Social Isolation, Loneliness and Community Connectedness in Camden: Health Needs Assessment

Contents

1. Introduction

Social isolation and loneliness not only have detrimental impacts on wellbeing but are increasingly recognised as major predictors of poorer physical and mental health outcomes[2,3]. The highest levels of social isolation and loneliness are estimated to have an equivalent health-harming effect as obesity and physical inactivity[3], and national prevalence of both are increasing with predictions that they will reach epidemic status by 2030[4].

Tackling social isolation and loneliness while strengthening community connectedness is a key strategic priority for Camden set out in Camden's Health and Wellbeing Strategy[1] and embedded as one of the community challenges in We Make Camden. In order to inform local decision-making in this area, it is important to establish a shared understanding of what the local needs are, what Camden is currently delivering to meet these needs, and explore what opportunities there are to enhance programmes in place within Camden to alleviate social isolation and loneliness.

This health needs assessment will review the national and local evidence with the aim of consolidating our knowledge about the local context identifying current strengths and identifying gaps in the support and services which could be addressed to help improve the quality of life and reduce the health and wellbeing burden from social isolation and loneliness.

2. What we mean by social isolation, loneliness and community connectedness

Social isolation and loneliness describe two distinct states of inadequate social support while community connectedness is a measure of the availability and quality of social assets available in the local area.

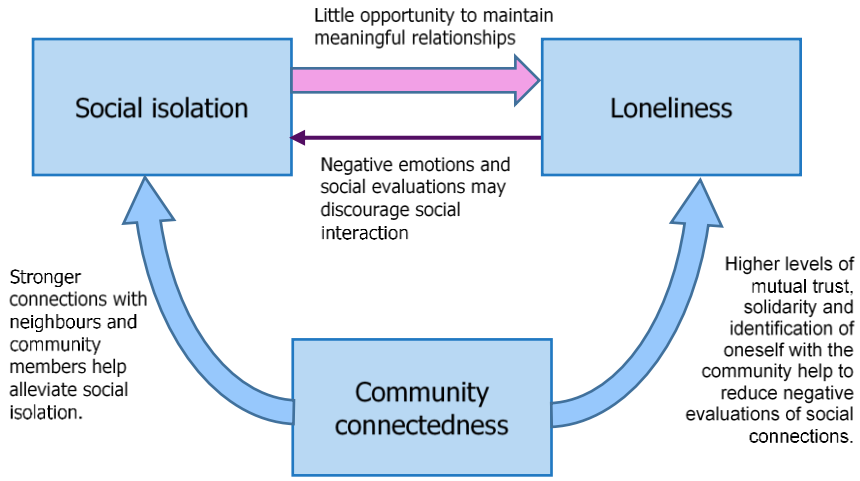
Social isolation refers to a deficit in the number of social contacts a person has in their day-to-day life[5]. For example, a person may be socially isolated because they live alone, have few social ties, and/or infrequent social contact with others.

Loneliness is the unpleasant feeling experienced when a person does not have the level or quality of connection with others they would desire[6]. While more common in people who are socially isolated, loneliness can occur for anyone regardless of their social network size. Most people experience loneliness at some point in their lives[7] but the greatest impact on health and wellbeing is from severe and chronic loneliness[8].

Community connectedness can be thought of as the 'sense of community' in a local area. Several factors have been identified as underlying the degree of community connectedness, including shared resources, a sense of solidarity, identification of oneself with the community, mutual trust between members of a community and a network of family, friends, neighbours and community members available to provide physical, psychological or financial help[9,10,11].

Social isolation, loneliness and community connectedness are interlinked. Social isolation is a risk factor for loneliness, while loneliness may have a less significant impact on increasing social isolation. Meanwhile, community connectedness helps to alleviate the effects of both.

Figure 1: The relationships between social isolation, loneliness and community connectedness



Produced with reference to Wigfield et al. (2020)

3. The impact of social isolation and loneliness on health and wellbeing

Social isolation and loneliness contribute significantly to poorer health and wellbeing outcomes. Both contribute to higher levels of smoking, physical inactivity and poor sleep[12,13,14], and people who have poorer social networks are also at higher risk of some long-term health conditions, including increased risk of cardiovascular disease and stroke[15], faster rate of cognitive decline in older age[16] and higher risk of developing dementia[17]. In terms of mental health, loneliness and minimal social networks appear to increase depression, anxiety and suicidal ideation throughout adulthood[18,19], and lead to a greater susceptibility to suicide and self-harm, particularly at an older age[20,21,22,23]. Relative to the general population, the risk of a premature death is 29% higher for people who are socially isolated, 26% higher for people who are lonely and 32% higher for people who live alone[24].

People who are socially isolated or lonely tend to make increased use of unplanned and emergency healthcare services, and are likely to stay for longer in hospital and more likely to be readmitted following a discharge[26,27]. A study by the Campaign to End Loneliness found that as many as one in ten visits to GP practices in the UK could be due primarily to the issue of loneliness rather than any specific medical need[28], while research from Scotland suggests that experiencing loneliness between the ages of 40 and 60 predicts approximately twice as many visits to GP practices[29].

There are several reasons patients who are socially isolated or lonely might be more likely to seek emergency medical care. The most obvious is the detrimental health effects that experiencing social isolation and loneliness can have on both physical and mental ill-health meaning that people subject to these risk factors are more likely to present with genuine health concerns[42]. Secondly, those people who are socially isolated or lonely are less likely to have access to a community caregiver (e.g. a family member, friend, or neighbour) able to support them with recovery from an illness, thereby leading to increased reliance on emergency healthcare services. The need for interpersonal communication may also motivate some people who are socially isolated or lonely to access health services even when they do not have a medical concern. Socialising at a GP surgery or emergency department can offer relief from the unpleasant feelings associated with loneliness[83].

There is some evidence to indicate that social isolation or loneliness also increases the risk of requiring social care services. A study of English older people found that those identified as lonely were at a significantly higher risk of care home admission independent of age, health status, memory deficits, and wealth, while it was estimated that 20% of all care home admissions in the study could be attributed to the issue of loneliness[30].

Encouragingly, having strong social networks is found to have an equally if not more pronounced protective effect on health relative to the harms of social isolation and loneliness[24]. Social connectedness is associated with improved psychological and emotional wellbeing, lower risk of physical health conditions and increased longevity[24]. A meta-analysis looking at the positive effects of social relationships and broader social integration revealed that they each increased the odds of survival by as much as 51% and 91% respectively[3].

4. Mechanisms through which social isolation and loneliness might cause ill-health

The mechanisms underlying relationships between social isolation, loneliness and poor health and wellbeing outcomes are complex and likely to involve multiple overlapping causal pathways[42]. There is evidence that social isolation is a precursor to loneliness which then has a detrimental health impact[42,84]; however many socially isolated people who do not feel lonely are also at risk of poorer health[24,42]. The following sections outline the currently understood mechanisms that may account for the physical health effects of social isolation and loneliness. Figure 2 which follows is one model that has attempted to show the relationships between these factors and some of the mechanisms at play.

4.1 Lifestyle factors

People who are socially isolated and/or lonely are more likely to engage in health-harming behaviours including cigarette smoking, low levels of physical activity, and poorer sleep habits[12,13,14], and at least one large study has found that a combination of these lifestyle risk factors mediated the link between loneliness and poor health outcomes[85].

One possible cause for the association of social isolation and/or loneliness with health-related behaviours is detachment from the community and lower sensitivity to social norms which would otherwise act as a health-promoting influence[86]. Another factor could be the a reduction in the ability to regulate emotions by people who are socially isolated or lonely which may lead to maladaptive coping mechanisms[86].

It should also be noted, however, that lifestyle factors, social isolation and loneliness are likely to operate in a multi-directional relationship such that as well as socially isolated and lonely people being more likely to engage in risky health behaviours, these behaviours can also increase the risk of a person becoming socially isolated and/or lonely[42].

4.2 Psychological pathways

People who are socially isolated and/or lonely experience greater levels of stress and are at risk of developing mental health conditions such as depression and anxiety[42]. Prolonged and high levels of stress can result in harmful biological responses including hypertension and inflammation[87]. The stress-buffering model proposes that the practical and emotional support available for people with higher levels of social support can lower the physiological effects of stress on the body meaning that it is less likely to lead to poorer health outcomes[42].

Meanwhile, social isolation and particularly loneliness has been shown to promote feelings of being unsafe and hypervigilance to social threat[86]. These cognitive biases can alter evaluations of social interactions and result in a build-up of stress, anxiety and low self-esteem. Poor mental health has been independently linked to worsened health outcomes.

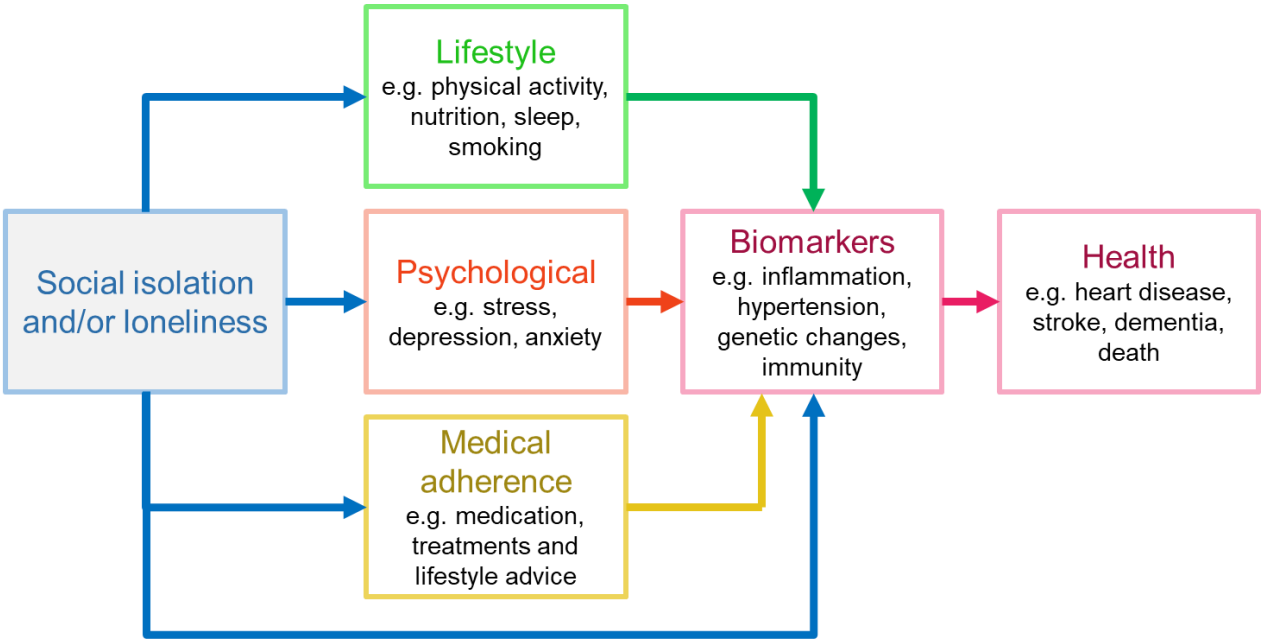
4.3 Biomarkers

Lifestyle factors and psychological pathways can both lead to chronic biological responses (e.g. hypertension, inflammation and poorer immune system functioning) that cause physical harm[42]. Evidence also suggests that social isolation and loneliness can have a direct impact on these biomarkers[42]. While the research in this area is still emerging, there is some evidence that prolonged social isolation and loneliness can result in long-lasting changes to the function of the cardiovascular system, nervous, hormonal and inflammatory pathways that increase the risk of ill-health[42].

4.4 Medical adherence

Adherence to medical advice (e.g., taking medications and following lifestyle interventions) is a documented predictor of health outcomes. There is evidence to suggest that the level of social support a person has can mediate their responsiveness to medical treatment[88]. The results of a large meta-analysis point to practical social support having the greatest effect on medical adherence with emotional support and structural indicators, such as living with others and being married, having a lower but still significant influence[88].

Figure 2: The factors and mechanisms between social isoaltion and loneliness and health outcomes



5. What do we know about levels of social isolation and loneliness in Camden?

5.1 Prevalence of social isolation

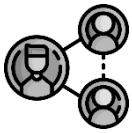
Social isolation is difficult to quantify due both to the wide range of factors that contribute and the lack of a universal definition[31]. However, proxy indicators such as the number of people living alone, the number of people who are single, separated, divorced or widowed, and metrics on community participation, can be used to obtain an estimate on potential need.

18% of the population in Camden **live alone**, which is higher than the proportion in London (13%) and England (13%)[32,33].

Around **41%** of all households in Camden are single-person households, the 4th highest proportion in the country[34]. **24%** of these are council tenants.

65% of the adults in Camden are single, separated, divorced or widowed[35]

39% of people in Camden who draw on care and support believe that they spend too much time alone[36].



15% of adult social care safeguarding referrals between 2019 and 2021 included a concern about social isolation[37].

5.2 Prevalence of loneliness

The most recent national survey data on loneliness is from April 2021. This showed that 7% of adults in Camden felt lonely often or all of the time, which is in line with the proportions for London (7%) and England (7%)[38].

However, Camden residents were more likely to identify themselves as being lonely some of the time (33%) compared with London (21%) and England (20%) and consequently less likely to report being lonely hardly ever (18%) or never (14%)[38]. The COVID-19 pandemic is likely to have impacted the prevalence of loneliness captured in this survey which took place during the second lockdown with restrictions on socialising between households. While there are no earlier comparable data for Camden, evidence at the national level shows an increase in the prevalence of loneliness in recent years from 5% in 2013/14 to 7% in 2020/21[39].

