, leading to sick leave and reduced social contact.

Participants at risk of homelessness also pointed out how their mental health could mean they need to distance themselves from family members because of what they are going through, which could be painful and misunderstood. This could lead to further isolation and loneliness. Indeed several participants experiencing mental health difficulties highlighted the fact that they could be blamed by others or even blame themselves for "*deliberately cutting themselves off*", when people did not understand that it was their illness that led to the loss of social networks.

One woman at risk of homelessness highlighted the fact that people may feel lonely even when they share intimacy and feel close to a partner, family member or friends:

> You can even feel alone when you're with your friends, and when you're with your family you can feel alone. "It's alright, […] you've got me." Yes, but still you feel lonely. […] Even two people that feel lonely together, sometimes they can't explain their loneliness to each other. They just feel lonely.

A male participant with a mental health condition graphically illustrated how prolonged social isolation led to considerable anxiety about meeting new people, which may be avoided at all costs:

> I think I spend so much time alone that now I kind of live in my own little world […] if you said that, "Would you like to go to this party of 50 people or would you like to go into that field, pour petrol over yourself and have a merry dance with a load of firelighters?" I'd say, "Bring the petrol. Make sure it's the good stuff." It's true though, isn't it?

Physical disability, ageing & loss of mobility

Parents felt that older people who become ill or lose their mobility, such as no longer being able to drive, were particularly vulnerable to isolation:

> *If you're of the older generation, like myself, if I didn't drive I'd be totally stuck. So, it's when you get to a certain age. Older people, they lose their peers and then they tend to withdraw. [...] They lose their confidence and their peers. So, they tend to back away from situations and that's how they become isolated.*

Practitioners supporting people with life-limiting illness also emphasised that it was the loss of mobility which led to LSI among their service users: *"Once they stop being able to get out of the house independently, that means they become isolated and then they become lonely".*

Carers of older people also pointed to the isolation and loneliness that may result from ageing and loss of mobility, particularly for those without care support or who lived alone. Support from ReadiBus was seen as particularly important in enabling people to get out of the house and attend day centres or other social activities. They also highlighted how ageing and health problems could mean they had to stop doing activities they enjoyed, such as going for regular walks, which was detrimental for their wellbeing and led to reduced social contact with their neighbours.

Significant life event or change

Many life events, challenges or troubling changes in the lifecourse were perceived to increase the risk of loneliness and social isolation, including bereavement, becoming a new mother, abusive relationships, mental illness, drug and alcohol addition, homelessness. A mental health practitioner suggested that loss of social networks often occurred *"at crucial lifetime change points [...] if [people are] not very good at keeping a network".*

A practitioner working with people who have experienced bereavement pointed to how personal coping mechanisms in wanting to deal with the experience alone could lead to isolation:

> *...sometimes people don't want anybody, they can't cope with everybody saying, "I'm so sorry," and all that sort of thing. They just want everybody to go away and they want to be on their own, and the trouble is that then that puts people off coming over to help or to talk to them or whatever, so they become isolated because of that.*

Parents also felt that a bereavement, particularly the death of a partner, could lead to reduced social participation and isolation: *"If they've lost one of their partners, like a husband or wife, that stops them from doing things that the used to do together so now they're on their own".*

Becoming a new mother was another life event associated with major changes in women's lives, which could lead to isolation and loneliness. As one mother commented: *"From working full-time to then, 'I've got this baby and I've got all day until my husband comes home from work. What am I going to do with myself?' There's only so much housework".*

Negative coping strategies

Participants with mental health conditions highlighted the fact that they could be driven to negative coping strategies such as alcohol addiction due to their mental illness. Recovering from alcohol addiction could lead to reduced face-to-face social contact, due to not being able to socialise in pub and bar environments. As one male participant explained:

> *I used to drink to wash away the voices [...] Then you go home on a Saturday night and you're playing internet chess because you can't go to a pub because, you know, and all that [...] but actually sitting in a pub with your chums is probably better than sitting around playing games of speed chess [online], obviously you've got no-one else to speak to.*

Practitioners working with young people with autism, with young carers and with students, in addition to those working with people with mental health challenges, drug and alcohol addiction and people at risk of homelessness regarded negative coping strategies that these groups engaged in as potentially leading to isolation and loneliness. Such coping strategies included poor diet, binge eating, drug and alcohol misuse, self-injury and suicidal thoughts.

Caring responsibilities

Focus group participants who were carers for family members with a disability or long-term health condition highlighted the challenges they faced in spending time with friends and socialising when they had caring responsibilities. This was particularly evident when people cared for a spouse or relative with dementia who may want to leave after a short period of time spent visiting friends.

Unpaid care work was also tiring which made it harder to socialise and maintain friendships. Participants highlighted the fact that engaging in social activities and maintaining friendships and social contact at weekends may be particularly difficult for carers, when few day care services were available. Carers also talked about a lack of understanding of carers' lives that they may encounter when meeting friends without such life experiences. As one female carer commented:

> I find a lot of the friends I used to have, I don't see now. With some, I feel uncomfortable really because they don't really understand. I tend to get upset sometimes, but interestingly enough I don't get upset when I do my one thing that is really a 'me' time and that is, I have a French class I go to.

The group of parents commented more broadly on the time pressures of balancing work and family life, which left little time for participation in the community and did not help to foster good neighbourliness which would help to reduce isolation.

Family wellbeing is recognised in the government strategy as crucial for preventing loneliness (Department for Digital, Culture, Media and Sport, 2018, p.57): "Research shows that parental loneliness is a predictor of their children's loneliness during school years. Over 40% of mums under 30 are lonely often or always". Parents in Reading also pointed out how new mums could be very isolated and struggled to attend playgroups, health appointments that took place early in the morning, due to *"getting the baby fed and clean and everything else and everyone else sorted out…"*. Parents with disabled children highlighted the additional caring demands placed on them, such as spending time at hospital seeing consultants, attending physiotherapy, hydrotherapy and other medical appointments, which meant that they missed out on opportunities to meet other parents at toddler groups, the school pickup and so on. This could lead to significant isolation.

Living alone

Carers pointed to the importance of day care services, not only for carers, but also in terms of reducing isolation and loneliness for older people with a disability or long-term health condition who lived alone. As a female carer commented, *"they never close for more than two days at bank holidays because a lot of the people who attend are on their own and they see no one. You see, now you're into loneliness"*; a male carer added, *"Some people it's their outing […] They've eaten a proper meal"*.

Participants providing peer support to people with mental health conditions commented on how loneliness may be particularly difficult when people have started to make connections and feel supported but then go home to an empty place:

Male participant: *I kind of think sometimes we do these courses, and as much as that's somewhere I can feel comfortable, [...] just somewhere you can connect with people [...], and then I get this terrible feeling I'm sending them home alone. You know, and sometimes they open up, and then they're going to sit home alone and think, "I'm alone."*

Female participant: *You can see it sometimes, they, and we, will just leave our loneliness at the door, and then we pick it up again.*

Similarly, participants at risk of homelessness commented on how loneliness may be keenly felt after meeting friends and returning home alone, as one woman said: *"I like to see my friends, I have friends, but when I go home... Like [friend's name] said before she got upset, bless her, when you go home, you feel alone"*.

As discussed further in Section 6.2, these examples highlight the importance of creating safe spaces where people with mental health conditions are able to make positive social connections.

4.2.3 Personal factors

Personal factors refer to factors concerned with feelings or emotions that were perceived to influence an individual's risk of loneliness and their ability to develop meaningful social connections. It is important to note that these factors often stem from wider social issues, situational factors and structural barriers, such as mental illness and homelessness.

Table 4:

Perceptions of personal factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of practitioner interviews where mentioned (n=21)	Focus groups where mentioned (n=6)
Low confidence/ self esteem	10	2 (homelessness; mental health)
Mental health challenges	6	2 (homelessness; mental health)
Fear and anxiety	4	3 (homelessness; mental health; parents)

RVA's (2017) survey identified a lack of confidence as a major barrier which prevented people becoming more socially active, reported by 37% of respondents in Reading.

