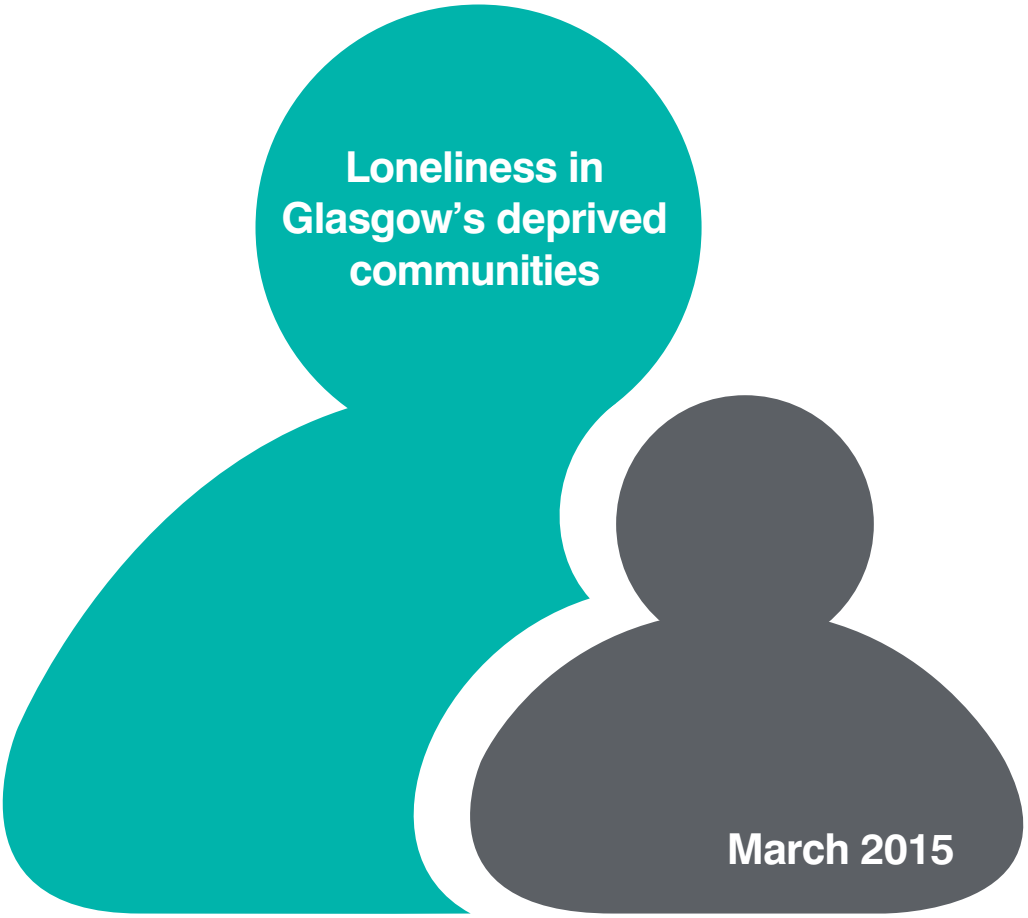
GoWell

GLASGOW COMMUNITY HEALTH AND WELLBEING RESEARCH AND LEARNING PROGRAMME

Briefing Paper 22

GoWell is a collaborative partnership between the Glasgow Centre for Population Health and the University of Glasgow's Department of Urban Studies and the MRC/CSO Social and Public Health Sciences Unit, sponsored by Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow and Clyde.

Loneliness in Glasgow's deprived communities



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GoWell is a planned ten-year research and learning programme that aims to investigate the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of individuals, families and communities. It commenced in February 2006 and has a number of different research components. This paper is part of a series of Briefing Papers which the GoWell team has developed in order to summarise key findings and policy and practice recommendations from the research. Further information on the GoWell Programme and the full series of Briefing Papers is available from the GoWell website at: www.gowellonline.com

Key findings

- There is a high prevalence of loneliness in deprived areas. Two-in-five adults surveyed in the GoWell areas experienced loneliness. This included 17% of men and 15% of women who reported frequent feelings of loneliness ("all of the time" or "often").
- Loneliness is not just the preserve of the elderly, but was most frequent among other social groups, particularly single adults living alone, and people with a long standing illness or disability.
- There is a strong association between loneliness and mental health, although causality may run in both directions. People with poor mental health, and those experiencing stress, anxiety or depression were far more likely than others to report frequent loneliness.
- Physical regeneration in relation to both the design and maintenance of the local environment is important for wellbeing. Low levels of use of local amenities and perceptions of the local environment as being of poor quality were both associated with feelings of loneliness.
- Social regeneration is also important for the prevention and treatment of loneliness. All three elements of social capital (social networks, local norms of behaviour, and trust in others) were found to be associated with loneliness. This included contact with family members, neighbour relations, concerns about safety and antisocial behaviour, and expectations of informal social control.