Loneliness as a term is not universally understood and can be stigmatising meaning that people may answer questions about loneliness in ways that do not reflect their underlying need. When national surveys include proxy questions about companionship or feeling left out and isolated, prevalence of loneliness is higher[39]. This indicates that the data available for Camden may underrepresent the actual prevalence of loneliness experienced in the borough.

5.3 Groups at increased risk

The following section highlights the population groups who are at increased risk of social isolation and loneliness based on national evidence.

5.3.1 Individual and relationship factors

People at a younger or older age

What the risk is: Older people are the most likely to be socially isolated and the risk of becoming isolated increases with age[31]. The prevalence of loneliness, meanwhile, follows a U-shaped

trajectory through the life course with a peak in younger age groups (aged 16-24) and a second, lower peak in old age[40].

Why there is an increased risk: Age is not a standalone risk factor for social isolation or loneliness but factors that correlate with age are likely to explain the differences in prevalence across the life course[42]. Older people, for instance, are more likely to suffer from long-term health conditions and disabilities, to have experienced bereavements of family and friends, to have stopped working, and to have fewer economic resources, all of which impact on the ability to remain socially connected[89]. The reason for a peak of loneliness in young people might be explained through the concentration of life transitions through this age period including moving away from home for the first time, leaving school, and starting university[90], but younger people also tend to have higher expectations for the size of their social networks[91].

Situation in Camden: As a central metropolitan borough with a university presence, Camden has a large proportion of students and younger adults, relatively few children and older people compared to national averages.

According to 2020 ONS population estimates, 13.2% of the Camden population are aged 16-24 years which is a higher proportion than both London (10.3%) and England (10.5%). 26,300 people in Camden are students in higher education, the second largest student population in London as of 2020/21.

Conversely, people aged over 65 represent only 12% of the Camden population, in line with the average for London (12.2%) but lower than for England (18.5%). Similarly, the proportion of people aged over 85 was estimated to be 1.7% for both Camden and London overall, compared to an England average of 2.5%. As with most areas, Camden has an ageing population with the population over 65 expected to increase by 21% in the next ten years.

People with a long-term physical health condition

What the risk is: People who have a long-term physical health condition (e.g. heart disease, chronic obstructive pulmonary disease, cancer, stroke) are at greater risk of social isolation and loneliness[42]. National statistics indicate that 15% of people with a limiting health condition or disability feel lonely often or always compared to only 4% for those without a health condition or disability[39]. Furthermore, the health-harming effects of social isolation and loneliness can exacerbate the physical health condition over time leading to a bi-directional relationship between poor health, social isolation and loneliness[42]. The risk of experiencing social isolation and loneliness increases for people whose long-term health conditions limit their day-to-day functioning and are especially prevalent in people who have multimorbidity[42].

Why there is an increased risk: The functional limitations of long-term health conditions can affect the ability of people to participate in the community leading to reduced social networks and fewer opportunities to socialise[42].

Situation in Camden: 15% of Camden's population aged 16+ have one long-term health condition and 12% have more than one.

People with a physical disability

What the risk is: People whose disability affects their mobility have been found to score higher on measures of social isolation and loneliness. National statistics show that people with a disability are almost 4 times more likely to be lonely often or always**Error! Reference source not found.**, while a study by Sense revealed that before the pandemic more than a third of people with a disability were chronically lonely rising to 61% in early 2021 and as high as 70% for young people with a disability **Error! Reference source not found.**. Two thirds of people who have a disability note that their mental health and wellbeing is affected by social isolation.

Why there is an increased risk: Due to issues with the accessibility of the local community (e.g., uneven roads, lack of public toilets), people with a disability may find it difficult to participate in

services and social activities available in their area. People with a disability may also be subject to stigma, discrimination and less likely to be employed which affects opportunities for socialisation[94]. Meanwhile, for some people, developing a physical disability after birth may lead to a sense of loss and psychological distress resulting in social withdrawal[94].

Situation in Camden: Disability data at the local level are not available.

People with a common or severe mental health condition

What the risk is: Experiencing a common mental health condition including depression, generalised anxiety disorder and social anxiety disorder, has been found to predict a greater risk of loneliness during mid and late adulthood[19,95] and people living with severe mental illnesses (e.g. bipolar or psychotic disorders) have further been estimated to be more than twice as likely to experience loneliness as the general population[96].

Why there is an increased risk: Having a mental illness can present multiple barriers to social participation including social stigma[97], limitations resulting from psychiatric symptoms and cognitive biases that promote negative appraisals of social interactions[98]. People with severe mental illnesses are also more likely to be single, separated, divorced or widowed, to be unemployed and to experience a greater level of poverty all of which are individual risk factors for social isolation and loneliness[99].

Situation in Camden: 19% of Camden's population aged 16+ have a common mental disorder, no different to London (19%) however statistically higher than England (17%). Meanwhile, the prevalence for people over 65 is 12%, which is slightly higher but not statistically different to London (11%) or England (10%). In 2014/15, Camden had the third highest diagnosis rate for serious mental health illness in London with a diagnosis rate of around 1%[44].

People experiencing cognitive decline

What the risk is: Neurodegenerative disorders such as dementias and Parkinson's disease can result in social withdrawal, isolation and loneliness even in the pre-morbid early stages of disease[42]. A study by Alzheimer's Society found that 38% of people with dementia say that they are lonely[100].

Why there is an increased risk: Difficulties with social perception, understanding what others are thinking or feeling, displaying appropriate emotions and behaving within social norms all contribute to difficulties forming and maintaining social relationships[101]. According to Alzheimer's Society, 70% of people with dementia stop doing their usual activities following a diagnosis[100].

Situation in Camden: Around 5% of people in Camden aged over 65 have been diagnosed with dementia which is significantly higher than for London and England[102].

People living with frailty

What the risk is: Frailty, social isolation and loneliness exist in a multi-directional relationship[42]. Usually experienced at an older age, frailty has been shown to have a greater impact on social participation when combined with other geriatric syndromes including urinary or faecal incontinence[42].

Why there is an increased risk: With increasing levels of frailty, a person is more likely to lose confidence, withdraw socially and to go out into the community less often[42]. People who are frail may also find their local areas inaccessible due to lack of seating, unsafe roads and long distance to amenities.

Situation in Camden: 32% of people aged 65 and over in Camden are classified with mild frailty, while 21% are classified as having moderate frailty. An additional 8% of people aged 65 and over in Camden are classified with severe frailty.

People with learning disabilities and/or autism spectrum disorders

What the risk is: Over a third (36%) of people with a learning disability in the UK have been found to feel lonely all or most of the time while a similar proportion (37%) indicated that they rarely or never go outside to socialise and 33% stated that they did not feel part of their local community[Error! Reference source not found.]. Reciprocal friendships are less common for people with learning disabilities and those that do exist are commonly with paid staff, family members or other people with learning disabilities[42]. People with severe and profound learning disabilities, meanwhile, rarely have any meaningful contact with friends[104]. People with an autism spectrum disorder (ASD) are also at higher risk of experiencing social isolation and loneliness whether or not they have a learning disability[105].

Why there is an increased risk: People with learning disabilities may be at higher risk of social isolation and loneliness due to deficits in communication and socialisation skills, lack of understanding from society, limited financial resources, and lack of opportunities to make social connections through work, education and the community[103,106]. Meanwhile, research shows that people with ASD are more likely to be lonely if they have a greater number of autistic characteristics, mental health symptoms, have had negative social experiences in the past (e.g. bullying), are subject to a lack of understanding or acceptance by others, experience sensory stress, aim to camouflage their features of autism, and if they are unemployed[105].

Situation in Camden: In the year 2019/2020, 0.4% of the population in North Central London had a learning disability[107], in line with the London average but significantly lower than for England as a whole (0.5%). There is limited local data on the numbers of people with an ASD without a learning disability in Camden. Population estimates for the year 2017, suggested that there were around 1071 adults in this category, representing a prevalence of around 0.4% of the population[108]

People with a sensory impairment

What the risk is: People with hearing loss[76] or a visual impairment[77,78] are more likely to become socially isolated and lonely especially when experienced at a younger age. The prevalence of loneliness has been measured as high as 28% in people with a visual impairment[109] while the odds of experiencing severe loneliness has been found to increase by 7% for every decibel of hearing loss before the age of 70[109]. The largest prevalence of loneliness meanwhile may be in people who have developed both hearing and visual impairments[111].

Why there is an increased risk: Sensory impairment can affect the ability of a person to communicate effectively. It may also cause a loss of confidence and make areas of the community inaccessible. Furthermore, a grieving process over impaired senses can increase the risk of mental ill health which is itself a predictor of social isolation and loneliness[109,110,111].

Situation in Camden: In 2019/20, 480 people in Camden aged over 65 were registered as being either partially sighted or blind[112]. No data was available on the number of residents in Camden with a hearing impairment or who having both a hearing and visual impairment.

People who live alone

What the risk is: People who live by themselves are more prone to experiences of social isolation and loneliness than those who co-habit[42]. Around 10-20% of people living alone indicate feeling lonely[Error! Reference source not found.].

Why there is an increased risk: Living alone means minimal social contacts within the home[42]. For older people especially, living alone may lead to days or longer without seeing or talking to another person. Living alone does not equate to social isolation however, and many people who live

alone are likely to be well-connected through the community and social networks outside of the home[42]. There is likely to be a distinction between those people who live alone because they choose do so and others who feel such an arrangement deprives them of social contact.

Situation in Camden: Around 41% of households in Camden are single-occupied, with 24% of these being council tenants[34].

People who have suffered a bereavement

What the risk is: Being widowed significantly increases the risk of loneliness among older people with a prevalence as high as 30%[0,115].

Why there is an increased risk: Bereavement is a life-altering transition involving the loss of emotional, physical and social support, sadness, social withdrawal, and acute or long-lasting loneliness[42]**.**

Situation in Camden: Around 4% of Camden residents were widowed at the time of the 2011 Census, lower than both London (5.0%) and England (6.9%)

People who are single, separated or divorced

What the risk is: People who are single, separated or divorced experience an overall elevated risk of loneliness[42] but the diversity of this group is likely to overshadow nuances in individual experiences**Error! Reference source not found.**. In some cases, for example, people who are single, divorced or widowed may engage more in the local community through keeping in touch with friends and relatives, participating in local organisations and volunteering in civic projects which protects against social isolation and loneliness. Furthermore, if a person is with a partner but the relationship is unfulfilling, this can instead increase the risk of loneliness[117].

Why there is an increased risk: People who are single, separated or divorced may miss out on the meaningful social relationships and support provided by a partner[42].

Situation in Camden: 65.5% of the adult population in Camden were single, separated or divorced at the time of the 2011 Census, compared to 54.7% in London and 46.3% for England. The majority of adults in Camden were single, representing 54.9% of the population, with 10.6% being separated or divorced.

People who provide unpaid care

What the risk is: Survey data indicates that around 81% of informal carers experience loneliness or social isolation, rising to 86% for carers providing 50 or more hours of care per week, and as high as 93% for parents caring for a disabled child[96]. Social isolation and/or loneliness was also more prevalent in carers aged 24 or under (89%) and among those who had been providing care for prolonged periods (84% for those providing care for 10 years or longer)[48].

Why there is an increased risk: The responsibility of caring for a relative, friend or neighbour reduces the time, energy and financial resources that informal carers can use to socialise and participate in the community[48].

Situation in Camden: The 2011 Census showed 8% of local residents providing unpaid care. Two thirds of these provided less than 20 hours per week, while 1 in 5 provide 50 or more hours[49]. More recent polling has shown up to 26% of residents may be unpaid carers, representing a more encompassing definition and significant rise due to the COVID-19 pandemic.

People who have just become mothers

What the risk is: According to a 2015 AXA Healthcare survey, 28% of mothers experience loneliness after giving birth to their first child[51].

Why there is an increased risk: Becoming a new mother is a major life event that can transform the way that women socialise and consequently lead to an increased risk of becoming socially isolated and lonely[51]. The new challenges of caring for a child can also present additional social support needs meaning that previously adequate social networks become insufficient to maintain wellbeing.

Situation in Camden: There were 2,240 new births in Camden in 2020[99]. National data indicates that 44% of all births in England and Wales were to first time mothers which, if applied to Camden, would estimate that there were approximately 986 new mothers in Camden in the year 2020.

People from a Black or Minority Ethnic background or a new migrant to the UK

What the risk is: When asked about their experiences of loneliness indirectly, 14% of Black people scored in the highest categories for loneliness relative to only 9% for their White and 7% for their Asian peers[39]. Meanwhile, research during the pandemic has shown that 23% of people from ethnic minorities reported often feeling lonely versus 17% for White people, while 38% felt 'alone' and as if they had nobody to turn to compared to 28% for White people[0]. At particular risk of experiencing social isolation and loneliness are new migrants to the UK. One study of UK older immigrants of Indian, Pakistani, Bangladeshi, African Caribbean, and Chinese ethnicities found that between 24-50% were lonely, and prevalence in all except Indian immigrants were significantly higher than the British average[57].