In this research, practitioners supporting people with life-limiting illness emphasised the importance of providing one-to-one support, such as through befriending schemes, before people lose confidence and become so low in mood so that they are not able to engage with activities in the community. Practitioners supporting people with learning disabilities also highlighted the anxiety that many service users experienced which hindered their participation. As one practitioner explained, time was needed to reduce anxiety and build confidence: *"enabling their level of anxiety to come down enough so that they can participate takes an enormous amount of time"*.

Participants at risk of homelessness and those with mental health conditions identified not feeling understood, in terms of their mental health, as causing loneliness and social isolation. They highlighted how difficult it was to meet others on a one-to-one basis due to low self-esteem linked to their mental illness. Some also felt that friends were too busy to spend time with them and they highlighted how negative thoughts about themselves could

spiral, if a friend, for example, cancelled meeting up. This could lead to feelings that they were a burden on others.

Practitioners supporting people with mental health problems highlighted the difficulties faced by people with limited social skills which meant they were afraid of being made fun of in group settings. They also noted that isolation compounded depression and led to further isolation:

> *If you're isolated, then you find it more difficult to speak to people so you become more depressed. One of the characteristics or symptoms of depression is to withdraw, so that you stop answering your phone, you don't go to any social occasion…. so you end up being isolated.*

Participants with mental health conditions highlighted social anxieties of being around other people and the difficulties of dealing with people's expectations and negative judgements about those who are more introverted. Several practitioners highlighted how fear and anxiety about socialising could be a major barrier to participation among the groups they worked with. A practitioner working with people with mental health challenges commented on how people sought to protect themselves by withdrawing: *"To protect yourself you back away because that feels the safest place to be. Then all those relationships break down. Then the relationships probably that you have are actually only with health professionals"*.

A practitioner working with deaf people example also explained: *"They're frightened to get out of their house. They just stay in their house; they're housebound really."* A practitioner supporting older people from BAME groups suggested that fear, suspicion and a mistrust of authority could result in a lack of take-up of services, such as day centres, designed for the 'majority' (non-BAME) population: *"there's just a fear of an authority figure or officials, and even people who will risk coming through our doors, there's that fear"*. The interviewee added:

> *It isn't that anybody says to them, "Oh you can't come here," but they just don't go [to mainstream day centres]. And that adds to the loneliness because they are feeling that, "There is nothing for us," and 'for us' implies, "I want to see only black faces around, I want to hear a West Indian accent or an African accent."*

A practitioner supporting people with autism and their families highlighted the difficulty of motivating young people with autism to join groups and socialise with their peers: *"With the teenagers, we frequently find they just hibernate in their bedrooms… They need to be motivated sometimes to socialise, and then they enjoy it when they do."* Similarly, a member of the University chaplaincy commented that students with mental health problems or disabilities such as autism *"are going to find social stuff a little trickier"*. He added that there was an acceptance that leaving home (an experience encountered by most students at the university) is disruptive, but there was increased risk of isolation and loneliness if students' social skills *"for dealing with normal disruption have some somehow been inhibited"*. Among students, as has been found in research with other young people in Reading (McClane, 2018), it was usually people who *"didn't fit in the group"* who were most vulnerable to isolation. According to young people, based on the findings of McClane's (2018) RVA report on youth isolation and loneliness in Reading, loneliness often stemmed from strained relationships with family and friends, lack of confidence and mental health difficulties or disability.

Participants who had experienced mental illness commented on how anxiety and isolation could lead to situations where they felt threatened and were unable to communicate about their needs. This could lead to an overwhelming fear of engaging with the world and a desire to protect themselves by not engaging in social relationships.

4.3 Conclusion

This section has explored perceptions of practitioners, community members and service users about risk factors which may lead to loneliness and social isolation. The analysis of societal, situational and personal factors demonstrates the complexity and multifaceted nature of vulnerabilities to LSI. Recognition of the specific needs of particular groups and individuals is crucial in order to target services and support effectively towards those most at risk, as is explored in Section 6. The next section sums up some of the vulnerabilities of particular groups and draws out the impacts on health and wellbeing.

5. VULNERABILITIES AND HEALTH IMPACTS OF LONELINESS AND SOCIAL ISOLATION

5.1 Introduction

Having explored the dynamics of loneliness and social isolation in the Reading from a range of perspectives in Section 4, Section 5 focuses on the second and third research questions guiding the study: Why are particular groups vulnerable to loneliness and social isolation? How does loneliness and social isolation affect people's health and wellbeing? It summarises key factors that influence why particular groups are vulnerable to LSI and explores the relationship between LSI and health and wellbeing, based on analysis of the focus group discussions with service users and volunteers and of interviews with practitioners.

5.2 Why are particular groups vulnerable to loneliness and social isolation?

As evidenced in Section 4, loneliness and social isolation were perceived as both causes and consequences of mental ill health. Chronic or life-limiting health conditions, disability and caring responsibilities were also identified as major factors that could make people vulnerable to loneliness and social isolation. People experiencing ill health, disability or those caring for them, however, were not the only groups regarded as vulnerable to loneliness and social isolation. People experiencing a range of situational circumstances related to their immigration status, ethnicity and/or religion, unemployment, homelessness, drug and alcohol addiction, bereavement, or their age (young or older) and whether they lived alone, could all represent risk factors for LSI or could exacerbate existing circumstances of social isolation and/or feelings of loneliness in Reading.

Focus group participants with mental health conditions raised several points about how mental illness could lead to the loss of social networks. One participant highlighted the particular issues faced by those with social anxiety such as finding large group of people difficult in public spaces and challenges taking public transport which could lead to isolation. Other participants discussed the stigma and difficulties they face in dealing with people's expectations and responses to their behaviour which was regarded as problematic. Some talked about difficult relationships at work and stress they experienced in the workplace which impacted on their mental health and made them not want to go into work, leading to sick leave and reduced social contacts.

Participants at risk of homelessness also pointed how their mental health could mean they need to distance themselves from family members or friends because of what they are going through, which could lead to further isolation and loneliness. Indeed several participants experiencing mental health difficulties highlighted the fact that their illness led to the loss of social networks.

Focus group participants who were carers of people with a disability or long-term health conditions highlighted the challenges they face in spending time with friends and socialising when they had caring responsibilities, particularly for someone with dementia who may want to leave after a short period visiting friends. Caring was also tiring which made it harder to socialise and maintain friendships. It may be particularly difficult for carers to have social contacts at weekends when few day care services are available. Carers also talked about the lack of understanding of carers' lives that they may face with friends.

Refugees and asylum seekers emphasised how isolation often resulted from limited opportunities to learn English and consequently, not being able to obtain a job. Communication barriers in accessing services and activities led to people staying at home and having reduced social contact.

Deaf and hearing impaired participants also highlighted the communication issues deaf people may face. These included not being able to use the phone, some deaf people not having learned to read or write English, and problems if carers of deaf people don't use sign language. Deaf participants and older carers also highlighted barriers in accessing information about social groups and activities that was only available on the Internet. This could be difficult for people for with limited computer literacy to access, reducing their social participation.

5.3 How does social isolation and loneliness affect people's health and wellbeing?

Unsurprisingly, all interviewees and focus group participants considered LSI to be detrimental to health and wellbeing, although the extent of the impact depended on an individual's personal coping strategies, situational and societal factors. Most participants considered LSI to be of greatest detriment to mental and emotional wellbeing, citing low mood, anxiety and worsening mental illness as key impacts. Equally, it was noted that being lonely or isolated can negatively affect an individual's identity, self-confidence and sense of belonging.

