Loneliness in Scotland

A National Summit

September 2016

Befriending Networks

First Minister Nicola Sturgeon signs the pledge to tackle loneliness in Scotland (courtesy of members Food Train Friends)

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Introduction

During 2015 the Scottish Parliament Equal Opportunities Committee conducted an enquiry and subsequent report into issue of social isolation in Scotland, which concluded by making a series of recommendations. The inquiry was informed by submissions from a variety of organisations, and meetings in Glasgow, Islay and Jura with individuals and community groups.

Concurrently, Befriending Networks was engaged in the third year of a three year initiative attempting to raise awareness of the issue of loneliness and its impact on health, which took the form of a series of workshops and awareness-raising events delivered across Scotland, mainly to professionals working in a health and social care context in a variety of settings, and at both practitioner and strategic levels. The workshop content included data on the prevalence of loneliness and a presentation of research evidence on its impact on health, information about the available measurement scales and the differences between them, and key findings about what works in tackling loneliness, which was not considered to be something that uniquely affects older people. (The EOC enquiry, likewise, concluded that loneliness is something that can affect people across the life course.)

Feedback from the workshops indicated that this information was new to many participants, although there was an awareness of the impact of loneliness and social isolation on the lives, and the mental and physical health, of people supported by health and social care services, and a recognition that a large number of service users of all ages were affected by loneliness. An overwhelming majority of participants at the workshop events stated that attending a learning event on the issue of loneliness was beneficial, and resulted in an increased awareness of how to support individuals to overcome loneliness as well as how to modify working practices to more effectively prevent and tackle the issue at a local level. Virtually all participants stated that the opportunity to network across sectors during the course of the day was invaluable. Over 90% agreed to share contact details in order to continue to network locally.

A common theme from workshop participants was that there should be an event at national level, given what is now known about the health impact of loneliness and social isolation. Many participants believed that the impact of loneliness on their work -particularly on their ability to spend sufficient time with service users-was not sufficiently understood by managers, heads of service, or strategic and commissioning staff within their services, nor sufficient attention paid to its impact on everyday service delivery.

Funding was therefore sought by Befriending Networks from the Scottish Government Equality Unit to deliver a National Summit on loneliness and social isolation, in order to:

- Increase knowledge and understanding of the research and data about isolation and loneliness, its prevalence and its impact on health, and its relevance across sectors
- Share a combination of intelligence gathered from Befriending Networks' workshop series, the EOC enquiry and report, data from the Link Worker initiative, and the Scottish Government response
- Share information about initiatives that have a demonstrable impact-an exploration of 'what works', including local initiatives and European approaches
- Explore possible strategic approaches in e.g. health and social care, transport, specific approaches to address loneliness and social isolation among young people, the role of technology, successful initiatives in housing
- Create a range of proposals about how to take the issue forward, and identification of possible strategic leads.

This report includes a transcript of each presentation, copies of presentations and video content. A summary of the main points discussed in workshops is also included, together with a synthesis of key points from the event.

A video overview of the day can be viewed at:

https://youtu.be/TMZsOT_bnxs

Opening address

Jeane Freeman, M.S.P.
Minister for Social Security

Ms. Freeman began by thanking delegates for their presence, and for the invitation issued to her to open the Summit. She apologised for the brevity of her visit, pointing out that it was the 'first day of term' at Holyrood and a very busy day with the programme for government. She indicated that although she unfortunately couldn't stay, the Scottish government supports the Summit, and so both she and the Cabinet Secretary Angela Constance look forward to hearing the feedback from today's discussions because the issue matters a great deal to them.

Ms. Freeman went on to say that, "of course, loneliness isn't actually about being alone. It's about feeling alone in the midst of often very many people. Feeling alone in your own home. Feeling lonely amongst others. And when loneliness hits you it's a sad place to be. And when it lasts and you feel isolated and problems that now seem insurmountable and you feel cut off from others and what's happening then you are alone in your own world and lonely in what can seem like a world that others are very comfortable in.
So yes, loneliness and isolation is absolutely something that should concern us all. And of course there are many reasons as has been said why government, any government should care. Loneliness and social isolation brings problems of ill health, both physical and mental. It denies all of us the richness of what that other person could bring to our lives and to our communities if they felt connected and part of what we're doing.
But the most important reason it seems to me why we should all care and that includes governments is the simple reason, the simple need that each of us have to reach out and help someone who needs that friendly word, that smile and that support because we know that we need it too.
So tackling loneliness and social isolation will have actions and strategies and funding requirements but at its core it has to have basic human compassion and care, one person for another."