Why there is an increased risk: A sense of belonging to the community has been found to be a significant mediator of loneliness[56]. People from Black and Minority Ethnic backgrounds who felt that they did not belong to their communities had a 67% prevalence of loneliness compared to only 16% for people who felt that they did. Racial discrimination also exacerbates loneliness with 49% of those who had experienced racial discrimination found to feel lonely compared to only 28% who had not. People from Black and Minority Ethnic backgrounds are furthermore predisposed to other risk factors for social isolation and loneliness including lower incomes, deprivation and financial hardship[0] and during the pandemic were also at elevated risk of ill-health and of experiencing bereavements which might have contributed to excess loneliness experienced during this time[120]. Migrants to the UK may be particularly at-risk of loneliness due to factors including unfamiliarity with the culture and community, financially precarious situations, and limited English language proficiency[57].

Situation in Camden: As of the 2011 Census, 35.5% of the Camden population were of a non-White ethnicity. Around 17.7% were Asian, 8.9% were Black, 4.4% were of mixed ethnicity and the remainder were from other minority ethnic groups[58].

As a central London borough, Camden experiences a high degree of population churn. Camden has the second highest rate of people migrating to the borough from other countries (non-UK) with a rate of 471 per 1,000 resident population in 2020 compared to 369 and 156 per 1,000 for London and England respectively. There were 20,044 long-term international migrants between mid-2019 and mid-2020[59]. The number of vulnerable migrants including asylum seekers living in Camden has increased in recent months which may be due in part to situations in Afghanistan and Ukraine. As of March 2022, there were 122 asylum seekers receiving support from the local authority in Camden[60].

5.3.2 Place and community factors

People who live in inaccessible neighbourhoods

What the risk is: The ease of access to local resources and destinations and walkability of neighbourhoods is an important predictor of loneliness[66].

Why there is an increased risk: Lack of easy access to amenities such as shops, cafes, libraries, leisure facilities and green spaces, and barriers such as high curbs, hills, lack of seating, and dangerous roads can minimise the opportunities for people to socialise in their local communities[66,121]. Especially if alternative means of transportation are unavailable or less convenient, giving up driving can further restrict the ability of a person to participate socially and increase the risk for social isolation and loneliness[66].

Situation in Camden: Walking in Camden accounts for 42% of all journeys made within the borough which is the highest in London outside of the City of London[Error! Reference source not found.]. Camden ranked third highest for public transport accessibility levels in an analysis by TfL in 2015[68] and, in 2020, Camden's traffic levels were among the lowest in London (31 out of 33 boroughs)[69]. However, between 2016 and 2018, death or serious injury on Camden's roads occurred at a rate of 50.9 per 100,000 population which was higher than the London average of 39.4 per 100,000 population and 6th highest ranked borough in London[70].

People who feel unsafe in their local community

What the risk is: People living in areas affected by high crime rates have been documented to experience fear that reduces the extent to which they feel safe to leave their homes and participate in their local communities[123].

Why there is an increased risk: Prior exposure to community violence, either by direct victimisation or being a witness to violence inflicted on others, resulted in reduction in the number of social contacts, perceived social support and increases in feelings of loneliness[124]. Some people who are subject to crime may develop post-traumatic stress disorder (PTSD) which can cause hypervigilance to threats, social withdrawal and increased feelings of loneliness[124,125]

Situation in Camden: The 2021 Camden crime rate was 107 crimes per 1,000 people, 19% higher than the London average of 87 per 1,000 people[71]. There were 7,097 violent or sexual offences recorded in Camden for the year 2021, indicating a rate of 26 crimes per 1,000 people, compared to the London average of 27[71]. Camden has the second highest crime rate in London after City of Westminster[71].

5.3.3 Social determinants

People from lower socioeconomic backgrounds

What the risk is: Income inversely correlates with social isolation and loneliness[61,126] while unemployment has also been strongly linked to an increased risk of loneliness with the relationship becoming particularly pronounced between the ages of 30-34 and 50-59 years[63,127]. There is mixed evidence on the impact of educational level on social isolation and loneliness in older age[62] but studies suggest that lower educational level predicts loneliness more significantly earlier in life, especially adolescence and early adulthood[63].

Why there is an increased risk: A low income presents barriers to socialisation as people may not be able to afford to take part in social activities and are more likely to live in deprived areas with fewer community amenities[63,126]. People in lower income groups are also more likely to be people who have had to give up work due to illness, disability or a caring role, all of which are separate risk factors for social isolation and loneliness[63,126]. Education level may have more of an effect on loneliness among young people since this is the period of life when people may be attending sixth form, university or starting new jobs. A lower educational attainment may preclude someone from participating in these rich social experiences[63].

Situation in Camden: Around 14% of Camden residents were income deprived in 2019[64]. Camden was the 91st most income deprived borough in the UK with 32 out of 133 neighbourhoods falling into the top 20% of neighbourhoods nationwide ranked by income deprivation. Approximately 3.4% of people of working age in Camden were unemployed 2021, which was lower than for London (5.8%) and Great Britain (4.5%). Meanwhile, around 5.8% of people aged 16-64

in Camden have no formal qualifications which is higher than the 5.5% for London as a whole but lower than the 6.6% for Great Britain[65].

6. Effects of the COVID-19 Pandemic

Restrictions on social contact, access to communal spaces, and shielding advice put into place across the UK through the COVID-19 pandemic are likely to have had a significant impact on the prevalence and severity of social isolation and loneliness nationally and locally[72,73]. During certain periods of the pandemic, people were unable to meet face-to-face, connect with family, friends and neighbours, or participate in regular community activities. Polling for the British Red Cross found that 41% of people found themselves to be lonelier after the 2020 COVID-19 restrictions, while millions were going more than two weeks without social contact[74]. As well as the acute impact on social isolation and loneliness that is likely to recover over time, a longer-term effect is predicted as many people have become disconnected from their communities, and are hesitant to re-engage with previous levels of social participation[74,75,76]. In addition, some programmes or activities were paused during the pandemic and not all of these have resumed, or have not resumed in their previous format.

Survey data analysed by the Office for National Statistics (ONS) revealed that the proportion of people 'often' feeling lonely across the UK increased from 5% in April 2020 to 7% by February 2021, representing an increase nationally of around 1 million people[73]. These effects have disproportionately exacerbated loneliness among those already at the highest risk while the least lonely groups before the pandemic have become even less lonely[77]. Groups identified as being particularly susceptible to increased loneliness during the pandemic were young people, people living alone, those on low incomes, people from Black, Asian and other minority ethnic backgrounds, unemployed people and people with a mental health condition[74,77].

Being a student emerged as an even greater predictor of loneliness during the COVID-19 pandemic[77] and young people aged 16-24 were around four times more likely to report 'lockdown loneliness' relative to people aged over 65[73]. Colleges and universities were mostly delivering online-only content during the vast majority of the pandemic limiting the opportunities for students to socialise and make new friends which is especially important at times of transition[78]. While the increased risk from being a student will possibly decline again as in-person teaching resumes and restrictions have ended, there may also be a long-lasting effect in those students who completed their courses during the pandemic and were unable to build the same lifelong social relationships as their predecessors[78]. Camden has a large number of higher education providers and the second largest student population in London making increases in loneliness among the student population of particular relevance to the borough.

Due to the shift towards virtual service delivery and social connection necessitated by the pandemic restrictions, digital exclusion among those people who are either unable or choose not to access and use digital devices has become more pronounced[79]. Digital exclusion is more prevalent in groups who are already more likely to be socially isolated or lonely including older people, people with chronic health conditions or disabilities and people experiencing deprivation[79]. Although in-person activities have now resumed, there are some services and activities where the move to more virtual connection may be permanent reducing the opportunities for people who are digitally excluded to socialise.

Data from the UCL Social Study shows that the prevalence of chronic loneliness has declined since the first year of the pandemic when elevations were first noted and has remained relatively stable over the past year[80]. This may reflect the easing of restrictions over time but also the innovative strategies that individuals, community groups and organisations developed over time to keep people socially connected.

As well as its impacts on social activities, the pandemic has also had a wide variety of other detrimental effects on people's livelihoods and lifestyles. Many people have experienced financial hardship through the loss of employment or businesses, increased health anxieties, and bereavements. These life events are likely to have compounded the effects of increased loneliness on health and wellbeing outcomes[77].

7. Resident insights

Engagement with Camden residents, including recent Neighbourhood assemblies and Community Conversations, have revealed that reducing social isolation and loneliness while improving community connectedness are important local concerns[81].

The key themes raised by residents included:

- **A need for better connected communities.** Residents were concerned about a lack of social cohesion and neighbourliness in their local areas and expressed a desire for easily accessible social events and venues that could bring people together and break down barriers between groups. The importance of encouraging intergenerational mixing was noted and that activities should be safe, welcoming and inclusive of people with disabilities. Interviews with older people from Black, Asian and other minority ethnic backgrounds revealed that they often lack a 'sense of belonging' in their communities and suggested a need for activities that are inclusive and welcoming of different cultural and ethnic backgrounds.
- **A need for improved community signposting and support to attend and engage.** Residents recognised that it was not always easy to find out about local services, support and activities and that this stopped people from engaging with their communities and improving their wellbeing. Others may need additional support to rebuild their confidence in social situations to attend for a first time, with the importance of warm and welcoming receptions at these activities highlighted.
- **A need for investment in youth services.** Social support networks for young people, such as through youth clubs, sports activities, and community mentors in local venues, were recognised by young people themselves as important for helping them to connect with others, providing them with guidance and helping them evolve as a person. Engagement with young people as part of the Camden Safer Network highlighted the need for these activities to go beyond traditional youth clubs and the importance of incorporating meaningful activities, such as building skills (for example, for work or creative outlets). Investment in youth services was seen by wider residents as a solution for helping young people to socialise in a positive way and reduce antisocial behaviour.
- **A fear over unsafe neighbourhoods.** Residents frequently cited feeling unsafe to go out to community venues and socialise because of a fear over antisocial behaviour and crime. These fears were caused or exacerbated by being witness to or experiencing crime, antisocial behaviour by groups of young people, a lack of CCTV in the neighbourhood and poor lighting. Engagement has also highlighted that those communal spaces that were looked after by the community made places feel and be safer.

8. What is happening in Camden?

8.1 Strategic overview

National policy context

Publication of the 2017 Jo Cox Commission on Loneliness for the first time brought attention to the scale and impact of social isolation and loneliness on the health and wellbeing of the UK population

and marked a significant shift in focus on this area by the UK Government. In 2018, the Government published its first Loneliness Strategy in response through which loneliness was identified as a major public health issue. The strategy set out three national objectives; to reduce stigma surrounding loneliness by framing the national conversation; to drive a lasting shift towards reduced loneliness; and to improve the evidence base and build a compelling case for action.

Reducing stigma surrounding loneliness by framing the national conversation

- The 'Let's Talk Loneliness' campaign was launched through NHS Every Mind Matters in 2019 which encourages people to recognise the signs of loneliness and overcome stigma through showing that loneliness can be experienced by anyone.
- The 'Lift Someone Out of Loneliness' 2022 campaign specifically targeted young people aged between 16 to 24 years, a group known to experience the highest levels of loneliness but the least likely to seek support.
- The Loneliness Engagement Fund was set up in 2021 to offer grants of up to £50,000 to community organisations across England who were able to engage with groups at high risk of experiencing loneliness.

Driving a lasting shift towards reduced loneliness

- Cross-governmental collaboration such as through the Tackling Loneliness Network is promoting interventions to reduce loneliness as part of diverse policy areas including, for example, work with the Department for Transport to improve accessibility of public transport, and with the Department for Health and Social Care to implement social prescribing.
- International relationships are being established and strengthened to share learning. In particular, the UK is working closely with Japan where programmes to prevent social isolation and loneliness have long been an area of focus.

Improving the evidence base and building a compelling case for action

- The Tackling Loneliness Evidence Group brings together academics and experts in the area of social isolation and loneliness to consolidate what we already know and identify gaps in the research.
- Priorities have been set for future research including measurement of loneliness, loneliness risks across the life course, the social stigma of loneliness, societal and cultural factors, and the interrelations with mental health.

Local strategy

Camden has strong foundations to build upon with the vibrant voluntary and community sector across the borough helping bring people and communities together. This was epitomised in the sector's response to the pandemic, where organisations large and small rapidly transformed the way they were working to support people in their communities, from delivering essential supplies to help people stay connected; supporting people to get online for the first time; or finding alternative ways to deliver socially-distanced support.

As we emerge out of the pandemic, there is a clear strategic alignment across the council and the wider health partnership to work together with communities and local partners to build on these foundations and to use all of our collective levers to reduce social isolation and deliver positive change for people in Camden. This is reflected in the strategic commitment in Camden's Health and Wellbeing Strategy, our Neighbourhoods programme, the borough-based partnership and the community challenges laid down in We Make Camden, as detailed below.

In recent years the Camden Health and Wellbeing Board has sponsored a range of participatory events, projects, and pilots[82] with the aim of putting residents' voices at the heart of our approach to health and care. A common theme has emerged across these activities, with residents telling us that many health and social issues have their origins in social isolation and loneliness. This is often coupled with the view that health and wellbeing is greatly improved when people feel connected to their local communities.

Underpinned by what residents have told us, our new long-term **Health and Wellbeing Strategy**[1] has emerged as a call to action to all residents, community groups and local organisations to make Camden the very best place to start well, live well and age well. The strategy seeks to reduce health inequalities by putting health at the heart of all local policy making. It adopts a population health approach to shift the centre of gravity of the health and care system towards prevention, neighbourhood working and the social determinants of health. The strategy has been developed and adopted by Camden's health and care partnership, including our NHS and VCS partners. It identifies three short term priorities for collective action over the next three years, to be sponsored and driven by the Health and Wellbeing Board. One of these priorities, Community Connectedness and Friendships, was chosen to respond directly to the challenge of social isolation in Camden.