Despite mental and emotional effects taking precedence, it was acknowledged by practitioners and service users that LSI can and does have implications for physical health because *"our physical and mental and emotion is much more interconnected than we realise sometimes"*. Participants at risk of homelessness highlighted the way that loneliness drained their energy, mentally and physically, but could also lead to loss of appetite and poor eating habits, as one woman observed:

> *When loneliness mentally drains you then it physically drains you, because then you physically don't want to get up. […] So, it drains your energy in itself […] So then you don't want to eat. Then you become malnutritioned [sic]. It all then plays a link in itself so it's all connected.*

Similarly, a practitioner supporting people who have experienced bereavement regarded this experience as affecting the whole body and impacting on people's physical health:

> *bereavement affects the whole body not just the mind, all the fight and flight symptoms […] Things like dry mouth, abdominal pain, all sorts of things, hallucinations, dreams all that happens after a bereavement. So physically they can go downhill, it affects the immune system, and if your immune system's lowered you become ill and you're back to the NHS again.*

A practitioner supporting people with dementia highlighted how a lack of social engagement clearly led to a deterioration in the health of people with dementia, as well as impacting on the health of carers who *"tend to neglect their own health and their own social needs"*.

Several practitioners also pointed to the links between LSI and inactivity, and unhealthy coping behaviours which affected people's physical health. As a practitioner working with people with mental health challenges commented:

> *If you are socially isolated, you're probably not having good diet. You probably have ongoing health issues and all that stuff, so all those things, and dependency, alcohol dependency as a means of fighting isolation and loneliness. It will start to build up. So, you get multiple problems.*

A practitioner who worked predominantly with students commented that students may use certain behaviours to *"fill the gap of social life,* [behaviours] *that look not particularly frightening but aren't really very healthy, and they don't get out of the problem"*.

With regard to teenagers with autism, one practitioner suggested being lonely or isolated means these young people are more likely to:

> *play computer games all day long, and order in takeaways, they will get clinically obese pretty quickly, and they won't have a routine to their life. They won't wash; they will smell, and they will get morbidly obese pretty quickly.*

Similarly, it was suggested by a practitioner supporting people with mental health problems, that lonely and isolated individuals have a higher risk of substance and alcohol dependency, *"as a means of fighting isolation and loneliness."*

Thus, as previous research suggests, poor health is considered a risk factor for LSI, while LSI exacerbates existing ill-health and disability. This inter-linked relationship is also apparent in situational challenges, such as homelessness; practitioners suggested people were isolated because of their volatile housing situation, while their poor housing makes them unwell.

Moreover, many interviewees suggested that being lonely or isolated increases the burden of existing health, situational or personal issues. For example, in the context of bereavement, one interviewee suggested LSI, *"makes their grieving a lot worse,* [simply] *because they don't have anybody to talk to"*. Similarly, one practitioner considered that LSI impacted on how people with life-limiting conditions, *"engage with things that are available, and if they want to take their medication….and if they attend their appointments"*.

Loneliness and isolation may affect the health and wellbeing of both parents and children, especially among mothers in Black, Asian and Minority Ethnic (BAME) communities. As a practitioner from an organisation representing BAME communities commented, *"the social isolation of women then stems it* [loneliness and isolation] *down into the wellbeing of their children…so it becomes a generational issue".* This suggests the potential intergenerational transmission of LSI and its negative consequences for health and wellbeing for younger generations of BAME groups.

The negative impact of LSI for health and wellbeing can also be considered from the perspective of the exploitation of those who are already vulnerable. A practitioner supporting people at risk of homelessness relayed her experience of how particularly vulnerable, isolated individuals are at increased risk of exploitation through cuckooing – a crime whereby drug dealers and other organised criminals take over the home of a vulnerable person. Isolation means an outsider is able to *"just take over someone's place, and they start running their little empire from there….That's a big problem, and that is something happening to isolated people because they haven't got the normal branches of support there"*.

5.4 Conclusion

This section has summarised key vulnerabilities identified by participants from marginalised groups and by practitioners supporting them. It has highlighted the multiple links between LSI and health and well-being, affecting not only mental and emotional wellbeing but also physical health and disability. The next section explores how existing services and support are working to tackle LSI, identifies best practices in alleviating LSI and synthesizes participants' views about how best practices can be strengthened, enhanced and developed in future.

6. PREVENTING AND TACKLING LONELINESS AND SOCIAL ISOLATION IN READING

6.1 Introduction

Having explored the dynamics of loneliness and social isolation in Reading, the vulnerabilities of particular groups and the relationship between LSI and health and wellbeing, this section focuses on how LSI can be prevented and tackled in Reading. It seeks to answer the final research questions guiding the study: Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading? How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future? The section draws on practitioners' experiences of providing services and support for vulnerable groups who may be at risk of LSI, as well as analysing the views of community members, service users and volunteers about what would be most helpful in reducing LSI in Reading and how best practices can be strengthened and developed in future.

6.2 Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?

Since vulnerability to LSI varies according to a complex interaction between societal, situational and personal factors (see Section 4), best practices and approaches for preventing or alleviating loneliness and social isolation and loneliness in Reading also vary according to the needs of particular groups and individuals.

6.2.1 Specialist support and safe spaces

Dedicated support groups within safe, understanding environments that provide opportunities for conversation and building supportive relationships with peers were identified by many practitioners and service users as crucial in reducing loneliness and social isolation. Older carers commented on how helpful it was to meet other carers in similar situations once or twice a week as part of a regular support group. Similarly, a practitioner working with young carers observed:

> I know one young person who comes to Young Carers because she wants to be around people, her own age group, where she can sit down and talk about what's happening at home…she's able to sit down and talk about what's happening at home and show us her photos. I think it's a space where they can talk, talk, and people will listen.

A practitioner working with deaf people emphasised the importance of deaf clubs in creating safe spaces where deaf people could communicate with each other through sign language:

> …going to a deaf club is very important and it's like their second home. It releases their frustration as well, of isolation at home that they've got. They can go and they can enjoy themselves and it's forgotten that we're signing. And then they've got that satisfaction when they go home.

Equally, a practitioner working with BAME groups highlighted the importance of the Rose Centre, a specialist community-led centre for Female Genital Mutilation (FGM), which ran women's and men's groups as spaces where community members were able to talk openly and freely, not only about FGM but about domestic abuse and healthy relationships, health concerns and so on. The Rose Centre provides a monthly drop-in for women from FGM practising communities, which helped to reduce their isolation, as this example demonstrates:

We had one lady referred in and she said she had been dreading it for the whole month [...] She couldn't believe how welcoming it was and how she was helped. That she'd be coming back every month now [...] It's a time when women can really come together and in a really informal way having tea and coffee and cake and things and the same with the men's group.

Similarly, although the monthly men's group was originally started as a space to talk about FGM, it was now a space for men to discuss a wide range of health and other issues they were concerned about and had led to gardening and other activities that enhanced their social connections and wellbeing:

now the men themselves say, "Can we talk about this, can we talk about that, can we talk about mental health, can we talk about prostate cancer, can we talk about why men don't talk to each other." They've now got an allotment and they're going to start doing gardening and things. [...] it makes a big difference to people.

For older carers, respite opportunities, such as day centres or respite care, were crucial in order to give them a break from caring and several called for greater availability of respite services at weekends and longer opening hours to reduce carers' isolation. Carers also highlighted how helpful they found specialist support and group activities for people with particular long term health conditions, both for those with a disability/ health condition and for carers.

Such safe spaces where people are able to meet others in similar situations may even lead to the development of support networks that are sustained outside of the specific support group 'time'. A practitioner supporting refugees and asylum seekers explained that creating safe spaces and opportunities to engage in group activities are advantageous because they give people, *"something that they can do to a) keep themselves occupied, but b) to continue to make friends"*. Similarly, a practitioner working with people with autism and their families commented: *"What we've found now is that the parents are meeting up outside of that* [group activity], *and they're going off doing their own outings......there are a group of them going together, and they can support each other, and they realise that they're not alone."*

6.2.2 Focused group activities

Many practitioners suggested that focused group activities were important for preventing or tackling social isolation and loneliness in Reading by providing opportunities for people to have social contact and develop friendships. Activities where participants could meet others through shared interests, such as craft or sport, were regarded as beneficial because they give people a different focus, particularly from mental health challenges or other difficulties they may be experiencing, in a way that simply meeting to 'have a chat' cannot. A practitioner representing a sports organisation that supports people with mental health problems thought that bringing people together for an activity such as sport was particularly important in reaching men experiencing mental illness and facilitating good social encounters:

The problem for men is... [they] potentially don't want to sit down and have a chat about their problems. [...] We provide a space for men to come together with sport at the centre of it. So it's not coming together because they want to chat but the reality is, is people are going to have a bit of chat when they come to the sessions. More often than not, those friendships develop and actually they all go and play football together. They'll end up going to watch some football together or join a five-a-side group together and things as well.