Ms. Freeman reminded delegates that, last year, the Parliament's Equal Opportunities Committee published its report on Age and Social Isolation, which was the first parliamentary enquiry anywhere in the world into that subject. She indicated that 'we should be pleased and a wee bit proud that our parliament had the foresight to do that', acknowledging that the Parliament's conclusion that the enquiry was necessary was due to the work of some organisations represented at the event today, among others. She indicated that the Government not only welcomed the report and the thoughtful

recommendations that it made, but gave a commitment to responding to those recommendations with a programme of actions.

Ms. Freeman acknowledged that there were no quick fixes and that no Government can either legislate away loneliness, or fix social isolation itself. But things that government can do include "building our recognition of the need to tackle the issue into each area of our work. We can work with other public agencies, third sector organisations and critically local communities to help and support the work that they do to tackle loneliness and isolation in those communities and through those agencies.
We can encourage and support community planning and health and social care partnerships to be mindful and plan to support and tackle the issue. And we can begin to alter the balance of public services and support to move away from crisis intervention, important though that is, towards tackling isolation before it leads to further harm, towards real preventative work.
And in all of that we should work in a way that should be the hallmark of this government, working directly with those who have the lived experience of marginalisation and exclusion and those who work with them, to build the practical approach that we should take".

Ms. Freeman went on to say that, as Minister for Social Security she is part of a portfolio headed up by Angela Constance to tackle poverty and inequalities. She asserted that: "one of the key things that needs to be in the heart of the work we do is tackling loneliness and social isolation. It breeds inequality and it comes from inequality so it is an essential part of what we are doing".

She acknowledged that there was already a lot of work being done across the country by people such as the conference delegates, many of whom are decision makers, invited because they have a key responsibility in the decisions they make and the leadership they show in their organisations to build in understanding of loneliness and social isolation into the work they undertake, including lobbying government and other relevant agencies.

Ms. Freeman stated that: "Our job as a government is to work at a strategic level with those public and third sector and community organisations and part of our support is, of course, money. The £20 million Community Empowerment Fund specifically there to support community lead projects that tackle poverty and inequality. The one year £ 500 000 Social Isolation and Loneliness Fund which focuses on supporting community based projects. Support to Age Scotland to help set up Silver Line Scotland, a service that in the first six months from January of this year received over 2300 calls about loneliness in addition to the average 130 'keep in touch' calls which they take on each week. And our support to Age Scotland to strengthen the growing Men's Shed Movement. And finally the Link Worker Pilot programme in Glasgow and Dundee which you'll hear more about later on today. What

you should also know is that we've made a commitment to an additional 250 Links Workers during this parliament.
So loneliness and social isolation is a sad place for any of us to be and none of us know when we might also be in that situation. So it is important for us to carry on the work that you are doing and for us as a government to support that work. It has real value to every single human being that you touch and it has real value to the kind of Scotland that this government wants to build. As your government we will do our part to support you. Thank you."

The Minister signed a symbolic pledge in front of the audience who were also invited to sign up to it over the course of the day:

Let's tackle #loneliness together in Scotland.

I pledge to play my part.

Ms. Freeman's presentation can be seen here:

https://www.youtube.com/watch?v=m27hF8TP6QM

Keynote Speakers

Professor Sabina Brennan
Trinity College Dublin

Professor Sabina Brennan is Co-Director of NEIL, a dementia research programme, at Trinity College Dublin and a Research Assistant Professor at the School of Psychology and Institute of Neuroscience. Her research focuses on dementia risk reduction, primary prevention and brain health and on understanding how we can delay the onset and severity of cognitive impairment.

In her presentation to the Loneliness in Scotland summit, she focused on improving brain health as a topic that should be of concern to all. By taking this health improvement approach, she advocated for removing the stigma and negativity attached to the label "loneliness" and viewing the positive steps that could be taken as a way of addressing feelings of chronic loneliness but also of achieving broader public health improvements. Having said this, Professor Brennan was clear that social isolation and loneliness increase

the risk of developing dementia in later life and that promoting sustained social engagement was one of her top tips for improving brain health.