In November 2021 **Neighbourhoods** was approved as a shared place-based approach to delivering for the residents of Camden. A neighbourhoods approach aims to produce better outcomes for citizens by shifting to a more relational, joined up, locally based and multi-disciplinary service offer that is centred around people and which prioritises prevention, strengths, community power and bottom-up innovation. Through this work, we want to encourage greater community connectedness by being convenors and connectors and empowering residents to find solutions in their local areas to challenges such as loneliness and social isolation. As part of the Estates and Neighbourhoods Mission, the council is piloting participatory budgeting on estates and developing action plans to improve the estates in partnership with their residents. This relational approach to the delivery of council services alongside the community encourages residents to come together and develop community, shared purpose and lasting relationships.

In 2022, **We Make Camden** emerged as the Council's renewed vision of Camden 2025, our vision for the borough. We Make Camden includes six overarching ambitions, one of which directly draws from the language and population health approach promoted within the Health and Wellbeing Strategy. We Make Camden also takes stock of the impact of the pandemic and identifies a range of missions and challenges that seek to address the most pressing issues now facing Camden. One of the challenges states that "no one in Camden should be socially isolated and without the means to connect to their community".

Camden's **borough-based partnership** is also prioritising improvements to community connectedness. Towards this aim, it is working to coordinate the borough's social prescribing services, supporting people with a variety of social needs to access the interventions and activities that matter to them. Current work in this area is to map and connect social prescribing services across the borough, identify what good social prescribing looks like and understand gaps in provision. The borough-based partnership will also examine how the various information and advice providers across Camden can better work together to improve the quality of information provided to residents and avoid duplication. Work is now looking at how we best bring the work of the Neighbourhoods and Community Connectedness workstreams together with the voluntary and community sector as equal partners as we develop ways of working at a neighbourhood level. This will help ensure that the voice of communities is at the heart of our approach to ensure that health and social care practitioners and services are better linked into their local community organisations and people.

8.2 Examples of current project focussed on reducing social isolation, building friendships and strengthening community connections

There are a considerable number of organisations across Camden helping to bring people and communities together. Much of this activity is delivered by Camden's voluntary and community sector. To support this, Camden distributes and manages £4 million in multi-year core grants and project funding to voluntary and community sector organisations, including multi-use community centres,

equality and cohesion partners as well as Camden's volunteer centre. These independent voluntary and community organisations provide priceless touchpoints for socially isolated residents to seek support and connection in their neighbourhood. The council also actively promotes community cohesion through a community festival scheme which supported 54 events with financial grants, free road closures, waste collections and parking suspensions.

Council services also have an important role to play. For example, Camden's libraries provide those living, working or visiting the borough with an opportunity for social connection. With many high street stores now using self-checkout machines and traditional bank counters being replaced with automated terminals, Camden library staff acknowledge that they may be the only person a resident may speak with face to face. The libraries also bring people together by hosting community activities including knitting groups, chess clubs and book clubs.

The below case studies show just some examples of the range of programmes underway to reduce social isolation, foster friendships and increase community connectedness and the impact these have on people's lives.

8.2.1 Social prescribing

The Camden Care Navigation and Social Prescribing service is available for adult residents across Camden who want or need support with a range of issues that impact on their lives. As well as practical issues such as support with finances, housing and food provision, this often includes people who are experiencing social isolation or loneliness and people who want help to become more active in their local communities.

Social prescribing offers a way for health professionals to find help for people who require social as well as healthcare support to improve their wellbeing. People who are referred to the Social Prescribing service meet with a link worker who spends time getting to know the person and identifies their concerns, interests and desires. The service then works to connect the person with relevant support services, activities and community groups in the local area who can help the person to achieve their goals and improve their social wellbeing. There are several additional types of social prescribing that may be considered. Green social prescribing, for instance, involves an extra element of interventions or activities in natural environments.

Social prescribing in action in Camden

The following examples of social prescribing provide case studies of residents supported through the Age UK Camden Care Navigation service:

- One 69-year-old gentleman was still coming to terms with his recent transition to a wheelchair and break up with a long-term partner when he was referred to the social prescribing service with severe social isolation and loneliness. The link worker assigned to this resident worked with him to identify a desire in learning to use the internet and also discovered a keen interest in sports. These insights were used to get the resident enrolled on a digital inclusion training course and link him up with his local branch of Disability Sports Coach and social community groups in the area.

- An 82-year-old lady was referred to the service due to social isolation, loneliness, weight loss, and significant anxiety over her health and risk from COVID-19. This lady was supported to strengthen her social networks with existing family and friends, referred to and helped with access to health services and provided with weekly wellbeing calls and referrals to mental health services to support with her anxiety.

- A 90-year-old gentleman came to the service following concerns around social isolation, loneliness and a loss of meaning in life after the death of his wife. Interviews with the Care Navigator revealed that the gentleman was extremely hard of hearing which was impacting on his social isolation. His time was organised around healthcare appointments and, while he had three children, he was finding it difficult to make meaningful social connections. Using his

indicated interests of archaeology, culture and gardening, the link worker supported the gentleman to attend events at Dragon Hall and North London Cares and through this he became introduced to the Calthorpe Community Garden where he now works on a Zen garden alongside other volunteers.

- A 57-year-old lady who had become socially isolated and lonely due to being housebound and not having access to the internet was referred to the service and expressed a desire to become more connected to the community alongside support with accessing GP and mental health services. After discussion with the client, the link worker discovered that the lady was unable to see family because she had not been able to get her COVID-19 vaccination and so a chaperone was arranged in order for her to be able to get vaccinated. The lady was also supported to join The Reading Project, a shared reading scheme, provided with information on becoming a telefriending volunteer and helped to build her confidence through supported community walks.

8.2.2 Winter Wellness Project

The winter can be a difficult time of the year for older people with cold temperatures and short daylight hours making it increasingly difficult to get out and about. The Winter Wellness Project is a collaboration between Camden & Islington Public Health department and the local voluntary and community sector, providing support to hundreds of older people and enabling them to enjoy community, conversation, connection and practical support during the most isolating months of the year.

Between 2021 and 2022, the Winter Wellness Project engaged with over 500 older people in Camden over the phone or on the doorstep and a further 57 outreach events were attended across Camden and Islington reaching 500 residents between the two boroughs. Support is targeted at people aged over 65 who are at heightened risk of social isolation and loneliness because they live alone and in areas of greater deprivation. Residents who would like assistance are referred on to services that can help with a wide range of practical issues and/or were invited to participate in social activities held online, over the phone, and in person.

The COVID-19 pandemic presented new challenges for the Winter Wellness Project which traditionally has relied on door-knocking to reach residents. This led to innovations in the service offer with new telephone and virtual outreach efforts and activities. Older people who did not have the technology or confidence to join online events were supported through one-to-one tech sessions while both large and smaller Phone-in-Clubs were set-up for residents who did not want to or could not participate virtually.

During the 2020/21 Winter Wellness campaign, the project supported Gay, a 93 year-old lady who is registered blind. Gay told the Winter Wellness team that she missed the stimulation of talking to other people. After discussing the different programmes available, Gay decided that she liked the sound of the Phone-in-club and throughout the winter of 2020/21, she participated in 24 over the phone socials. Gay had the following to say about the support she received:

"I really enjoy the clubs. I always come away feeling happier than when I went in. It's strange, but I always have the feeling I have been out of the house somehow and have met some nice new friends. It takes your mind off yourself and always gets us talking about ourselves in an outgoing way. I'm gradually getting to know people. Even though I find it hard to hear, I am starting to recognise people's voices. Everyone connected to [the Winter Wellness Project] is so kind."

8.2.3 Family Group Conferencing

Adult Family Group Conferences (FGCs) are family-led decision making meetings. They empower and support the adult, along with their family and wider support network, to make decisions about their

future and help them to develop a plan that addresses their concerns and focuses on their desire for change.

In FGCs *family and wider support network* means the relatives, close friends or neighbours that the adult considers to be important to them and the topic of the meeting.

Central to the process is the empowerment of any adult who may have difficulty expressing their views. A crucial element of FGC is ensuring that the adult's voice is heard and that they are encouraged and enabled to participate fully in the process. This principle applies whether or not the adult has the capacity to make the final decision; only the final process for agreeing the plan will differ. Participation may be assisted by the use of an independent advocate, or by the support of a friend or family member who will be prepared by the coordinator to help them undertake this task.

Zila's story

Zila is the carer for an older man who lives in Camden. He is on dialysis and attends the clinic three times per week. He also lives with severe mobility issues and speech restrictions. They share a culture, so she makes sure to make food that is both good for his condition and that he loves.

Since the first lockdown, the man had felt isolated and wanted to reintegrate back into society. The Lead Nurse for Frailty and Dialysis at the Royal Free Hospital identified social isolation and made the referral to the Adult FGC service. Jourdelle was the Family Group Conference Coordinator and set to work gathering the man's partner, children, professional network and caring team together for a virtual FGC meeting to discuss steps to get him out socializing again.

Together at this virtual FGC the attendees shared their thoughts and ideas with the man and made a plan to prioritise his favourite activities, such as attending football matches in the community.

Zila spoke about how before the FGC meeting, the support coming to her client and herself was purely financial, however, having the FGC meeting opened up practical support after she told them all at the FGC meeting what was needed.

The family plan created at the FGC could be summarised with one word, *support*. This included increasing his care so that he could navigate public spaces with adequate support. The plan also agreed upon the acquisition of supportive equipment such as a wheelchair with battery assistance to make accessing the community easier. Another element was to reintroduce the family structure into his life, with an invitation to make visits between the children and their father more regular.

Jourdelle was pleased that the man's interests would be at the forefront of any action taken. Zila liked that everybody could talk and put in their own opinions; it felt as if they were coming together.

Since the meeting, Zila has spoken about the support she has received from the FGC service. She remains his primary carer, but the family now spend time with him during her time off. Jourdelle described the FGC as progressive, reflecting on the difference in the individual's situation from where they had begun the meeting to what was the result at the end of the process.

8.2.4 Community champions, bringing communities together

Community Champions is a three-year pilot project to deliver resident-led approaches to improving health and wellbeing. The project, which launched in 2020, is based on estates in three areas in Camden: Regent's Park; Kentish Town and Kilburn. Each area has a funded full time Champion Co-ordinator, hosted by a community organisation. The Co-ordinator's role is focussed on engaging with residents to understand their priorities to improve health and wellbeing, and to recruit and support a network of Champions to deliver activities and initiatives to address these issues.

In all three areas, increasing opportunities to connect with neighbours was raised as a key priority in resident engagement. This included suggestions to improve community spaces and facilities to help

bring people together; more regular events and activities based on the estates; as well as initiatives that help foster a sense of community.

A number of initiatives have been developed in response, including:

- **Regular well-being walks** led by Community Champions as an opportunity to explore the local area and meet neighbours.
- Resident led **community events**, for example an intergenerational Mad Hatters Teas Party and a multi-cultural Spring Story Telling event celebrating Ramadan, Passover and Easter.
- Well-attended **monthly coffee mornings** that have been running for the last year, now being hosted by a local café in Kentish Town. This has continued to attract regular attenders as well as those attending for the first time.
- Projects to **improve communal spaces** to help bring residents together, for example, spring clean-ups; art-projects to create murals on hoardings; and improving communal gardens to address safety concerns and create spaces that bring people together.
- Creation of a **story telling trail** in Regent's Park, between young champions and older people living in supported accommodation.
- Regular activities such as women's only exercise sessions, cooking sessions, and drop-in activities for young people.

One of the key aims of the Community Champions programme is to learn more about the impact that neighbourhood approaches have on communities' health and wellbeing. Engagement with residents was particularly challenging in the first 18 months of the programme as this launched in March 2020 at the start of the pandemic. However, resident insights are now being collected as part of the programme evaluation including the impact that the programme has had on residents sense of belonging to the neighbourhood and any impact on social isolation.

Feedback from a few of the community champions on their experience to date:

"It offers you a wide range of events to be part of, you really feel belonging and that you have a role even when you don't know it yet. It's intergenerational and multicultural".

"I want to increase community spirit and help others and make a difference".

"Not only will it help me to make a change in people's lives but also help to build a better, safer and friendly community. Becoming a Champion, for me, means to put a smile on someone's face and to reassure them of positivity".

"I hope to make a difference to a local community, especially following a year where we have been so isolated".

8.2.5 Learning disability, Living a Good Life Project

The "Learning Disability, Living a Good Life" project was developed with people with learning disabilities and their family carers following lockdown, when the face-to-face day service was forced to close. Feedback from people with learning disabilities was that during lockdown they missed their friends, they didn't want to go back to doing the 'same old stuff' and wanted to feel part of the community. Family carers also told us that they would welcome a move away from a traditional 'school day' model and towards a more sessional activity offer. Camden Learning Disability Service (CLDS) reviewed the evidence and found that maintaining friendships and feeling valued has a positive impact on the physical and mental wellbeing of people with learning disabilities. This project aims to improve how CLDS support people with learning disabilities to achieve this and consequently contribute to their growth and development. In doing so, this aims to help reduce the stark

inequalities, particularly in life expectancy, poverty and employment, faced by people with learning disabilities.