Carers valued group activities for people with long-term health conditions, such as art classes run fortnightly by the Stroke Club. Such activities could help to provide a sense of self-efficacy that fostered wellbeing. As one female carer commented: *"I notice that when*

he's in art, he gets totally absorbed. So I think that is good for him because it's something that he can actually, for an hour or so, he can actually concentrate on what he's doing".

A practitioner supporting blind and visually impaired people acknowledged that some people came more for the social interactions enabled by group activities: *"We do have people who come to the craft clubs who don't actually want to do craft, they come to chat, have tea and coffee, we provide lunch and it gives them a day out. They have the opportunity to meet up with friends".* Such group activities gave people a reason to attend an activity and the opportunity to make social connections and develop supportive friendships without having to admit, to themselves or others, that they may be lonely or isolated.

6.2.3 Making services and activities socially, financially and physically accessible

There was key emphasis among practitioners on the need to make services and activities accessible, with accessibility defined by the diverse needs of particular groups or individuals.

Ensuring activities were located in a place that was accessible for public transport was considered vital in facilitating group activities to tackle LSI, because as one practitioner working with people with physical disabilities expressed, *"what's the point in me offering a pub lunch if someone can't get there?"* The costs of public transport were also identified by service users and practitioners as a barrier to engaging in leisure and social activities.

Carers highlighted the importance of ReadiBus transport in enabling older people with mobility impairments, particularly those living alone, to 'get out of the house', go shopping and attend other social activities. As a male carer commented: *"Without that ReadiBus they really can't get anywhere at all even if they're pushing a trolley. They go into the town centre, to go just locally and they're picked up again and it's very good".* A practitioner working for ReadiBus suggested the service was about enabling people to maintain their independence and empowerment which are *"strong tacklers of loneliness and isolation".* Furthermore, practitioners found that by using ReadiBus transport regularly, people often developed friendships and support networks with other bus users:

> *the process of using ReadiBus can bring them into contact with other people in similar circumstances so they've got something in common [...] and so you get these informal social groups evolving [...] There are no outside agencies doing this, it's just people doing it for themselves.*

While accessing the 'mainstream' bus network may be desirable, ReadiBus practitioners had found than only a small number of people were able to change from using ReadiBus to mainstream transport and required initial one-to-one support to build their confidence: *"That was the difference. They wouldn't have done it if someone wasn't going to go with them to make it safe".*

Practitioners working with people with learning disabilities identified a range of concerns and anxieties that this group may face around getting to venues and participating in activities:

> *booking the bus [ReadiBus] and making sure... "What happens if the bus is cancelled or can't come," or, "It can take me one way and not the other, so how am I going to get home?" So, there is all that, and then, "Am I going to be able to get in the house when I get back?" All these things, and then, "Am I well enough? Have I been to the doctors and is my health good enough for me to, actually, be able to come out?" Oh, and continence issues [...] can they come out for long enough before they need a change. You know, loads of stuff around just being able to get here...*

For older and disabled people, accessibility may also be related to information about activities and support groups being available in print and in accessible formats. Older carers, for example, identified a need for more information about social groups and activities

available in the community, particularly for those who are not computer literate and who cannot access the Internet: *"I've got friends who can't or won't [access the internet], and it's very difficult because nobody wants to send you information in an envelope. That's 65ps, isn't it? So you are cut off in some ways which is a bit unfair"*. Practitioners also highlighted the need to tackle "digital exclusion" and provide information in print, videos in British Sign Language rather than just giving a number to telephone and other accessible formats.

In the context of families with children with autism, a practitioner suggested flexibility was very important. The length of family fun days (4 hours) was specifically designed to encourage attendance, as this practitioner explained: *"they* [the family] *might only come for two hours, but it* [they] *can be a little bit more flexible about getting there"*. This was seen as an essential to "*get the whole family out.*"

For some BAME groups, women-only activities may be needed to ensure they are accessible to women, such as English language classes, healthy eating, Zumba and seated exercise classes. As a practitioner working with migrant women at Reading Community Learning Centre commented:

> *….very few women [go to mixed groups] because it's not culturally acceptable. […] We do know women who get stopped even coming to us. I met one the other day who said, "My husband doesn't know I come here. I'm not sure, if he knew, he'd let me." So we have to accept.*

Ensuring activities were affordable was recognised as crucial by many practitioners, because as articulated by a practitioner working with people at risk of homelessness, *"If you can't pay £2.50 for a coffee, you're not going to be going into cafés"*. Similarly, ensuring people have access to 'mainstream' leisure facilities was important in enabling people to engage in healthy activities that promoted their wellbeing, such as swimming: *"Going swimming used to be free for unemployed people. It's not free any more"*.

In circumstances where there was a cost attached to group activities, it was important that costs were kept consistent. One practitioner working with people with autism and their families explained:

> *What we found that's really difficult is when you get given a large grant at short notice, either by the local authority, or by the NHS, where they want you to put on lots of activities…. free of charge… then it [the free activity] only runs for a certain period of time.*

This could lead to problems with the sustainability of service provision, since charges may need to be introduced when the grant came to an end, which was very unpopular:

> *there has to be a £5.00 charge on this so we can keep running it, and then people don't want to have to pay. If you start it at the beginning where it's a charged for group, and everybody is making a contribution, and it's their group, they're much more likely to continue doing that. Whereas, if it's free, and then they've got to start paying, they don't like it, and that can be a real pain.*

Financial consistency was thus important for both service providers and users.

For some people, smaller, less intimidating groups and activities may be easier to access because, as an interviewee working predominantly with students argued, *"a small event that's [is] quite easy for someone to come into, [it's] not that threatening, [and] you're more likely to make personal encounters."* Some practitioners acknowledged, however, that although group sessions or events can be useful for some people, for the most severely lonely or isolated, group activities or events may be simply too overwhelming. A practitioner working with people with mobility impairments suggested that:

if you take a view that the way to tackle social isolation and loneliness is to put on events, and you expect people to come, even if you put on transport, it might work for some, but there're a lot of people that [it] won't work for because of the reasons why they're socially isolated and lonely in the first place. So, I think some of those things [activities and events] miss the point.

6.2.4 Advocacy and assistance 'taking first steps'

Practitioners recognised the need for one-to-one tailored support, confidence-building and assistance with 'taking the first steps', in order to tackle loneliness and social isolation, particularly amongst the most vulnerable groups. Ensuring support is available to help people take the first step in overcoming personal factors for LSI, such as low confidence, self-esteem and social anxiety, and fostering the development of social networks was regarded as highly important. For example, a practitioner working with deaf people said, *"Because they can't communicate,* [they feel it's] *better to walk away….but if they've got someone with them, they can build up their confidence."*

Similarly, a practitioner working with refugees and asylum-seekers stated that:

I can't over-emphasise enough that somebody from Iraq, for example, might love table tennis. [However,] them knowing there's a table tennis club in South Reading is not dealing with their isolation and loneliness, because the chance of them turning up on a Monday night on their own, not knowing anybody, is absolutely zero".