INTRODUCTION / STUDY CONTEXT

The current period, in the early 21st century, has been called "the age of loneliness"[1]. Recent studies have reported high and increasing levels of loneliness in industrialised countries, including the UK and Australia[2,3]. Moreover, Britain has been labelled "the loneliness capital of Europe"[4], based on comparisons across 28 EU member states which show that people in the UK have below average levels of satisfaction with their social life, and that the UK is ranked 26th out of 28 countries according to the number of people who say they have someone near them to give support if needed[5].

Loneliness has been distinguished from social isolation. The latter refers to the absence of contact with other people, whereas loneliness is "a subjective perception in which a person feels lonely"[6]. Thus, loneliness is "the manner in which a person experiences or evaluates his or her isolation or lack of communication with other people", where the number or intimacy of relationships with others is less than that which is desirable or admissible.[7,2]

Loneliness has most often been studied in relation to older people, with recent findings in the UK pointing to a rapidly increasing problem among older men living alone[6]. But loneliness has also been studied in respect of other social groups such as students and internet users. Loneliness has been ascribed to poor health, low income, increasing use of technology, and a culture of competitive individualism.

Loneliness is recognised as having an important impact on people's quality of life. A spectrum of health problems has also been associated with loneliness. These include: mental health problems, including depression; stress and sleep deprivation; negative effects on the immune and cardiovascular systems; increases in health-damaging behaviours such as overeating and unsafe levels of alcohol consumption[8-11]. Middle-aged and older adults have also been found over time to have higher blood pressure and lower levels of health-enhancing behaviours (such as physical activity) if they are lonely.

The health impacts of loneliness were encapsulated in a meta-review of nearly 150 studies, which concluded that "individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships". This effect size was said to be comparable to that of quitting smoking, and greater than the effects on mortality from other risk factors such as obesity and physical inactivity[12].

There are a number of reasons why loneliness is an important issue to be studied within GoWell, which is investigating the health and wellbeing impacts of housing and regeneration interventions and investments in some of the poorest parts of Glasgow. There have been very few studies of loneliness in deprived areas, and those which do exist have focused on older people[13,14]. This is despite the fact that many of the health problems associated with loneliness are often of greatest concern in deprived areas[15].

We are therefore interested in the prevalence of loneliness among the general population living in deprived areas as it may be an unrecognised health issue in these locations. As stated by one group of researchers, "the influence of residential satisfaction on the experience of loneliness has received little attention"[16], and thus loneliness may be something that regeneration interventions can help to tackle.

RESEARCH OBJECTIVES

Our aim was to investigate the extent and nature of loneliness within deprived communities in Glasgow, its associations with the residential environment, and its health consequences.

Four main research objectives were pursued:

- How prevalent are feelings of loneliness, and which social groups feel lonelier than others?
- Are there particular kinds of social contacts and social support that lonely people have less of?
- How is loneliness associated with aspects of the home and neighbourhood?
- What is the relationship between loneliness and measures of mental health and wellbeing?

METHODOLOGY

Survey and data source

We interviewed 4,302 adult householders across the 15 GoWell communities in mid-2011, achieving a 45% response rate. All the communities involved are relatively deprived, falling within the 15% most deprived areas in Scotland. The survey investigated participants' views of their home and neighbourhood, their sense of community and their physical and mental health.

How we measured loneliness, social and environmental factors, and mental health and wellbeing

We measured loneliness by asking respondents how often they had felt lonely over the past two weeks, with responses categorised as follows:

- Frequent loneliness: "all of the time" or "often".
- Occasional loneliness: "sometimes".
- Not lonely: "rarely" or "never".

For *social contacts*, respondents were asked how often they meet with relatives, with friends, and how often they spoke to their neighbours ("most days", "once a week or more", "once or twice a month" or "less often than once a month"). They were also asked how many of the people in their neighbourhood they knew ("most", "many", "some", "very few" or "no one"), and to what extent they would stop and talk to people in their neighbourhood ("a great deal", "a fair amount", "not very much" or "not at all").