The project was set up at the end of 2021 to achieve the vision that people with learning disabilities in Camden would be supported to live a good life for them in the way they want, with friendships, personal growth and having a valued place in society at its core. Key aspects of the project include ensuring everyone with learning disabilities has a completed Person Centred Plan which articulates their goals and ambitions, to help them achieve their potential. This is in the form of a 'Wiki' or personal website, which are portable, easily accessible and adaptable by all services. Building on this, a 'growth toolkit' is being developed and implemented with providers, to ensure they are equipped to support individuals to grow and develop as far as they can and want to. Finally, a single and consistent point of access for all services and day opportunities for people with a learning disability is being developed, coordinated across all learning disability and mainstream providers. Alongside this, people with learning disability will be able to participate in a broad range of day opportunities or roles where they can learn and grow as individuals but also forge and sustain meaningful friendships.

This is a two year project, and so far:

- 20 Wikis have been rolled-out with one provider and the project is starting to work with a second provider.
- the growth toolkit has been developed and is being piloted with a provider.
- the Opportunities Planning Group consisting of practitioners and providers meets monthly to discuss and agree activities for individuals which support their aspirations, with 32 people discussed so far.

An online tool is also being developed where people with learning disabilities and their family carers can access information about what activities and opportunities are available locally, both for people with learning disabilities and mainstream opportunities.

9. Gaps and opportunities

9.1 Strengths in the current system

Drawing upon the insights gained from a range of stakeholders engaged in the preparation of this assessment including from adult social care, health, housing, and the VCS, it was clear that Camden already has many areas of strength that can be drawn upon in the challenge to prevent social isolation and loneliness. A full list of those interviewed is provided in Appendix 1. Some of the key strengths identified include:

- **Presence in the community.** Camden has a wide-ranging and dynamic community and voluntary sector that supports local residents with a diverse set of needs including by providing opportunities to help residents connect and make new friends. While some community and voluntary organisations are involved in the direct provision of social interventions such as peer support groups and befriending schemes, still other organisations supporting residents offer opportunities for outreach and early identification of social isolation and loneliness in historically hard-to-reach groups. One example is the Camden Carers service which has been innovating in-person and online groups and outreach efforts to ensure that unpaid carers in Camden have the support they need to keep connected to their communities.
- **Investment in citizens.** Through Citizen Funded Projects, the council is incentivising and supporting local residents to use their own experiences and expertise to set up and run community initiatives, bringing people together around shared interests and values.

- **Co-production with stakeholders.** By facilitating Neighbourhood Assemblies, community conversations and specific outreach projects with residents and professionals, the council already has a culture of engaging and coproducing solutions to community issues with key stakeholders. These avenues for engagement can act as starting points for ensuring the input of residents in the design of new interventions and strategies. The Community Champions programme is an example of good practice in Camden where the identification of issues and the development and running of initiatives is led by residents.
- **Working models that can be adapted and expanded.** Projects such as the Winter Wellness Programme for older people living alone, Living a Good Life for people with learning disabilities and befriending programmes exemplify models of good practice that can be adapted and used to respond to need in a wider range of groups at risk of social isolation and loneliness.
- **Established staff training programmes.** Training programmes such Making Every Contact Count (MECC) and Mental Health First Aid are available and widely promoted to all staff who might have contact with residents and offer opportunities to build in awareness around social isolation, loneliness and the options available to refer on and support. An example is the Home Improvement Service where participation in MECC training has been built-in as a condition of the commissioned contract and where the provider has fed-back that the training has been transformational in being able to have conversations and build rapport with residents.
- **Embedding a 'What works' approach to support.** The council supports residents who may come into contact with adult social care services from a positive angle, asking 'what works?' to build a picture of the residents' preferred lifestyle before focusing on individual projects. This helps to construct a holistic view of each resident and ensures they can be more effectively supported in their social lives.

9.2 Opportunities for improvement

Conversations with stakeholders across multiple sectors including adult social care, health, housing and the VCS provided a first look at some opportunities for development across Camden to help prevent social isolation and loneliness. A summary of the key themes are provided below:

- **Referral criteria limiting access to support.** Some services providing social support are not available to a wide range of people who may be at risk. This includes the local befriending services where people who are socially isolated or lonely must fulfil certain criteria (e.g. being over a certain age, having a certain condition or living in a certain area) to be able to participate. While it is accepted that there must be limits according to need, there is evidence that some groups who are known to be at risk are excluded from support.

- **Not being able to identify everybody who is at risk.** Many of the risk factors for loneliness (e.g. the progression of long-term conditions, disability, cognitive decline, and frailty) are not noticed or recorded by health and social care staff who are in position to refer to services offering social support. There may also be gaps in the research around risk groups meaning that certain demographics that are at risk get missed from screening approaches. Recognition of these at-risk groups is an important first step to preventing the development of social isolation and loneliness.

- **People being unaware or reluctant to access the services available.** People who recognise themselves as becoming socially isolated or lonely may not be aware of the range of services, activities and support available to help them become more socially connected (e.g. befriending services) leading to them missing out on opportunities to prevent or reduce social isolation and loneliness. Meanwhile, other people may be aware of opportunities but reluctant to engage, often requiring extensive outreach work to build confidence over a longer time period.

- **Delays in being able to access support.** Delays were occurring between residents presenting as at risk of social isolation/loneliness and getting access to the support that could help. Reasons for the delays were capacity constraints affecting the speed at which assessments of need can be carried out, as well as logistics and payment processes that resulted in delayed payment for services.

- **Need for flexible service and support provision.** A hybrid approach of remote and in-person access to services, support and activities is required to ensure that everyone is able to access social support in the way that works best for them. While some people prefer to meet fact-to-face and may be unable or unwilling to use remote access technology (including phones), other people find access to online or over-the-phone support more accessible, convenient or less intimidating. A further point was that not everyone at risk of social isolation or loneliness wanted or needed to participate in immediate two-way interaction and that email or social media chat groups involving asynchronous messaging was more valued by certain groups.

- **Need for multi-faceted services.** It was recognised that several services provided by or commissioned by the council address surface needs but do not have the skills or expertise to support residents with the underlying causes of these needs. One example given was support for people with hoarding issues where services are available to support with clearance but unable to provide the psychological and social support to intervene on the root causes.

- **Need to understand who is best placed to engage.** An understanding of the council's services as well as the range of activities and programmes run by VCS organisations would help to identify links with various groups of residents and who is best placed in terms of having trust/rapport with that particular community. Some people may be unwilling to engage with 'council' services because of past experiences or perceptions of what it means to receive support from the local authority.

- **Communities are inaccessible for certain groups of people.** It was raised that people with particular needs (e.g. people with dementia, older people, or people with reduced mobility) may face barriers in accessing social support in their communities due to the inaccessibility of the local area.

- **Complexity of need has increased.** The pandemic has changed the level of need that residents accessing community support require. It was noted that while generic social groups worked previously, community outreach now needs to be much more targeted requiring additional capacity.

- **Capacity is constrained.** Front-facing staff may be experiencing burn-out from working through the pandemic, meanwhile volunteering levels are lower than they were pre-pandemic. Funding of the community sector is also at risk as emergency COVID-19 funding has ended but the pandemic has also impacted the ability of community organisations to fundraise effectively. The result is that organisations are needing to become more cost-efficient.

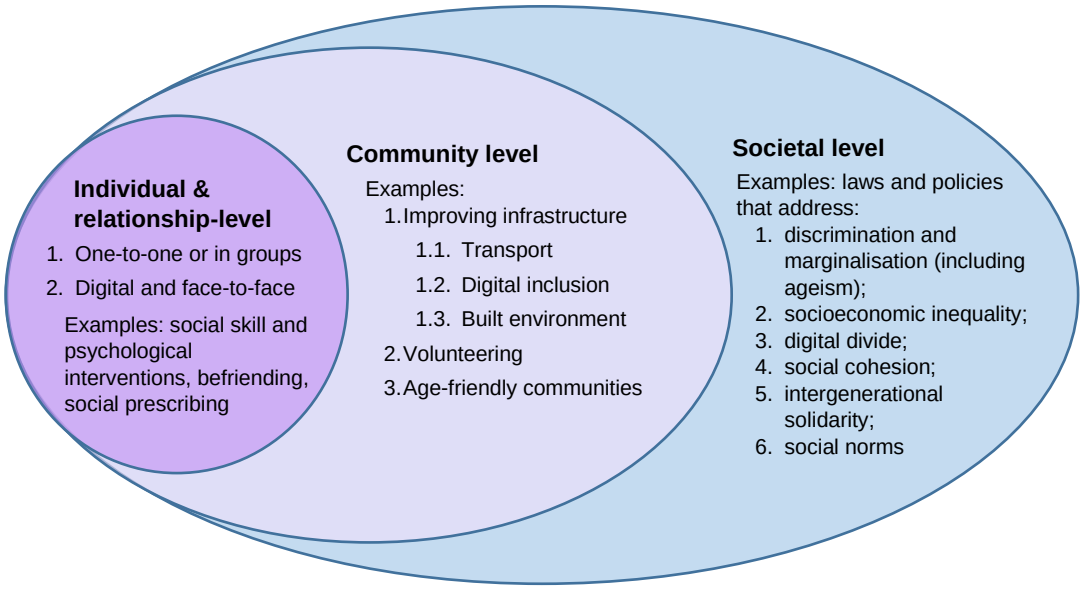
- **Lack of long-term sustainability.** There was recognition that there have been many projects and initiatives that made a significant difference around connecting communities for a short time but due to lack of commitment to long-term funding, have needed to shut down taking key learning on successes and limitations with them.

- **Affordability for new community-led initiatives.** Recent inflationary pressures and rises in the cost of living have made it less feasible for residents with ideas for new community groups and activities to set these up. Residents may be experiencing constraints on their budgets, especially if from low income backgrounds and the costs of hiring a venue (e.g. community centres) has increased.

10. Evidence on effective interventions

Strategies to address the issues of social isolation and loneliness can act on three levels; at the individual and relationship level, the community level, and at the level of society[128]. Success is likely to rely on a multi-level interventions with cross-sector collaboration[128]. Figure 3 illustrates overlap of the three levels and provides examples of the types of interventions that apply in each.

Figure 3: Overview of interventions across the individual, community and societal level to prevent social isolation and loneliness



Replicated from: World Health Organisation, 2021. Social isolation and loneliness among older people: advocacy brief.

Research looking into the effectiveness of strategies aiming to target social isolation and loneliness is still in its early stages[42]. Most interventions that have been evaluated to date are specifically for older people and at the individual and relationship levels[42]. Gaps therefore exist in the assessment of interventions able to address social isolation and loneliness at the community and societal levels and in other high-risk groups with distinct needs. While still important, evidence suggests that interventions targeting social isolation and loneliness among older people may be less effective at improving health and wellbeing outcomes than intervening earlier in the life course[24].

10.1 Individual & relationship level

Interventions at the individual and relationship level aim to address social isolation and/or loneliness for a particular person or group of people[128]. These interventions can help to reverse, stop the progression and mitigate the effects of social isolation and loneliness but do not address the systemic and environmental risk factors that may cause it. Generally, interventions to reduce social isolation and loneliness at the individual level have been found to be most effective when the following principles are in place:

- Ensuring that the intervention is adapted and appropriate to the local context[129].
- Using a community development approach to ensure members of the community are involved in the design and implementation[42,129].
- Focusing on the promotion of activities with a constructive purpose (e.g. developing a local space as a community garden) as opposed to passive activities without a clear aim[129].

- Targeting a specific group of people connected through e.g., a shared cultural, demographic or medical background or shared common interest[129].
- Having a robust theoretical basis to explain how and why the interventions should result in a reduction in social isolation or loneliness[129].
- Embedding a person-centred approach that frames the activity in a positive way (e.g., supporting healthy and active ageing) instead of explicitly about reducing social isolation and loneliness[42].
- Ensuring accessibility for people who may have a range of health conditions or disabilities to minimise the risk of disparities in who can benefit from local programmes. This includes recognising differences in the digital skills of the target groups[42].
- Maintain awareness of inadvertent harms that certain interventions may cause if used inappropriately or excessively. Technological solutions, for example, should be provided as a supplement rather than a replacement for real-life relationships to avoid exacerbating social isolation and loneliness[42].

While interventions to address social isolation necessarily involve the introduction of new social contacts, interventions aiming to reduce loneliness are not restricted to the delivery of group activities. Evidence suggests that for some people one-to-one interventions, training in and regular use of technology or engagement with new, productive and meaningful activities can be just as effective at preventing a person from experiencing loneliness[42,129].

Types of interventions:

Social Facilitation	Psychological Therapies	Social support from health and social care
What it includes: Social groups involving the facilitation of peer-to-peer socialisation (e.g., friendship clubs, shared interest groups, groups for people with a shared culture or identity) and strengthening connections with existing family and friends. **How it works:** Delivers mutual support by bringing people together who share the same needs, interests or concerns **What the evidence says:** Social facilitation activities are generally effective in reducing social isolation and loneliness among older people, regardless of whether delivered in-person, over video or by phone[129]. Success may be attributed to the supportive environment, sense of companionship, and of belonging elicited through participation[129]. There is evidence that it may be particularly useful for connecting people with shared cultural and minority ethnic backgrounds who may experience cultural and language barriers when trying to socialise with the wider community[129].	**What it includes:** Cognitive and social psychological therapies, mindfulness and stress reduction, reminiscence therapy and humour therapy **How it works:** Social isolation and loneliness can be triggered or exacerbated by cognitive biases that promote negative thinking and social withdrawal[130]. Psychological approaches promote improved socialisation through changing perceptions and thought processes **What the evidence says:** A range of psychological therapies have an effect on reducing the social isolation and loneliness experienced across ages[129,132]. The specific attributes responsible for the effect, however, are difficult to determine since therapies frequently include a variety of tools, including facilitated group-based activities as well as individual level cognitive and social therapy.	**What it includes:** Training and resource for health and social care staff to deliver social as well as healthcare interventions e.g., allied health professionals delivering community rehabilitation, social and community navigators, nurses offering time for socialisation as part of their home visit rounds and social prescribing. **How it works:** Links at-risk individuals to social support and/or provides direct social interaction opportunities to people who are socially isolated or lonely. **What the evidence says:** Little evidence is currently available; however, positive effects have been demonstrated for some interventions on reducing social isolation and loneliness among older people[42,129].