Equally, a practitioner working with people at risk of homelessness suggested it is important to ensure that there is, *"Someone to hold your hand…. somebody there, maybe to do it for you at first but then to build up the confidence in them slowly* [and say]*: "Now you speak to them,"* or, *"Now you do the whole thing".*

Several practitioners felt that people would benefit from taster sessions and initial one-to-one support to build people's confidence before attending appointments, making phone calls or coming to group activities on their own. A practitioner providing sports activities for people with mental health challenges, for example, felt that establishing a buddying system of volunteers who could provide individually tailored support would encourage people to attend the initial sports sessions.

Indeed, an interviewee working predominantly with students felt that *"encouraging people to have courage and agency that they can do something"* was important because, *"in the end I* [as a support worker] *can't make your social life. Only you can do that, but I could help you do that."* These approaches are significant because they focus on empowering individuals, and in some circumstances enable them to manage, and potentially tackle barriers to social participation, thereby reducing social isolation and loneliness. However, as noted in Section 4, wider societal and situational factors may also prevent good social encounters.

6.2.5 Peer support, befriending and volunteering

Peer support, befriending and volunteering were identified by many practitioners and community members as very helpful in reducing and preventing loneliness and social isolation. Indeed, a practitioner supporting people with life-limiting illness highlighted the positive impact of befriending schemes on the wellbeing of end-of-life patients; research had found such social interventions could potentially lead to longer lives.

Carers and parents saw volunteer activities they engaged in within their local neighbourhood as important for their wellbeing and helped to reduce social isolation. Mental health peer support volunteers felt that their role was very important because of their lived experience of mental illness and psychotherapy support:

"We bring, and it's possibly something the other side of the table can't, really. That is what we bring, that lived experience, and that, really, is our speciality. I think it's valuable, as well, I really do". (male participant)

"Yes, and also the fact that we're volunteers, not paid staff, also can make quite a difference to a lot of people". (female participant)

Peer support volunteers who had benefited from mental health support as service users wanted to *"give back"* to others experiencing similar problems. They also saw volunteering as providing useful workplace experience that helped to prepare them for returning to work. As a practitioner working with people with mental health problems articulated, peer support volunteers, *"offer such hope for people and they are very easy to engage with"*, due to shared life experiences.

Peer support volunteers also acknowledged however how hard it was to always *"instil hope in other people"* while experiencing their own mental health challenges. Thus, while people may benefit greatly from volunteering in a peer support role, they may still need support and advocacy to attend groups and activities themselves.

Furthermore, some practitioners acknowledged that some people may find it particularly challenging to commit to, and sustain their participation in, groups or volunteering over a period of time, due to their particular circumstances, disability or illness. As a practitioner working with people with mental health challenges recognised, *"people don't want to sign up for three months of....doing pottery with elderly people, for example. But they're quite happy to go and hand out bottles of water at the Reading Half Marathon."*

6.2.6 Signposting to 'someone to talk to'

Several practitioners emphasised the importance of signposting people on to existing support groups or activities, such as Cruse Bereavement Care volunteers signposting their clients on to Age UK or friendship groups in their neighbourhood.

All of the focus group participants highlighted the importance of being able to talk to someone – a professional or peer support volunteer – about feeling isolated and lonely. One mother, for example, highlighted the importance of one-to-one support from someone *"who cares"*:

At my lowest, if I'd had someone who is impartial to speak to, I might not have got into the position I was in. So if I'd had someone, someone who didn't know me, who didn't judge me […] You need that person […] who cares. Even if it's for 15 minutes, that time with you – you just feel that you need to be cared for.

Similarly, peer support volunteers commented on how people with mental health problems sometimes just wanted someone to talk to: *"Sometimes there are just people, you're set to ask them about their condition, and then you end up just chatting to them, and it ends up, you're in a mental health group and you're talking about ukuleles, and I'm not making it up"*. They highlighted the importance of good social interactions for people who experience social anxiety and may be isolated: *"a lot of the time it is just about making a connection between human to human, we are two people, let's just be humans together in a situation where we understand we're all a bit socially awkward"*.

Peer support volunteers also highlighted the importance of the Samaritans telephone support service for people who may be lonely:

there are certain shifts in particular where you won't get the really desperate people, you'll get the really lonely people. Who can also be desperate, but a lot of the time they haven't spoken to anybody all week. […] That was all the contact she had for a week, and she left that call feeling so much better for just that tiny, tiny bit of contact. It was less than 15 minutes and it made such an important difference to her life.

Given the 24 hour nature of the telephone support provided by volunteers through the Samaritan's, this appears to be a helpful resource for people experiencing loneliness.

6.2.7 Support from healthcare professionals

Carers of older people with long-term health conditions such as dementia highlighted the importance of consistency of support from General Practitioners (GPs) and how helpful it was to be able to see the same doctor as much as possible. They also thought that regular walking groups organised by GP surgeries to promote health and wellbeing (such as 'Walk for your Heart' aimed at people with heart conditions) were helpful in reducing isolation.

Mothers highlighted the important role that primary healthcare professionals could play in signposting people on to support groups and specialist services, such as for new mums experiencing post-natal depression:

> *...if your doctor just said, "Well, look, I can't talk to you now but speak to this person and they might be able to help you". Sometimes [...] it's just talking to someone and listening to them that will make them feel better. It will give them a reason to get up in the morning.*

Participants who had experienced mental illness identified a need for greater recognition of loneliness and social isolation in mental health services. They commented on the fact that mental health practitioners rarely mentioned or recognised loneliness or social isolation issues when treating their mental illness:

Male participant: *I've been in and out of psychotherapy and psychiatric institutes since about 2010, 2009, probably, but up until this year no-one ever came up and asked me about loneliness or social isolation issues.*

Female participant: *No, absolutely.*

Female participant: *Yes, no-one seems to care about that as an issue.*

Male participant: *[...] No-one had ever asked me, "Who are you going home to?" Never was it ever mentioned at any point. It was only until this year that it's kind of come about, really.*

This suggests a need for greater recognition across mental health services of the significance of issues of LSI for people experiencing mental illness.

6.2.8 Raising awareness about LSI, social anxiety and mental health

Many participants who had experienced mental illness called for greater awareness about LSI, social anxiety and mental health in schools, workplaces and among the public in order to tackle the stigma surrounding mental illness and foster greater understanding of how to support people experiencing anxiety, for example, in public places. The mental health first aider training scheme was seen as particularly helpful in this regard.

In the context of anxiety and communication difficulties in public spaces, participants with mental health challenges commented on the usefulness of emergency cards provided by the police which they could give to a member of the public or community safety officer to help call someone to help them get home in situations when people are unable to communicate.

Parents also felt that more effort should be made to encourage workplace wellbeing and foster greater support among colleagues to "*look out for people*" at work. They commented on an attitude that was sometimes apparent: "*'We're at work. We can't worry about that'. [...] But you can, because your wellbeing helps you do the job*". Participants suggested possible practices which could promote wellbeing in the workplace, such as hiding happy stones or having a bowl in the office where people could anonymously write down how they were feeling that day and someone else could reply anonymously with something positive that

they read and put back in the pot for someone else to also benefit from. Some participants acknowledged, however, that not everyone would be comfortable sharing personal difficulties at work and might actively try to keep their personal life *"private"*.

6.2.9 Befriending, good neighbourliness and faith communities

Groups of parents and older carers of people with long term conditions felt that befriending, reaching out and 'keeping an eye' on elderly neighbours, single parents and people who lived alone was important in reducing their isolation. Parents felt that befriending or companion services would be helpful for older people who live alone in their own homes and questioned why befriending services had been cut back Reading in recent years. Practitioners also felt that befriending schemes were helpful in enabling people to get out of the house and engage in community activities: *"accompany people to get out and about so that they start connecting what's all around them"*. The Reading Befriending Forum, which brings together different organisations running befriending schemes, appears to help participating organisations work in partnership to reflect on and improve practice in this area.