With regard to *social support*, respondents were asked how many people (not living with them) they could ask for different kinds of help: practical – to go to the shops if unwell; financial – to lend them money for a few days; emotional – to give advice and support in a crisis.

The residential environment was divided into three parts.

Housing was measured according to dwelling type, with particular interest in any effects of living in a high-rise flat, compared with living in other types of flats or in houses. Lengths of residence in the home and in the area were also included.

The *neighbourhood physical and service environment* was measured according to respondents' perceptions and use of the area within a 5-10 minute walk of their home. This environment was calibrated according to how many of six items respondents rated as being of good quality from the following six: attractiveness of buildings; attractiveness of the environment; the quiet and peacefulness of the area; parks and open spaces; street lighting; paths and pavements. Three groups were created as follows: all items (6) good; most items (4 or 5) good; half or fewer (3 or fewer) good. Respondents were also asked which of a list of 11 everyday amenities they had used in the last seven days. Three groups of levels of use were created for both local use (3 or more, 2, 1 or 0) and non-local use (2 or more, 1, 0).

The *neighbourhood social environment* was measured in respect of belonging, familiarity, trust and safety. Respondents were asked if they felt part of the community: "a great deal", "a fair amount", "not much"/"not at all". As above, how many people they knew in the neighbourhood ("most"/"many", "some", "few", "no one"). From a list of ten antisocial behaviours, respondents were asked how many they considered to be a problem in their neighbourhood (none, one or two, three or more). Two trust or safety items were also used.

Perceived collective efficacy, or informal social control, was measured by asking respondents whether they thought it was likely that someone would intervene to stop an incident of harassment in the area ("strongly agree"/"agree", "neither"/"don't know", "disagree"/"strongly disagree"). Lastly, respondents were asked how safe they would feel walking alone in the area after dark ("very safe"/"fairly safe", "never walk alone", "a bit unsafe"/"very unsafe").

Mental wellbeing was measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[17], which asks about 14 feelings over the past two weeks, covering positive affect and positive functioning. We divided respondents into low, medium and high mental wellbeing. *Mental health* was measured using the Short Form health questionnaire (SF-12) mental health component score[18], with respondents divided into three approximately equal-sized groups according to their score from 0 to 100. Respondents were asked if they had experienced stress, anxiety or depression regularly over a period of 12 months of more, and were divided into those without such a problem, those with a problem, and those whose problem had worsened in the last three years. Respondents were also divided into those who had or had not seen their GP about a mental health or emotional problem in the past 12 months, and also into those who did or did not have a long-standing illness, disability or infirmity, which could include mental health as well as physical health problems.

Our analyses

A form of statistical analysis called multinomial (polytomous) logistic regression was used to explore the associations of loneliness with the other factors of interest. Respondents who reported being "rarely"/"never" lonely formed the baseline comparison group. Separate odds ratios (OR) and 95% confidence intervals (CI) were calculated for respondents who reported being "sometimes" lonely and for those "often/always" lonely.

A two-stage approach to the analysis was taken for each of the six domains: social contact; social support; housing; neighbourhood physical and service environment; neighbourhood social environment; mental health and wellbeing. First, univariable analysis was undertaken in which the impact of each variable within each domain was examined. Second, multivariable analysis considered the simultaneous impact of all predictor variables within each domain. All analyses controlled for sex, age, household type, employment status, education, long-standing illness (except where this was the outcome of interest), and citizenship.

RESULTS

How prevalent is loneliness in Glasgow's deprived communities?

- Two-in-five men (39%) and women (40%) reported feeling lonely in the past fortnight, including 17% of men and 15% of women who reported frequent loneliness.
- Loneliness was most common among those of working age who were long-term sick or disabled, nearly a third of whom were frequently lonely (31.5%).
- Loneliness was also common among people living alone: a quarter of single adults aged under 65 (24.5%), and a fifth of older single people aged 65 or more (19.1%) were frequently lonely.
- Older people living in a couple, and adults living in two parent family households were the least likely to report being lonely.
- There were also differences across age groups (middle-aged people experiencing slightly more loneliness) and by education (those with no qualifications being slightly more lonely) and employment status (people in work, training or education being less lonely).
- No significant difference was seen between British citizens and other (migrant) respondents.

What forms of social contact and social support are associated with loneliness?