Befriending Interventions

What it includes: Volunteer programmes to contact people who are already socially isolated or lonely or are at risk of becoming so, either in-person or remotely.

How it works: Providing people with limited social contact an opportunity to socialise, make a new friend and build confidence.

What the evidence says: Both in-person and telephone befriending may help to reduce social isolation and loneliness in older people with this seeming to provide a sense of belonging and comfort. There is evidence that it is more effective in certain groups over others i.e., older people with chronic health conditions[130]. Volunteers may also benefit from the social connections and friendships established through befriending schemes themselves[130].

Leisure/skill development interventions

What it includes: Groups that bring people together around a shared leisure activity (e.g. gardening, sports or travel groups, voluntary programmes, community projects) or solitary projects

How it works: Group activities provide meaningful social connection with others who are engaged in the same hobby or project. Individual-based activities can add a sense of meaning that mitigates the detrimental effects of reduced social contact.

What the evidence says: The effectiveness of community activity groups is dependent on the type of activity and level of social interaction involved[129]. Interventions that do demonstrate reductions in social isolation and loneliness tend to be reliant on engaging people in constructive, educational activities with a clear goal, being able to maintain relationships with others, and having a high degree of social interaction[129].

Technological interventions

What it includes: Digital skills training, use of technologies including social media, smartphones, artificial intelligence and robotics.

How it works: Socialising on the internet keeps people connected with video conferencing and virtual reality technologies especially helpful for people less able to travel. Artificial intelligence (e.g., conversational virtual assistants) may also be beneficial.

What the evidence says: Older adults who use the internet, social media and smartphones are less likely to be lonely than those who do not, although the evidence is mixed on whether more frequent use predicts reduced loneliness[129]. Digital skills training programmes have been found to be effective at connecting older people with their friends and family online. One training intervention that used young adults as teachers found that it also increased their self-esteem and confidence[130].

Social and emotional skills training

What it includes: Training programmes that support people to improve interpersonal communication through developing social skills and ability to manage unhelpful emotions.

How it works: Equips people with the skills to socialise with others and make new friends

What the evidence says: Social and emotional skills training has been found effective at reducing loneliness among young people (aged up to 25 years)[132] while friendship enrichment training in later life may also be effective[42].

Animal interventions

What it includes: Pet ownership or sharing, care and therapy animals, robot companions.

How it works: Bonds with animals supplement social contact from humans

What the evidence says: Pet owners are less likely to become socially isolated or lonely and this appears attributable to pet-owner bonds rather than any peripheral relationships established with other humans (e.g. while dog walking)[129]. Artificial (robot) animals can also provide a protective effect[129].

Addressing individual risk factors

What it includes: Treating health conditions and providing aids and support to disabled people.

How it works: By reducing symptoms of health conditions and providing aids for disabilities, barriers to social participation can be lessened for certain groups.

What the evidence says: There is some evidence that treatment of hearing loss, cognition enhancement and mobility support can reduce the risk of people with functional impairments becoming lonely[42].

10.2 Community level

Interventions at the community level aim to prevent social isolation and loneliness by targeting the structure and function of local areas. This includes changes to the built environment and the relationships between local people, services and organisations[128]. While it has been widely acknowledged that changes to the built environment and local community structures are likely to be important for preventing social isolation and loneliness, few studies have looked into the effectiveness of these approaches[128].

Many people at risk of social isolation or loneliness have needs that can make accessing the local community difficult. This includes people with reduced mobility, cognitive decline, learning disability and frailty. Interventions that reduce barriers to these people participating in their local community are likely to improve social support and reduce the risk of social isolation and loneliness[128]. Such interventions may include improved community transport and road safety, crime prevention measures, more seating areas, public toilets and local amenities[130]. The creation of age friendly and dementia friendly communities are examples of these strategies of improving accessibility for people with defined needs in practice[128].

The 2022 'Reconceptualising Loneliness in London' report produced jointly by the Neighbourly Lab, Campaign to End Loneliness and What Works Wellbeing highlights some of the strategies that may be key to addressing the problem of severe loneliness at the community level across London[133]. These include:

- **"Loneliness-proofing" new developments.** The All Party Parliamentary Group (APPG) on Loneliness Inquiry has advocated for a new standard to "loneliness-proof" future developments by incorporating social spaces into the design of new residential units, while also encouraging investment in the development of local communities, particularly in deprived areas.
- **Creation of new communities.** Building on the community groups that were developed during the COVID-19 pandemic and capitalising on local online (e.g. WhatsApp) chat groups that help connect people. This also includes examining community assets such as libraries which can be repurposed as social hubs. The 'Idea Store' in Tower Hamlets is a trailblazer in combining traditional library services with social outreach.
- **Training for front-facing staff.** A wide range of front-facing staff including postal staff, bus drivers as well as health and social care workers have the opportunity to identify and respond to loneliness given the right skills. Training programmes such as 'Essential Mix' aim to equip front-facing staff with the understanding of signs and risk factors for loneliness as well as help staff think about ways to capitalise on their everyday interactions with residents to reduce feelings of loneliness and social disconnection.
- **Fostering a kindness-based community.** Nudging Londoners toward becoming more sensitive to the experiences and needs of others they share the city with may help to increase connections with the community and provide new opportunities to support people who are at risk of severe loneliness. Kindness can be incorporated into London's culture through promoting champions among front-line staff and through communications campaigns (e.g. through advertising space on the TfL networks).

10.3 Societal level

Interventions at the societal level target systemic issues that can lead to increased risks of social isolation and loneliness across the population[128]. Strategies that combat harmful stereotypes (e.g. towards older people, people with disabilities and people with dementia) and break down barriers between demographic or cultural groups are examples of societal level interventions that can encourage community connectedness[42,128]. Awareness campaigns around social isolation and loneliness may also be important for changing public attitudes towards seeking support for oneself or

others who have become socially disconnected[42,128]. Meanwhile, more wide-ranging policies such as to reduce economic inequalities can ensure that people have the resources to participate fully in their communities[42].

10.4 Case studies of programmes in other areas

Three Good Friends

How it works: Leeds City Council pioneered roll-out of an 'Asset Based Community Development' programme to foster and strengthen community connections and help people make and maintain friendships. The programme involves the recruitment of 'Community Builders' (members of local community and charitable organisations) who are responsible for identifying and developing local assets, strengths and connections between people. Grants were then available from the council to help set-up and develop self-sustaining social activity groups based on local ideas.

What needs it fulfils: Aims to address need in a diverse range of groups across the community who may need support connecting with their local community and making friends.

Outcomes: An evaluation has demonstrated that the programme promotes the establishment of good friendships, increases community connectedness and helps local organisations work together. These effects were also found to be significantly cost-effective with around £14 being returned for every £1 invested.

Norfolk 'Healthy Libraries'

How it works: Libraries in Norfolk are working with the local Public Health team to establish themselves as 'Healthy Libraries' which aim to reach people who would not otherwise access services. Library staff are all trained in talking to service users, recognising needs and ensuring they are signposted to the right support. Libraries are also working with the VCS to act as hubs for social activities including:

- 'Just a Cuppa' which offers a chance for tea/coffee and a chat in-person or online
- 'Read My Mind', a men's reading for wellbeing group
- 'Come Singing' which provides an opportunity for people with dementia and their carers to sing and socialise in-person, online and over the phone.
- 'Norfolk Nature Stories', storytelling in a natural environment for people with a visual impairment
- 'Refu-Tea', welcome sessions for refugees helping them to access support and navigate communities.

What needs it fulfils: Provides sign-posting and social activities for a wide-range of primarily older people who may be not be reached through other services. It also works to reduce need in other at-risk groups such as people with a visual impairment and refugees.

Outcomes: Has become an embedded practice in all Norfolk libraries. Have set an ambition to achieve 'no lonely library customer' status.

Health Connections Mendip – Community Connectors

How it works: Health Connections is a GP led programme in Mendip, Somerset to connect people to the right services to support their health and wellbeing needs. As part of this, Health Connections has compiled a directory of local support organisations and trains members of the community to act as 'Community Connectors'. The Community Connectors are able to share information about the range of services and support available with family, friends, neighbours and colleagues and they can also train people up in the use of digital technology to be able to access the directory of support directly.

What need it fulfils: Links people who might not otherwise reach social support to available services and activities in their area.

Outcomes: The programme has over 500 Community Connectors delivering around 10,000 signposting conversations every year. Participants also include members of the local community such as hairdressers who are able to spread awareness in convenient settings to people who might otherwise not be reached.

'Happy to Chat' Benches

How it works: Pioneered in Cardiff, 'Happy to Chat' benches are park and street benches with a sign or marking that makes it clear that people who sit down are happy or would like someone to join them for a chat. They aim to remove the initial awkwardness of whether to make conversation with a stranger who may be experiencing social isolation or loneliness.

What needs it fulfils: Provides the space for everyday connections and making new friends for anyone in a local community who feels they would benefit from some social contact.

Outcomes: While the effects of the benches on social isolation and loneliness have not been evaluated, they have been adapted and adopted across the UK including in Edinburgh and Newcastle as well as around the world. Anecdotal evidence and case studies also indicate a positive effect on connecting people who would otherwise be socially isolated or lonely.

Supermarket 'Chat Checkouts'

How it works: A large supermarket chain in the Netherlands has opened new checkout lines for people who not only want to pay for their shopping but also have a chat. Alongside this, it is also opening 'Cozy Corners' where customers can have a coffee and a chat, and sponsoring a cooking programme to connect older people with university students.

What needs it fulfils: Aims to provide people who are socially isolated or lonely with an opportunity for social interaction in the course of their day-to-day lives.

Outcomes: Customers have responded positively to the initiative and the supermarket chain aims to implement it across its 200 stores across the country.

Walk and Talk CIC

How it works: London-based online programme that combines exercise classes with social activities for middle aged and older adults. Participants in the programme take part in a 10-week course over Zoom which involves strength, balance and body-weight exercises and group discussion on health topics such as diet, exercise, stress and sleep.

What needs it fulfils: Aims to address social isolation and loneliness among middle and older aged adults through establishing new support networks and promoting healthy behaviour change.

Outcomes: The programme has been shortlisted as one of the best social prescribing services in the UK. A randomised control trial showed that completing the 10-week programme reduced social isolation and loneliness as well as mental health conditions including depression and anxiety.

Compassionate Neighbours Project

How it works: Offers a friendship development programme for people with a palliative diagnosis in London. It works by matching volunteers with people who are nearing the end of their life at one of 14 hospices and aims to create new friends, provide emotional support and help keep individuals at the end of their life connected to their communities. There are no boundaries on the friendships created through the programme as opposed to other befriending programmes where a professional distance may be encouraged. After participating, some people with a palliative diagnosis have offered and found benefit in volunteering themselves.

What need it fulfils: Research demonstrates that people with a palliative diagnosis are at greater risk of social isolation and loneliness. This project aims to reduce this risk.

Outcomes: Over 200 Compassionate Neighbours were recruited. Of participants in the programme, 91% agreed that their quality of life and community connectedness had increased through the programme.

Independent Age – Reconnections Service

How it works: The Reconnections Service is a programme set up in Worcestershire that focuses on removing barriers in the way of older people (aged 65+) remaining connected with the community. People who are referred to the Reconnections Service are asked 'what does good look like for you?' and it is their expertise on their own lives that is used to shape the support received.

What need it fulfils: Older people (aged 65+) who are disconnected or at-risk of disconnection from their friends, families and communities.

Outcomes: The Reconnections Service has been found to reduce feelings of loneliness amongst older people. Examples of positive outcomes from the programme included finding opportunities for older people to share their knowledge and skills through inter-generational mentoring, and sourcing mobility aids for people who were restricted in being able to access their communities.

Walsall Housing Group (whg) – Champions of Kindness

How it works: Whg Housing Association have embedded early intervention and signposting into their offer through establishing 'Champions of Kindness' (local experts by experience). They work with their residents to help them adapt their lifestyles to become healthier through regular engagement and relationship building as well as offering services such as befriending, gaming groups for young people and outreach to carers. The Champions of Kindness also operate pop-up shops offering packages of supplies to lower income families in exchange for a pledge to carry out an act of kindness. These packages also contain information and invitations to local community social groups to help encourage people to connect.

What needs it fulfils: People who live in social housing are at a higher risk of social isolation and loneliness due to factors including relatively poorer health and lower incomes. The Champions of Kindness programme aims to identify the early signs of social isolation and/or loneliness and prevent it through promoting a closer and kinder community.

Outcomes: The programme aims to promote a way of working in social housing to prevent social isolation and loneliness and promote community connectedness. There are not yet any evaluated outcomes from the programme.

Friendship Enrichment Programme for older women

How it works: Women aged over 55 in the Netherlands were invited to participate in the Friendship Enrichment Programme which provided them with encouragement, training and guidance in making developing new friendships and improving existing ones.

What needs it fulfils: Older women the most likely to have suffered the death of a spouse and to live alone making friendships more important for preventing social isolation and loneliness in this group.

Outcomes: Women who participated in the training were more likely to report expanding and improving friendships than the control group. They also had significantly lower levels of loneliness one year after the training than did those who had not taken part.