Parents also suggested that community members could help to welcome new neighbours and point them in the direction of community hubs, social clubs and community centres. Similarly, participants with experience of mental illness highlighted the importance of people being aware of community spaces and caf*é*s where people can have positive social interactions:

> just the ability for people to know, be aware, that there are places you can go where there's more social interaction, in terms of, there are available places like coffee and chat etc., but, I know that everything costs money but there's got to be an answer in terms of we can't all live alone (male participant).

Older carers and practitioners supporting older people from BAME groups also highlighted the important role of churches and faith communities in welcoming people who may be isolated and providing activities that may help to foster social connections and promote their wellbeing.

6.3 How can best practices to prevent or reduce loneliness and social isolation be strengthened and developed in the future?

This final section draws on the interviews with practitioners and focus groups with service users, peer support volunteers and community members to identify priorities for action in improving, strengthening and enhancing best practices to alleviate and prevent loneliness and social isolation in Reading.

6.3.1 Raising awareness about LSI and links to health and wellbeing

Greater awareness of the issue of LSI, and the links to health and wellbeing, in addition to the issues faced by particular groups, were identified by practitioners as highly important in preventing and tackling loneliness and social isolation. Indeed, the Government Strategy on Loneliness (Department for Culture, Media and Sport, 2018) identifies the need to build a national conversation to raise awareness and reduce the stigma around loneliness. Practitioners in Reading suggested that LSI should be "*normalised*" and recognised by different statutory service providers, third sector organisations, employers and schools to ensure they are able to meet the needs of everyone and are reflective and outward facing. Raising awareness about loneliness involved the recognition that, "*Being lonely is a normal part of life. It's not a mistake*", as a member of the University Chaplaincy observed, and affects everyone at different times in their lives.

Indeed, the prevention of LSI was regarded by many practitioners as particularly beneficial and potentially more cost-effective in the longer term than waiting until people needed specialist interventions. A practitioner working with BAME groups commented: *"it is much more cost effective to help somebody before they become isolated and depressed and then get into the whole healthcare system"*. A member of the University chaplaincy observed, *"If you wait long enough, you'll probably get medical intervention – hopefully, not too late – but what you probably really need is nice people"*. Supportive relationships and enabling positive social interactions within an understanding and safe environment were key in addressing LSI at an early stage.

Practitioners supporting people experiencing drug and alcohol addiction emphasised the need to reduce the stigma surrounding addiction among 'mainstream' service providers so that their clients were able to access services and resources without being judged or being made to feel *"not welcome to access those services"*.

Furthermore, given the evidence presented in Section 4 about the barriers people faced in accessing healthcare and how people experiencing mental health challenges are at high risk of LSI and may experience a particularly profound sense of loneliness, greater recognition of this issue and ways to tackle LSI is needed at all levels of the NHS and mental health service provision.

Peer support volunteers with experience of mental illness felt strongly that mental health first aider training was very helpful in tackling the stigma surrounding mental illness and supporting people at times of crisis, which in turn reduced people's sense of isolation and loneliness. They felt mental health first aid training should be promoted in every school and workplace.

6.3.2 Increased availability of specialist support services for groups at risk of LSI

As discussed in Section 6.2, specialist support services are needed to address the specific needs of particular groups at risk of loneliness and social isolation. Some practitioners supporting disabled people and those with long-term health conditions recognised the importance of making 'mainstream' (non-specialist) activities and events inclusive and accessible to all. As a practitioner working with people with dementia articulated, *"in an ideal world, we wouldn't have separate services for people living with dementia"*. This view was also reflected by a practitioner who worked with people with autism: *"what we would really like is a future where the world is autistic-friendly, so that people could access any service they wanted to access. They don't have to have specialist services for them."*

Many practitioners however acknowledged that dedicated support from trusted professionals and/or peer support was often still required to address particular situational or personal risk factors for LSI. Indeed, given the significant stigma that many vulnerable groups face within statutory service provision and the wider community, as discussed in Section 4.2, specialist services are often needed address their specific needs.

Specialist support services were valued because they are underpinned by an understanding of the particular needs of that group and can be tailored to the individual. Individually tailored support was identified as crucial by practitioners supporting people with life limiting illness, for example: *"...really being led by the patient and what they would like and going at their pace with it."*

Several practitioners emphasised the importance of support groups and activities being available at weekends in tackling loneliness. As a practitioner working with people experiencing bereavement observed, feelings of loneliness and isolation may be particularly acute at weekends:

> *weekends for lonely people are the worst, Saturday and Sunday are terrible. On a weekday you can go out shopping, Saturday and Sunday families go out to the park and students go and do their own thing or go home, but isolated people are just very lonely.*

An NHS mental health practitioner also commented on the need to provide services at weekends, when people experiencing mental health challenges may be particularly lonely: *"the emphasis is what we can we do that is cheaper and that is accessible? What can I do on Saturdays and Sundays? During the week, people who work have some kind of structure to their week, but then, all of a sudden, Sundays, there's nothing to do."*

Many refugees and older carers identified a need for longer opening hours of specialist support groups, day centres and respite care, particularly at weekends. A female refugee and carer for example, commented that more dedicated support groups or day centres were needed for refugees, given their often limited social networks in settlement countries: *"It seems like there is a need for a day centre where refugees can meet, have access to own country, family abroad. Communication is a big barrier […] have many services available".* A need for a significantly increased availability of dedicated support services for refugees was identified, with much longer opening hours than was currently available – *"open seven days, not just two hours a week".*

Similarly, English language and life skills classes in women-only spaces at Reading Community Learning Centre provided valuable opportunities for women refugees, asylum-seekers and vulnerable migrants to build their confidence and develop supportive relationships, as also evidenced in the RCLC/ Participation Lab (2018) report. As a practitioner commented:

> *Alongside all the classes, the other thing they [minority ethnic women] really talk about is the friendships they built within the centre across nationalities, across cultures, across religions, sometimes in some cases across different sides of civil wars. They make friendships. And support each other. They quite often talk about the centre as their second family. It's that kind of feeling of women supporting each other.*

Alongside building life and social skills support among vulnerable groups, including refugees and migrants and people with mental health challenges, several third sector organisations provided opportunities for volunteering which helped to prepare people for work and improve their employability.

6.3.3 More collaborative working between organisations, and RBC, 'joined-up' thinking and signposting

Collaborative working was identified by many practitioners as a key priority for action, despite the acknowledgement that this was challenging in the context of austerity and cuts to statutory and third sector services:

> *People are suspicious of working too closely with other people. And the problem is that now that the resources are getting thinner and thinner people worry about collaboration, because they feel as though they're going to lose their money to somebody else. It's sad, but it's sort of true* (practitioner working with refugees).

> *I think we've always got a tendency to safeguard our own interests. I think it would be great if there was more joint working across, because this [loneliness and social isolation] happens in all the areas, in all the estates in Reading, especially where there is poverty* (practitioner working with people with mental health challenges).

Funding cuts, suspicion and safeguarding of interests appear to be significant barriers to the development of closer working relationships in this context.

Greater 'joined up thinking' about LSI and recognition of the need to meet the needs of Reading's diverse population was considered paramount for reducing loneliness and social isolation in this context of austerity, funding priorities and social policy. Several practitioners highlighted the importance of considering how local needs differ according to geographical location: *"in West Reading, maybe, their needs in relation to loneliness and isolation will be different from those of the people who live in Woodley"*.

Practitioners suggested drawing on the local knowledge of community groups and leaders, faith communities and third sector organisations working at the grassroots when planning and implementing services. As a practitioner supporting older people from BAME groups suggested: *"the council knows that there are these social needs, but yet it's how to implement it, how to get to the people. […] We have to use the local people, we have to ask them questions"*. Indeed, some practitioners called for greater recognition of the needs of BAME groups in Reading, since they may be subjected to racial harassment and discrimination and may be particularly vulnerable to social isolation: *"through their policies* [RBC need] *to show that they are committed to diversity and that they are committed to the needs of each of their residents in Reading and not just the majority population"*.