After adjustment for demographic characteristics (including gender, age, household type, employment, education, long-standing illness and migrant status), frequent feelings of loneliness were more common among the following:

- Those who had contact with family members once a month or less. Compared with people who had contact with family most days, this group was 90% more likely to feel lonely all the time or often. This experience of loneliness existed whether family members lived locally or at a distance.
- Those who had little contact with their neighbours. Compared with those who had contact with their neighbours most days, those who had contact weekly or less often were almost 30%, and those who had contact monthly or less often were 60%, more likely to experience frequent loneliness.
- Frequent loneliness was also more likely to be experienced by those who rarely stopped to talk to people in the neighbourhood. This group was about 40% more likely to be frequently lonely than those who said they talked to people in the neighbourhood "a great deal".
- Those who knew few or no people in the local neighbourhood were 50% more likely to report frequent loneliness compared with those who knew many people in the area.
- Compared with those who had multiple sources of social support available to them, those who had no available source of practical support were 50% more likely, and those with no source of emotional support were 70% more likely to report frequent loneliness.

What aspects of the home, neighbourhood and community are associated with loneliness?

- After adjustment for standard demographic characteristics, frequent loneliness was not related to length of residence in the area or to dwelling type (flats compared with houses).
- Those who used only two local amenities in the past week were 40% more likely, and those who used less than two were nearly 60% more likely to report frequent loneliness than those who used three or more local amenities.
- People who rated their neighbourhood environment as being of lower quality – those who rated half or fewer of the items as being "good" – were 40% more likely to report occasional or frequent loneliness.
- Those who reported more antisocial behaviour problems in the area, who thought it unlikely that neighbours would take action in an instance of antisocial behaviour, and those who felt unsafe walking alone at night-time were all more likely to report loneliness by between 30 and 50%.

Table 1. Summary of associations with loneliness.

	Associated with higher feelings of loneliness	**Associated with lower feelings of loneliness**	**Not associated with feelings of loneliness**
Living circumstances	• Living alone	• Cohabiting older people • Two-parent family households	• Length of residence in the area • Dwelling type
Personal characteristics	• No qualifications • Long-standing illness, disability or infirmity	• In work, training, education	
Social contact, networks and behaviours	• Infrequent contact with family or neighbours • Rarely talking to people in the neighbourhood • Lack of sources of practical or emotional support	• Knowing more people in the neighbourhood to speak to • Use of local amenities	• Taking part in local clubs and associations • Walking frequently in neighbourhood
Perceptions of local area	• Perception of weak collective efficacy • Feeling unsafe walking alone at night-time • Perception of more antisocial behaviour in area	• Neighbourhood physical environment rated as being of higher quality	

Is health and wellbeing associated with feelings of loneliness?

The strongest associations were found with mental health. Compared with those who had the highest scores on the SF-12 mental health component score, those with mid-range scores were twice as likely, and those with low scores were four times as likely to report frequent loneliness. Those who said they had a long-term problem of stress anxiety or depression were twice as likely as other respondents to report frequent loneliness. Those who had been to their doctor in the past year about a mental health or emotional problem were a third more likely than others to report frequent loneliness.

The association with the WEMWBS score for positive mental wellbeing was much weaker, with those with a low score on this scale being about a fifth more likely to report frequent loneliness compared with those with higher mental wellbeing.

DISCUSSION AND RECOMMENDATIONS

In our study of deprived areas in Glasgow, we have not found loneliness to be the preserve of older people by any means. In other parts of the GoWell programme, we have identified large numbers of people living in our study communities who have mental health issues or who are of working age but out of the labour market due to long-term illness or disability. Now we find that these two groups are among those who also experience high levels of loneliness. These findings highlight the need for efforts to be made to identify isolated and socially-excluded residents, many of whom feel vulnerable, lacking in confidence, or fear the social stigma associated with having mental health problems, and to provide social support to them so that they may be socially integrated into the communities in which they live. They are unlikely to achieve this without help. This might be in the form of lay support from other community members or more formalised services from professionals or agencies. In the absence of such personal support programmes, other evidence suggests that demands on health services from these groups will increase over time. Some social landlords in our study areas are beginning to provide such tenant support services, but a question arises as to the best balance of formal and less formal support, and about where responsibility lies for coordinating and providing such services so that they can be extended and sustained over time.