11. Measuring success

Current measures of social isolation and loneliness used in the research and in evaluation of interventions are imperfect. Some of the problems associated with the existing metrics include:

- **Social desirability bias.** Many people do not want to volunteer that they are socially isolated and/or lonely[134]. This may result from cultural stereotypes around who is expected to be socially isolated or lonely and a reluctance to associate oneself with social isolation or loneliness due to embarrassment and stigma. For example, young people and people from some ethnic minorities are less likely to want to describe themselves as 'lonely'[135].

- **Lack of precise definitions.** Concepts such as social isolation and loneliness are difficult to define[42,136]. Due to the number and diversity of social contacts a person may have, determining to what degree a person is socially isolated is problematic[31]. Proxy measures, such as living alone and relationship status that are currently used are crude and do not factor the huge degree of variability in these categories[31]. Meanwhile, loneliness is a subjective experience and as such not easily measured. The issue is exacerbated by differences in how individuals themselves understand the term 'lonely'.

- **Variability.** There are a large number of tools available to measure social support and this can lead to problems in consistency and comparability between the effectiveness of different interventions and the level of risk in certain demographic groups[42,136]. Variability may sometimes be necessitated by the context or group being considered (e.g., to account for different cultural understandings).

- **Changes over time.** The degree to which a person is socially isolated or lonely can fluctuate over time[42]. Single measurements may therefore miss or overstate actual changes in social isolation or loneliness.

In order to ensure any local strategy can be monitored in terms of its effectiveness in addressing social isolation and loneliness in the borough, it will be required to consider possible solutions to the limitations of these measurement tools.

11.1 Addressing social desirability biases

Social desirability bias occurs because people are reluctant to associate themselves with a condition or state that may make others view them less favourably. Referring to oneself as 'socially isolated' or 'lonely' can be stigmatising and therefore questions such as 'how often have you felt lonely in the past month?' which is commonly used in surveys by the UK Government may result in social isolation and loneliness being underrepresented in some statistics and research.

To a certain degree, separating out the concepts of social isolation and loneliness into their component factors and asking about those can help to address the issue of social desirability bias[54]. For example, the Revised UCLA Loneliness Scale asks individuals about how often they lack companionship, how often they feel left out and how often they feel isolated from others while the Berkman-Syme Social Network Index focuses on how often individuals meet with friends and family or participate in community activities[42]. As people are not required to identify themselves explicitly as 'lonely' or 'socially isolated' in these tools, they may be more honest in their responses. When the UK Government used the UCLA Loneliness Scale in place of its usual question, it was found that the prevalence of loneliness was much higher than originally recorded and especially so in some groups e.g., people from minority ethnic backgrounds[54].

11.2 Addressing lack of precise definitions

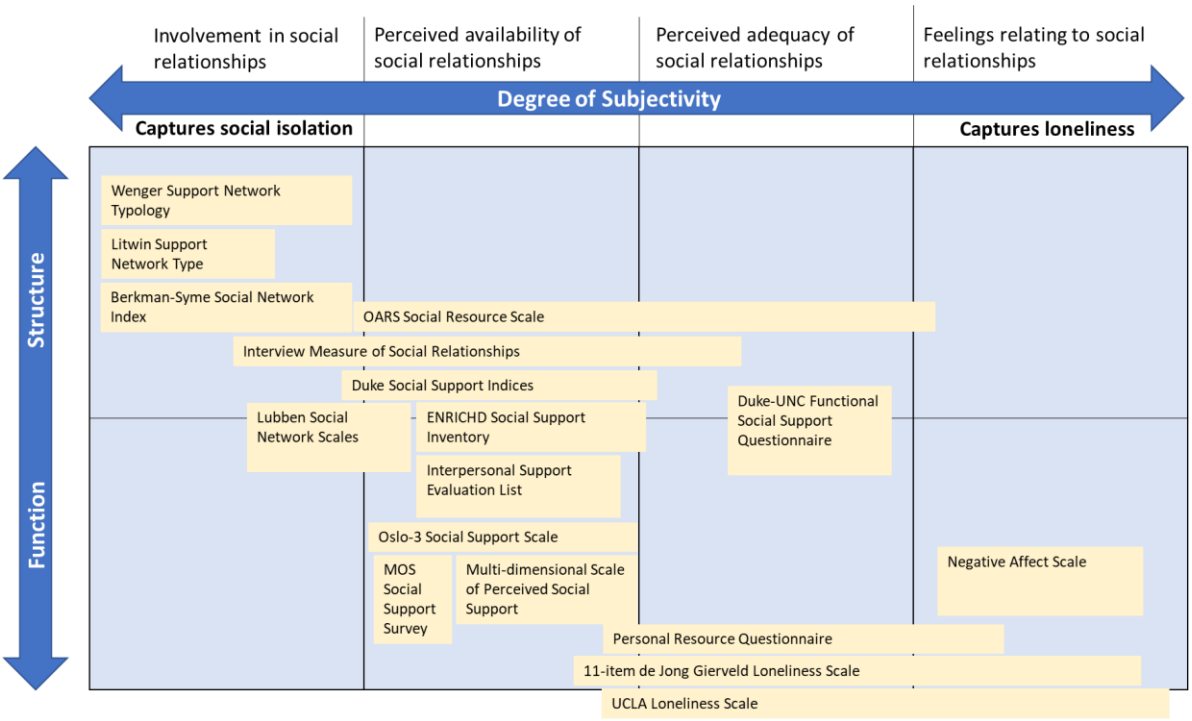
Although used interchangeably in common speech, social isolation and loneliness are distinct states and can be experienced independently of one another. It is therefore important that attempts to measure these experiences do not conflate the two. Separate tools are needed to distinguish the degree of social isolation and the degree of loneliness.

Questionnaires to measure social support can be categorised by both their degree of subjectivity and whether they measure structural or functional dimensions of social relationships[136]. The degree of subjectivity spans from measures of involvement in social relationships (e.g. number of friends, participation in social activities) to measures of feelings relating to social relationships (e.g. assessment of the depth and satisfaction gained from relationships). Questionnaires to the lower end of subjectivity are better for capturing social isolation while questionnaires that are more subjective are more effective at capturing loneliness. Structurally focused questionnaires, meanwhile, examine

the existence and quantity of social relationships while functional measures look at the type of relationships and their role in providing social support.

The following diagram plots the most commonly used questionnaires on the two dimensions of subjectivity and structural-functional focus. It is important that the appropriate questionnaire is selected to match the aims of the investigation.

Figure 4: Plot of measurment tools for social isolation and loneliness by their level of subjectivity and degree to which they measures structural or functional relationships.



Replicated from Valtorta NK, Kanaan M, Gilbody S, Hanratty B. Loneliness, social isolation and social relationships: what are we measuring? A novel framework for classifying and comparing tools. BMJ open. 2016.

To mitigate differences in the way that various people understand terminology surrounding social isolation, loneliness and community connectedness, it is generally advised that any studies, evaluations or investigations use a questionnaire or tool that has already been validated in the research community as measuring what it intends to[42]. Creating new survey questions or adapting/removing existing ones risks misrepresenting the underlying issues.

11.3 Addressing variability in measures

There are a large number of tools designed to measure various aspects of social relationships and the previous section presents just a highlight of the most commonly used. For appropriate decisions to be made and success to be measured on a practical level it is important that a balance is found between maintaining comparability and shared language between professionals while also reflecting the individual needs of each particular service and demographic group.

For most applications, standardisation across local services by agreeing on a shared definition and methodology is likely to be useful in facilitating comparisons between the spread of social isolation and loneliness across demographic groups and the effectiveness of different interventions[42]. It would enable professionals from multiple areas and services to work cohesively on a joint strategy with a shared understanding of the issues.

The standardisation of measures is likely to have drawbacks, however, including a lack of specificity to the service and group served. Due to the diversity in how council, voluntary sector and health services are delivered, standardisation would necessarily require a higher-level measurement of social isolation and loneliness that might fail to capture service-specific measurements of success. Issues also arise for certain groups of people who might not respond to standardised questionnaires optimally. For instance, people with learning disabilities or people from different cultural and ethnic backgrounds might benefit from an adapted questionnaire or outreach method that takes account of differences in how they like to be engaged and understand social concepts.

11.4 Addressing changes over time

Fluctuations are likely to occur in experiences of social isolation and loneliness[42]. This means that, although a person is generally lonely or socially isolated, at a particular timepoint they may be feeling less socially isolated or lonely (e.g., because they recently spent time with family). Single measures of social isolation and/or loneliness could therefore lead to inaccurate conclusions about the level of need and change in need (i.e. after an intervention). Measuring social isolation and loneliness at regular timepoints would address this issue and allow average changes to be monitored over time[42].

11.5 Importance of qualitative measures

While quantitative measures can establish the level of need and demonstrate the effectiveness of an intervention, qualitative research provides additional evidence useful for measuring success[Error! Reference source not found.]. The advantages of using qualitative evidence for understanding social isolation, loneliness and community connectedness might include:

- Helping to capture the reasons, mediators and moderators of change.
- Demonstrating more nuanced, smaller-scale, or early stage changes.
- Drawing out themes to identify and characterise social isolation and loneliness without social desirability concerns.

12. Mapping potential areas to focus

The following section brings together the key learning from the literature, stakeholder interviews, and a workshop held in July 2022 with representation from across council areas, the NHS and voluntary and community sector. It maps out the key challenges, what we are currently doing, and potential opportunities to help inform the next steps in reducing social isolation and loneliness and increasing community connectedness in Camden. It is structured into four domains that map on to the population health approach at the centre of Camden's Health and Wellbeing Strategy to support the implementation of the strategy's priority focussed on community connectedness and friendships.

Individual and relationship factors	
What are the challenges?	**Key groups at increased risk include:** • Younger age groups (16 – 24), including the large student population and international students in Camden. • Older people, including considerations of how to engage older men which can be challenging. • People with a long-term condition, disability or mobility issues • People with a learning disability/autism, including those without a diagnosis and not drawing on care or support. • People from Black, Asian and minority ethnic groups • Vulnerable migrants and other marginalised groups, including those for which English is not their first language.

	• People who are single/divorced or living alone • People who have suffered a bereavement • Unpaid carers • New mothers • New fathers (with less access to social support in comparison to new mothers) • People with a sensory impairment • People who are housebound • LGBTQ+ community • People who are homeless • Transient families, and families who have been relocated through domestic abuse **Other challenges:** • Increased risk among people going through key transitions (e.g. injury and surgery; retirement; moving from flats to street properties). • Intergenerational impacts, with children less likely to be able to afford to live in borough near parents. • A need for greater awareness among professionals of who is "on the brink" / at-risk. • Young people who don't yet know what their interests are • Sustainability of VCS services and funding streams, such as Outreach activities through the Ageing Better in Camden • People who are not ready to engage with social prescribing, or accessing other support or activities in the community. • Formalisation / labelling, that can put people off speaking about how they are feeling and who may not perceive themselves as lonely / in need. • For those with a learning disability diagnosis the focus is on supporting people on an individual basis (individual – carer) instead of groups with shared interests.
What are we currently doing?	• Befriending services for older people (e.g. Age UK Camden) • Intergenerational friendship matchmaking (e.g. 'Love Your Neighbour' North London Cares) • Voluntary sector support and social opportunities to unpaid carers (e.g. Camden Carers & Mobilise) • Children's Centre activities and support for young children and new mothers. • Winter Wellness programme identifies and offers support to older people • Learning disability 'Living a Good Life' project • Learning from the Ageing Better Camden Black, Asian and other ethnic Community Action Project (CAP). • Commissioned and voluntary sector services offering bereavement counselling and support • Family Group Conferencing • Fitzrovia Youth in Action is the largest youth charity in Camden and provides opportunities for young people in Camden to engage in community activities. • Community Champions programme • Caretaker Visiting Scheme • The "Opportunities Planning Group", part of Living a Good Life Project, is a directory of local activities / resources available to help build relationships for people with learning disabilities. It is being developed over time by presenting individual case studies each week and the opportunities that they have taken up.

	• Intergenerational programmes are helping to connect older people referred by social prescribers to younger people recruited more generally across Camden. • Chat and link, delivered by Voluntary Action Camden • Good Gym and Age UK work around digital support/literacy. • Work that Voluntary Action Camden are doing looking at how to support people who are not yet in a place where they can engage with social prescribing. • Kentish Town Farm/Therapy dogs (in line with animal interventions).
What are the potential opportunities?	• We could expand the 'Opportunities Planning Group' (part of Living a Good Life) to create a directory of support available to individuals across a wider range of at-risk groups. • Address practical barriers that stop people from accessing existing services (e.g. lack of confidence on public transport and practical reasons for not feeling able to leave the home); such as a volunteer-run travel confidence-building programme. • More intergenerational work, including potential for digital literacy programmes such as paring students with older people. • Campaigns and outreach • More focus around supporting younger age groups, including students. • Providing the additional support to help people to attend and engage with activities (similar to Helping Hands Islington) • Need to look at how we better support people through key transition to reduce their risk of isolation and loneliness. • Expanding use of the Ageing Better Camden Warm Welcome so that people have a positive experience when they first engage with activities to encourage them to return. • Building on the learning and approach used by the Ageing Better Camden Community Connectors. • Plugging the gap for people with mobility issues. Lots of demand on the VCS to support people to leave their homes, but lack of capacity within VCS/ASC. Explore support for communities / mutual aid group etc to accompany people outside of their homes.