Practitioners working with people with learning disabilities also expressed frustration that the needs of this group were often overlooked, both at national and local levels:

> *…even the Green papers at government level, when they were looking at disability, learning disability was not included. When Reading Borough Council consider anything, learning disability is not included. You cannot just ignore a whole section of the community.*

While funding constraints were identified as the greatest barriers to implementing many of the priorities and best practices identified in this report, the need for 'joined-up thinking', however, was also related to the interlinked and cumulative nature of LSI, which meant that a seemingly unrelated action can have a significant impact on the occurrence of LSI among vulnerable groups. As a practitioner working with people with learning disabilities expressed: *"it's joining the dots up to look at the bigger picture, and seeing how one thing affects the next, rather than just actually thinking, 'How am I going to save money in my department?'"*.

Third sector practitioners specifically called for more collaborative working with Reading Borough Council that recognised their specialist expertise in working with particular groups who are vulnerable to LSI: *"listen to us and work with us […] We want to make this work"*. A practitioner working refugees pointed to the value, for example, of jointly bidding for central government funding with Reading Borough Council (RBC): *"I think that works for the council and for us"*. Given how resource-constrained many small voluntary and community organisations are, one practitioner working with BAME groups suggested how helpful it would be to have *"backing"* from RBC when applying for external grants: *"giving real, active support to grant applications"*.

A practitioner supporting young carers thought working in partnership with other organisations to bring together different groups who may be experiencing similar issues, such as young carers and young refugees, was helpful: *"for young carers and refugees to know what each other is going through and talk about their experiences, because, right, the same issue, they're going through it over here, the same issue"*.

Closer, more collaborative working and signposting on to other services and support was also identified by practitioners as enabling different services to refer cases onto each other and enable support for those who were socially isolated to be sustained over longer time periods. This was perceived as helping to reduce the occurrence of people *"falling between the cracks"* of an increasingly rigid system. As a practitioner working with people experiencing or at risk of homelessness expressed:

it would be really good for the social isolation if we could, when we're finishing working with somebody, we could liaise with some volunteers to say, "This person is going to be moving. They could really just do with a visit once a week, or go out shopping, or take them somewhere".

Some practitioners working with BAME groups emphasised the importance, not just of signposting, but supporting people to access statutory and third sector services since they had often developed relationships of trust with vulnerable migrants over time. They saw their role as enabling and supporting people to access specialist support and resources regarding for example, domestic abuse: *"Our job is not to say, 'Oh, we can deal with this'. It's to actually open up the resources that they didn't even know about".*

Third sector practitioners involved in facilitating social prescribing also highlighted a lack of knowledge among general practitioners (GPs) about available services and support, which led to limited non-medical recommendations. Greater collaborative working across statutory health and social care services and the voluntary and community sectors to address these barriers could include raising awareness about the important role health care professionals could play in signposting people on to sources of support.

6.3.4 Increasing the affordability and social accessibility of transport

Ensuring transport is affordable and accessible to the most vulnerable groups was identified as a continued priority for action. This priority reflects the fundamental role transport has in enabling social encounters. Many practitioners acknowledged that Reading has an impressive transport network compared to surrounding areas, and that ReadiBus transport is a much appreciated and respected alternative service for people with mobility impairments that should continue to be supported.

Concerns surrounding the accessibility of transport were primarily associated with affordability and issues of confidence. For instance, even if there is a bus that goes to wherever a person wants to go, if a person cannot afford £2 per journey or does not have the confidence to travel via bus, the fact that there is a bus running is irrelevant. There was also considerable concern about potential changes to concessionary fares for people using ReadiBus in future.

Ensuring the most vulnerable individuals are able to access the transport network in Reading was seen as a priority. An interviewee who works with people with life-limiting illnesses observed, *"ReadiBus is great, but actually for a lot of patients who are ill, it's just too long to be sat on a bus".* Practitioners supporting people with complex health needs and those supporting older people from BAME groups suggested the introduction of a volunteer transport scheme in particular neighbourhoods would be beneficial:

"if they could invest more in transporting people from point A to point B, get people from the community itself... people from the neighbourhood, the community itself, individuals, who would want to bring people in... Just give us some more money to get drivers, to get people out of their homes" (practitioner supporting older people from BAME groups).

"...volunteer driver schemes where you'd actually have a driver pick you up and take you somewhere, which is much more appropriate for our patients" (practitioner supporting people with life-limiting illness).

In addition to volunteer car schemes, ReadiBus practitioners suggested that neighbourhood volunteer transport schemes, which enable a volunteer to accompany people to travel on the bus, may help to build people's confidence in using Reading Buses and ReadiBus. For some, this support may enable them travel independently after a few journeys.

6.3.5 Developing peer support, befriending and volunteering schemes

As identified in Section 6.2, many practitioners supporting diverse groups of people who may be vulnerable to LSI felt that peer support, befriending and volunteering schemes were very useful in providing tailored one-to-one support and assistance in enabling people to take the first steps to engage in social and leisure activities and to access support groups and services. A practitioner supporting disabled people with physical impairments, for example, thought that one-to-one support was more helpful in tackling loneliness than group support: "*I think that must be about feeling someone wants to be with you and be interested. So, groups don't stop isolation so much.[...] We are doing things very much on a one-to-one basis*".

There were concerns however about cuts to befriending services and several third sector practitioners commented on the difficulties they faced in recruiting and retaining volunteers to provide sustained support for service users. As a practitioner working with blind and visually impaired people commented: "*People find it very difficult when they trust somebody and then they're gone...volunteer recruitment is just constant, ongoing and it's really difficult*".

Furthermore, several practitioners commented on capacity issues and the difficulty of having to rely on volunteers so much to deliver services due to funding constraints, as one practitioner working with BAME groups commented: "*the barriers for us are about capacity. I and another volunteer are leading on the friendship lunches. I cannot ask my staff to do one more thing. They are very close to burnout now. Very exhausted. They are very committed*".

6.3.6 Fostering good neighbourliness, faith communities and community development

As discussed in Section 6.2, several of the focus groups with service users and community members identified a need to foster good neighbourliness, support from faith communities and greater community involvement to tackle LSI. This was also emphasised by some practitioners, particularly those working with BAME groups: "*It's the person next-door, it's a community effort, the church and the community, whichever thing is going on in the community itself. The council cannot look at every single thing, it's impossible. We have to get up and say, "Well, we're gonna do something..."*".

Practitioners working with BAME groups were concerned that although BAME groups often "*do really well at supporting each other within their [ethnic] group*", social interactions and links between BAME and majority White communities were more limited and difficult to achieve. As a practitioner working with marginalised BAME women reflected: "*We need to do more of the whole cultural awareness side. We need to build more links with the outside world.... [with] people for whom, English is their first language. It could be a whole variety of people but local people*". Community development and fostering good neighbourliness, particularly in welcoming migrants, was identified as a key priority for the longer term: "*it's actually about trying to turn neighbourhoods into more friendly, accepting places*". Another practitioner working with BAME groups also felt that the emphasis should be on greater community engagement and ensuring that diverse ethnicities are represented in Reading:

> if we could actually do more community engagement and work with our communities and all of them together and put the funding and the resources into making sure that people feel that they're equally represented in Reading I think that is how we would actually tackle the problem more.

A practitioner working with people with dementia also felt community development was the cheapest and most effective way of preventing and tackling LSI: "*To me, that's the win/win [...]. It will take time but later down the line I think we will reap the rewards of investing in that for now*".

6.3.7 More accessible information, communication and promotion of activities and services

RVA's (2017) survey identified a lack of knowledge about what was going on as a major barrier to people becoming more socially active, reported by 36% of respondents in Reading. In this research, greater accessibility of information and promotion of available services and activities was recognised by practitioners and community members as highly important. Older people who may not be computer literate and those without Internet access as well as several practitioners also identified a need for the promotion of services, support groups and activities in print formats to tackle *"digital exclusion"*. As a practitioner from a supporting organisation articulated, "*People really still crave and want printed things through their doors and these noticeboards, as well as accessing information online"*.