Again, as in earlier GoWell research, we have found that aspects of the neighbourhood environment are important for psychological wellbeing. That physical regeneration can contribute to good mental health is about two things: the quality of design of what is provided by way of buildings and environments, and the standards to which the environment is maintained over time. It may be that a poor quality environment directly affects people's mood, or that such environments support lower levels of social activity, either or both of which can feed through to feelings of loneliness. The quality of the residential environment is also important with regard to the local amenities that people might use, and which can help to prevent loneliness. Provision of such amenities in deprived communities is often insufficient, resulting in communities with fewer resources either lacking amenities, or lacking amenities of good quality and attuned to people's social needs. A stronger focus on social amenities is required in the consideration of services for deprived communities.

It has been argued by many researchers, observers and commentators that "relationships matter", and that the people we know "constitute a resource" that we can use, particularly where we share common values or have a common outlook with them[19]. Further, it has been shown that this 'social capital' has strong associations with physical and mental health at the individual and community levels[20].Our findings indicate that all three elements of social capital – networks, norms and trust – are important to the prevention of loneliness. Both close networks of support and broad networks of acquaintance are important. The latter may also help enhance trust in co-residents, which when lacking can make people feel vulnerable, unsafe and lonely. These feeling are, of course, a product of the interplay between personal vulnerability and the social conditions in deprived areas.

Our findings support the case for greater attention to social regeneration which aims to develop community capacity in the form both of informal social groups and of more formalised community organisations which can provide greater opportunities for collective engagement, strengthen collective norms, and build social trust as an important component of holistic regeneration. In order to move in this direction, regeneration partnerships might seek to identify the range of community-based groups and organisations in an area which are already working with people who are experiencing or at risk of loneliness. This can then form the basis for further collaboration between sectors and organisations so as to target support to those who need it; for example, expanding the opportunities for 'social prescribing' whereby primary health care services seek to link people to non-medical forms of support within their community[21].

The argument for more social regeneration is in accord with calls for investment in people (including in the form of education, skills development and confidence) as well as places as the approach to be taken to community empowerment[22]. However, it should not be the case that adequate provision of social amenities within communities depends upon, or awaits, the development of community capacity such that land and buildings can then be passed to the community for ownership or management. The provision of social infrastructure can be more clearly seen as a prerequisite for strengthening communities and preventing loneliness.

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Mirjam Allik (Researcher)
Laura Baggley (PA/Administrator)
Sheila Beck (Ecological Monitoring Team)
Julie Clark (Researcher)
Claire Cleland (Researcher)
Jennie Coyle (Communications Manager)
Angela Curl (Researcher)
Anne Ellaway (Principal Investigator)
Ade Kearns (Principal Investigator)
Louise Lawson (Researcher)
Phil Mason (Researcher)
Emma McIntosh (Health Economist)
Jennifer McLean (Ecological Monitoring Team)
Kelda McLean (Programme Administrator)
Jill Muirie (Ecological Monitoring Team)
Cat Tabbner (Community Engagement Manager)
Carol Tannahill (Principal Investigator)
David Walsh (Ecological Monitoring Team)
Elise Whitley (Researcher)

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Research publications

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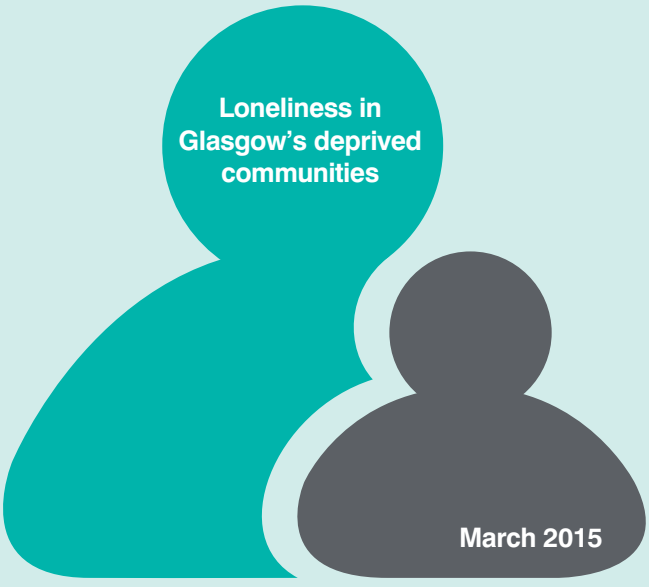

CONTACT DETAILS:

For further information, please contact the report author:

Prof Ade Kearns
Department of Urban Studies
University of Glasgow
25 Bute Gardens
Glasgow
G12 8RS

Email: ade.kearns@glasgow.ac.uk
Phone: +44 (0) 141 330 5049