Health and Social care and community services	
What are the challenges?	• Professionals may not feel they have the skills, capability, resources or pathways to support people with their social connections. • Reach and effectiveness of social prescribing services – including how to support people who are not ready for social prescribing/accessing other support or activities. • Social prescribing is resource-intensive, often requiring a rapport to be built between residents and the social prescriber before they will have the confidence to take up a suggested activity. • Lots of social prescribing referrals relate to mobility issues and are requests to 'take people out', help with shopping which is not the remit of the service. Where this is fed back to into Adult Social Care to build into individuals' care packages this is often not possible. • No free childcare for under-2s, presenting challenge for single parents • Lack of support for people with dementia (those not meeting threshold of need) Recognising the reasons or previous experiences as to why people may not be accessing support (including among LGBTQ+ community; older adults).

	• By the nature of the most at-risk being socially withdrawn, there may be no engagement with the people who are most in need of support. • Services often reliant on people coming to them rather than actively trying to find people at-risk in the community. • Professionals not having the knowledge about where to refer people • Many people present with surface issues and it takes time and patience to uncover underlying issues of social isolation and loneliness. • Challenge around the way that we fund or commission services or interventions, which are very short term.
What are we currently doing?	• Developing, promoting and monitoring local social prescribing services • Streamlining Camden's information and advice services, ensuring that residents get the best advice from the right service with minimal duplication. • Making Every Contact Count (MECC) training - ensuring opportunities for signposting / referring people at risk of social isolation / loneliness.
What are the potential opportunities?	• Extend MECC training to all parts of the system, linking to the places that people go to for support. • Can Public Health help with joining up the different measures across the range of different social prescribing services to better understand impact and reach, and at Neighbourhood level? • Capitalising on existing MDTS to discuss/address social isolation as part of these. • Need to understand that some people might not want to/be ready to commit to a more intensive social prescribing intervention and to have different options available that don't require the same level of commitment.

Place and Communities	
What are the challenges?	• Tackling discrimination (cultural-racial, disability, ageism) • Tackling inaccessible communities • Addressing fear of crime/perceptions of safety • Hard to reach people in communities in need – is expensive and labour intensive to achieve real outreach • Lack of community services to support people with mobility issues • Lots of things for young people to do in Camden but less awareness of what's on and how to get involved • Recognising the Council is not always best placed to deliver some of this support. • Economic situation and financial constraints on VCS: we cannot take for granted that the VCS will be there in the coming years • Spaces for men closed during the pandemic • Challenge in capturing all of the work happening at a VCS level and measuring this. • Housing adaptations & repairs should be made within an appropriate timescale to give people the means to make the most of their homes and communities. • Housing officers are often not aware of the range of needs that people from certain at-risk groups experience which affects the speed at which housing can be offered and it's appropriateness. • Venues are becoming increasingly unaffordable for local residents with ideas to set up and run their own community activities (e.g. the cost of renting a community centre for a couple of hours can cost £60).

What are we currently doing?	• Neighbourhood Assemblies to identify and respond to issues identified by local residents / communities. • Community centres and voluntary sector provide local social activities and outreach services. • Community champions initiative to improve opportunities for socialisation in local areas and addressing safety concerns. • Camden Trauma-informed communities • Housing team's caretaker scheme in social housing providing social contact to council tenants at risk of social isolation or loneliness. • Parks for Health programme • Improving community accessibility by making it safer and easier to walk, cycle and take public transport. • Youth Safety Taskforce has been set up bringing together diverse stakeholders to prevent youth violence. • 'Designing Out Crime' service works with the police to advise on ways that new developments can reduce the risk of crime. • Some excellent (but isolated) examples of intergenerational work • Trauma informed training in some services • Multi-use community centres provide a live picture of what's going on • Community pharmacies - North London Cares • North London Cares intergenerational support as an example of a great model. • We make Camden kit – focused on food and social isolation. • Extended school offer – events and activities taking place through the summer holidays. Some great examples where this has been expanded to bring in wider community (not just those connected through children who attend the school).
What are the potential opportunities?	• Subsidise costs of hiring venues so that residents can run the activities that they really want or provide space for free. • Make all community spaces good for people with hearing impairments (i.e. LOOP) • Train housing teams on awareness of those residents at risk. • Replicate Islington's 'Help on Your Doorstep' to help connect communities • Bring back the Camden Community Connectors • Fund and support community centres to run better outreach activities targeting people who are traditionally hard-to-reach • Address funding, support and infrastructure for the VCS • Camden Borough Partnership can explore commissioning opportunities through health system transformation, promoting a Council led small grants programme, approx. £5k for community organisations. Including criteria to address loneliness through social connections. • Support the sense of community to exist amongst community partners and practitioners • Neighbourhood working – support people / staff to access / know about the opportunities / support available locally • Training for people who deliver post to recognise social isolation and loneliness so they know how to engage with people on this. • 'Community meals don't need to be in a community centre' • Make & Mend shops reaching those who need it • Tapping into businesses as a force for social good • Building networks of support centred on anchors in the community (e.g., schools) • Extension of trauma informed training across the board • Support local VCS organisations to have a decent website (Community Partnerships)

	• Training for people to support those with mobility issues

	The social determinants of health
What are the challenges?	• The cost of living crisis is going to make socialisation less affordable for people, especially those already on low incomes. • Need to think about how we support residents who do not consent to support. • Housing – poor quality and insecure housing can drive social isolation and loneliness, as well as poor design that limits opportunities to connect. • Social isolation and loneliness considerable issue in sheltered housing • For people with a learning disability, maintaining social connections and support networks after leaving school can be a big challenge (also the same challenge for care leavers) • Identifying social isolation and loneliness is only part of the issue – need to have an intervention to support people. Neighbourhood level support could facilitate this • Council debt and advice work can be quite transactional and doesn't always link to ambitions around loneliness and social isolation • Social prescribers receive a huge number of referrals related to housing and spend too much time attempting to help people engage with the council. When people are struggling with housing concerns, their symptoms of loneliness and social isolation multiply. Multiple reported instances of Housing officers 'ghosting' social prescribers.
What are we currently doing?	• Good Work Camden supports residents into high quality employment. • Working with schools and colleges to provide Camden residents with a high standard of education and career opportunities. • Helping residents who want to engage in their community financially though the citizen funded projects. • Council debt and financial advice work • Make Every Contact Count (MECC) training • Re-purposed libraries as community hubs
What are the potential opportunities?	• Food banks could be used to provide welfare and benefits advice, provide period poverty, laundry and washing products. • Redeveloping areas but enshrine a commitment that local existing residents are prioritised for employment and ongoing tenancy, especially in deprived / regenerated areas. • Bring in a quota for local colleges and universities to have a proportion of students from local postcodes to keep local engagement with young people. • Supporting schools and colleges to encourage/maintain friendships of their students when they leave (alumni support). • Supporting people to identify if they are socially isolation and/or lonely. Perhaps do this through strengths-based approach by looking at what they would like and what matters to them, instead of using 'loneliness' and 'isolation'. • TRAs – could signpost residents to access support / connect residents • Leverage informal social hubs: pubs, barbers and hairdressers, cafes, parks, supermarkets, local shops, pets (dog walking groups) • Upskilling neighbourhood officers to recognise social isolation and loneliness • Look at recommendations from Campaign to End Loneliness specifically developed around the built environment

	• Linking in with other sectors – police / community police • Social and student landlords as access points / touch points – can enable outreach to hard to reach communities • Debt and advice / financial support work can be better linked to ambitions around loneliness and social isolation • Support resident facing staff to talk to residents about wider issues E.g., Debt advisors to receive MECC training • Adapt culture of resident facing teams with policy changes, example highlighted was Islington Council Contact Centre: 'The calls will take as long as they take' • Develop a better understanding/awareness of social isolation and loneliness among the range of services/support (e.g employment, education provider, housing etc). • Include social isolation as a measure of every project in Camden so new projects build this into their measures. This will help us build a better baseline and understand change over time.

13. Recommendations

The following recommendations have been jointly developed among participants at the workshop held in July 2022, with participants asked to prioritise key opportunities to be taken forward as recommendations, using the following prioritisation framework:

- Reflective of local need
- Potential to reduce inequality and disproportionality
- Feasibility of implementation
- Potential to shift the dial

The priority actions have been grouped into eight, key areas.

13.1 Sharing current knowledge and best practice including:

- Expanding the use of the Ageing Better Camden Warm Welcome so that people have a positive experience when they first engage with activities to encourage them to return.
- Ageing Better Camden Community Connectors; work is underway to set up training for system partners to ensure the learning from this successful 4-year programme is not lost.
- Better capture, champion and share the work of the Camden Community Champions programme.

13.2 Improving identification of and engagement with those who are chronically lonely and isolated. This needs to include those not ready to engage in formal activities. Suggestions from workshop attendees include:

- Recognition of the gap created when the Ageing Better Camden Community Connectors programme ended, and a please to recreate this support.
- Replicate Islington's 'Help on Your Doorstep' to help connect communities (first there is a need to review what is already happening in Camden that may be similar to this).
- Fund and support community centres to run better outreach activities targeting people who are traditionally hard-to-reach.

13.3 Digital inclusion is essential for promoting social connection and 'Digital' is one of the 6 challenges in We Make Camden ('Everyone in Camden can access and be part of a digital society'):

- There is a need to link work on both Camden missions.

- It was recognised that there may be a lot already happening in this space but concerns that projects are not joined up and learning is not being shared.
- Opportunities for intergenerational support through digital (e.g. through new / transient students paired with older residents).

13.4 The corporate Neighbourhoods work is an important vehicle to take work forward to tackle loneliness and social isolation. It was felt neighbourhoods is an appropriate 'geographical level' to take action. Opportunities for neighbourhood working include:

- Adopting a strengths-based approach through identifying (mapping) and capitalising on community assets and repurposing / reimagining these assets (schools, pubs, local shops, supermarkets, libraries, cafes, community pharmacies, parks) to support community connectedness (this links to the opportunity to undertake a borough wide campaign).
- Review social prescribing data at a neighbourhood level to understand the impact and reach of the service, streamline referral processes, and better tailor support to different communities/groups.
- Make better use of neighbourhood housing officers and caretakers to support the reduction of social isolation and loneliness. It is essential to recognise that training alone will not be adequate, individuals will need the time and space in their role to have meaningful conversations and provide support.
- Explore the role of student and social landlords to identify those experiencing loneliness and/or social isolation and provide / refer into support.
- Work with communities to address ear over unsafe neighbourhoods: Residents frequently cited feeling unsafe to go out to community venues and socialise because of a fear over antisocial behaviour and crime.

13.5 Undertaking a borough-wide communications campaign to:

- Support the reduction of stigma
- Increase awareness of the issue more widely whilst ensuing appropriate, non-stigmatising language is being used (e.g. loneliness is a negative term and many do not self-identify as lonely)
- Encourage a kinder, loneliness / social isolation aware population
- Support people to identify if they are socially isolated and/or lonely. E.g., through a strengths-based approach by supporting individuals to think about / identify what they would like and what matters to them, instead of using terms with negative connotations such as 'loneliness' and 'isolation' (link here with MECC Training)

13.6 Explore service area specific opportunities to help reduce social isolation and loneliness:

- Costs associated with accessing community venues is a key barrier to their use by voluntary / community groups
- Council interactions with the public (e.g., debt and advice work) is there a gap / opportunity in how these 'transactions' are handled to identify / support those that are lonely / socially isolated
- Opportunities through parks for health
- Engage Camden's planning team to design in opportunities for social connection within developments. Explore opportunities to leverage section 106 funding / Community Investment Programmes (CIPs).
- Opportunities to work with housing (e.g. caretakers, landlords, housing officers). (It was questioned whether the council is the best provider of support through housing ('ghosting of social prescribers')).
- Extend MECC training to all parts of the system (Public Health is already working to increase comms on the current offer that is already available to anyone who works, volunteers or lives within the borough).

13.7 **Consider different ways of commissioning to re-direct health system money away from costly acute forms of care to preventative community services**. This would support the development of more sustainable programmes and a more resilient VCS e.g. through a Community Chest, Camden small grants programme, or other coproduction / citizen ownership schemes (including criteria to address loneliness through social connections).

13.8 **Work with the VCS** to identify and implement ways to:

- Improve support people at key life transitions / following important life events that place them at high risk of loneliness and social isolation e.g., diagnosis, surgery, becoming a parent, retiring, bereavement.
- Address practical barriers that stop people from accessing existing services / socialising e.g., lack of confidence on public transport and practical reasons for not feeling able to leave the home.
- Plug the gap for people with mobility issues. There is a lot of demand on the VCS to support people to leave their homes, but lack of capacity within VCS/ASC.

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Appendix 1

List of stakeholders interviewed as part of the analysis into strength and gaps in the system:

1. Head of Community Partnerships, London Borough of Camden
2. Senior Community Partner, London Borough of Camden
3. Service Manager - Prevention and Wellbeing, London Borough of Camden
4. Chief Executive Officer, Camden Carers
5. Chief Executive Office, Mobilise
6. Assistant Director for Primary Care - Camden Directorate, North Central London CCG
7. Commissioning Manager – Neighbourhoods, London Borough of Camden
8. Senior Participation Officer – Corporate Services, London Borough of Camden
9. Principal Participation Officer – Corporate Services, London Borough of Camden
10. Principal Social Worker – Adult Social Care, London Borough of Camden
11. Head of Transformation and Performance, Adult Social Care, London Borough of Camden
12. Head of Impact and Learning, The Cares Family
13. Dementia Wellbeing Lead, Age UK
14. Information and Advice Manager, Age UK