As noted earlier, the lack of information about activities and services in inaccessible formats represented a major communication barrier for deaf people that hindered their social participation. As a practitioner working with deaf people commented:

> at the moment it's barriers to service that's really a big problem. The information, it's really difficult to read it, and clients in Reading come and they tell me that they can't read it. And it says to make a phone call for more information, and it's really quite poor. There are no signing videos, there's no one doing British Sign Language, there's nothing, so there's no access for us.

Equally, refugees and asylum seekers and other BAME groups pointed to the lack of interpreters and limited information available in languages other than English, which represented significant communication barriers that prevented them from accessing services and support.

6.4 Conclusion

This section has identified many best practices among existing services and support groups that help to alleviate and in some cases, prevent LSI in Reading and how these can be strengthened and developed in future. What is clear across the interviews and focus groups is that services, support and activities must be 'accessible' in terms of affordability, transport and tailored to the specific needs of particular groups who have been identified as vulnerable to loneliness and social isolation. The next section concludes and outlines the key recommendations for action.

7. CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This research project has explored the dynamics of loneliness and social isolation in Reading by analysing the vulnerabilities of particular groups from a range of perspectives. By focusing on societal, situational and personal risk factors and barriers that prevent people from developing good social connections and networks, the research has demonstrated the complex, multi-faceted nature of LSI and how for example, cuts in public services or barriers to statutory service provision may further marginalise people who are already vulnerable to loneliness due to their particular circumstances, such as mental health challenges, disability, ageing and loss of mobility, caring responsibilities, living alone or other significant changes, disruptions or transitions over the lifecourse. The project has demonstrated the closely entwined relationship between isolation and loneliness and health and wellbeing, with LSI representing both a cause and consequence of emotional, mental and physical ill health.

It has been widely recognised in the research literature that there is no one-size-fits-all approach to tackling loneliness and social isolation. The research has identified a number of best practices in alleviating and preventing LSI among statutory and third sector organisations working with vulnerable groups and community members in Reading (see Section 6). These include:

- Specialist support and safe spaces
- Focused group activities
- Making services and activities socially, financially and physically accessible
- Advocacy and assistance 'taking first steps'
- Peer support, befriending and volunteering
- Signposting to 'someone to talk to'
- Support from healthcare professionals
- Raising awareness about loneliness, isolation, social anxiety and mental health
- Befriending, good neighbourliness and faith communities.

The project also identified a number of areas where best practices to prevent or alleviate loneliness and social isolation in Reading can be strengthened and developed in the future (see section 6.3 and recommendations, section 7.2).

A key mechanism for successful loneliness interventions identified by Victor and others' (2018) review is in 'reconnecting' those who are experiencing loneliness within their community via the development of meaningful relationships. Central to such interventions is the need to tailor services, in terms of sociodemographic, spatial or loneliness experience characteristics, to individuals. There was also a need for recognition that loneliness interventions could potentially stigmatise users, if not advocated sensitively.

Service providers in Reading appeared to be aware of these issues and did not label or regard their work only as 'loneliness interventions', but rather felt that existing services they provided to marginalized groups aimed to facilitate good social encounters and could lead to the development of meaningful relationships among service users, with staff, peer support volunteers, befriending volunteers or community members. The research suggests that these practices and approaches could help to reduce loneliness in those already lonely and/or prevent loneliness among those at risk.

Victor and colleagues (2018, p.51) suggest the need for interventions to identify their goals in terms of either loneliness reduction in those already lonely or loneliness prevention for those at risk (or both). The evidence suggests that that tailored and/or targeted interventions towards those vulnerable to loneliness would be more likely to result in reductions in loneliness. This research in Reading was however only able to provide a snapshot of a small selection of service users' experiences. More detailed evaluations of particular services are required to assess whether particular approaches led to reductions in loneliness among those already lonely or whether they prevented loneliness, with long-term follow-up and appraisal of cost-effectiveness needed (Victor and colleagues, 2018).

It must also be acknowledged that this qualitative study does not seek to be representative of all social groups who may be vulnerable to LSI in Reading, but rather to give in-depth insight into a diverse range of perspectives and experiences of practitioners working across statutory and third sector organisations and those of service users, peer support volunteers and community members in diverse circumstances. The six focus groups sought to include the views and experiences of a range of people who may be vulnerable to loneliness and isolation due to situational or personal risk factors, including refugees and asylum seekers, deaf and hearing impaired people, people with experience of mental illness, people at risk of homelessness, older carers and parents. However, we found it difficult to recruit vulnerable young people to participate in the study, despite evidence nationally and locally that children and young people may experience relatively high levels of loneliness compared to other age groups (ONS, 2018; McClane, 2018). As Victor and colleagues (2018, p.51) observe, the lack of evidence specific to young and mid-life adults is "a clear gap in our knowledge base and reflects the conceptualisation of loneliness as a problem of later life".

We also were unable to recruit primary healthcare professionals to participate in the study and consequently, were unable to include their views and experiences, particularly of initiatives aiming to provide more joined-up thinking and signposting of support, such as 'social prescribing'. Our research has however identified a number of barriers to accessing healthcare services, particularly among people experiencing mental illness, homelessness and drug and alcohol addiction. The findings also highlight the important role that General Practitioners (GPs) and other healthcare professionals can play in signposting people experiencing loneliness on to voluntary and community organisations for one-to-one support, specialist support groups or community activities.

Social prescribing schemes are identified in the Government's Loneliness Strategy (2018, p25) as a key means of "helping people to secure the support they need". NHS England estimates that 60% of Clinical Commissioning Groups have commissioned some form of social prescribing scheme, which,

> enables organisations to refer people to a range of services that offer support for social, emotional or practical needs. This could include feelings of loneliness, as well as for debt, employment or housing problems, or difficulties with their relationships (Department for Culture, Media and Sport, 2018, p.25).

The Government Strategy notes that existing evidence from individual schemes suggests that social prescribing may improve outcomes for people and reduce pressure on the NHS.

7.2 Recommendations for action to alleviate and prevent loneliness and social isolation in Reading

Best practices for reducing LSI need to be specifically targeted to meet the diverse needs of the people most at risk of loneliness and social isolation according to socio-economic, geographical, gender, age and ethnicity differentials, in addition to situational and personal factors. These include immigration status, homelessness, drug and alcohol addiction, mental health, disability, loss of mobility and long term illness, caring responsibilities, living

alone, lifecourse transitions and so on (see Section 4). There was also a need identified for services, support and activities also need to be socially, financially and physically accessible and to address barriers in accessing statutory service provision.

To ensure that the best practices discussed in Section 6 are strengthened, enhanced and developed in the future, this project has identified the following recommendations for action:

- Raising awareness about loneliness and social isolation (LSI) and its links to health and wellbeing among statutory and voluntary and community sector service providers, employers, schools, members of the public.

- Greater provision of specialist support services for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends.

- Fostering more collaborative working 'joined-up' thinking and signposting between organisations, Reading Borough Council and primary healthcare providers.

- Increasing the affordability and social accessibility of transport, including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives.

- Developing and supporting peer support initiatives and befriending and volunteering schemes.

- Fostering good neighbourliness, supportive faith communities and community development .

- Providing more accessible information, communication and promotion of activities and services in appropriate formats.

Finally, despite distinctions between the concepts of 'loneliness' and 'social isolation' being widely recognised in the literature, in this research, we often found the two concepts being used interchangeably among practitioners and service users. The government strategy published in 2018 focuses on loneliness, rather than loneliness and social isolation, with accompanying guidance about how to measure loneliness and resources to tackle it. Reading Borough Council's multi-agency steering group, thus, may wish to consider having a clearer focus on alleviating and/or preventing 'loneliness', specifically, as the work develops in future. These conceptual differences are important since they influence "the interpretation of evidence as to what interventions work, for whom and in what context" (Victor and colleagues, 2018, p.8).

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TACKLING LONELINESS AND SOCIAL ISOLATION IN READING, ENGLAND

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