Her opening statements acknowledged that the support for the issue of loneliness given by Scottish Government exceeded what she had experienced in Ireland to date. She felt that loneliness was such a cross-cutting issue that all Ministers should be involved in any strategy devised, to avoid the issue being parked under an individual portfolio e.g. health. However, she was also clear that addressing loneliness could not be left to national government alone and that responsibility for this should be cascaded down through societal levels including at the level of the individual person.

"Feeling lonely is like being thrown in at the deep end with no one to save you."

"Loneliness is a killer"

(Residents in social housing, Ireland)

She went on to acknowledge that while most of the research and focus around loneliness is linked to its impact on older adults that the issue can affect people across the lifespan and demonstrated this by asking delegates to raise their hands if they had never experienced loneliness - which none did. This helped her establish the point that loneliness is part of human experience. She shared that her own experience of loneliness had been as a new parent, essentially isolated at home. She went on to state that having essentially evolved as social beings with an inherent need for social contact, our societal measures of success based in part on how big a box we could isolate ourselves in from the rest of humanity may be flawed and contributing to the prevalence of loneliness.

She set out to define loneliness and described it as an aversive feeling – something unwanted, and as a mismatch between the quality and quantity of social contacts an individual has and what they feel they need. She also noted that it was subjective and contextual - so that no two individuals were likely to experience the same level of loneliness from comparable levels of social connectedness and an individual identifying as lonely in their workplace, may not identify as lonely when pursuing a leisure interest. Because of these elements, she stressed it was important not to assume social isolation as an automatic consequence of social exclusion - where communities, e.g. those living with dementia, are socially excluded, they may still experience meaningful social contacts within their community, so not identify as lonely or isolated. It is therefore a complex or as Professor Brennan put it, a "human" issue.

She spoke about a theory of why feeling lonely had been retained as an adaptive behaviour in our evolution as it acted as a driver of change making us seek out social contact. However, the purpose served by this feeling was designed to work in an acute setting and becomes problematic with chronic exposure.

The drive to seek social contact in an evolutionary sense was key to human success and was based around forming relationships providing mutual aid. Professor Brennan felt understanding this was vital to the design of interventions, which are often perceived as imbalanced and with only one party being the beneficiary. So the type of bonds formed between people that prevent feelings of loneliness developing need this mutuality to be effective.

Professor Brennan felt that more understanding of what loneliness is would help remove the stigma attached to it and make it easier to discuss. She spoke of a misconception that people become lonely due to inherent poor social skills – being less likeable. There was no research evidence to support this.

However, she went on to describe the physiological impact of being excluded or having no or significantly reduced social contact. From an evolutionary perspective, this increases vulnerability and the body responds by being on a heightened and constant state of alertness for self-preservation. This is signified by heightened activity in the visual cortex of the brain, fragmented sleep patterns (as a lone organism is more vulnerable to attack) and interestingly, reduced activity in the area of the brain responsible for empathy.

Therefore, research shows that feeling lonely reduces empathy, which can have the knock-on effect of reducing social skills. So loneliness is responsible for reducing empathy and social skills in an individual as part of the body's response to it, as opposed to the misconception that people with low empathy and poor social skills are those who become lonely. Due to brain plasticity, this is not an irreversible change, so is key to the design of interventions.

Professor Brennan commented on how the changed structure of Western society, moving away from traditional social contact groups contributed to the increase in loneliness. She also went on to discuss social media use and made the important point that where this is used to promote face-to-face contact it can decrease loneliness, but if used to replace this, it can increase loneliness.

Chronic loneliness impacts on anxiety, sleep quality, increased blood pressure - increasing risk of heart disease and developing dementia, suppression of the immune system. It can be predictive of suicide, increased use of A&E services and medication.

Professor Brennan spoke of a 2015 meta-analysis review bringing together 70 longitudinal studies over an average of 8 years covering 3.5 million participants on the impact of loneliness, social isolation and living alone. The results showed an increased likelihood of death by 26-30% for those reporting any of these issues – irrespective of age and socio-economic status. This is strong evidence for loneliness and isolation being taken seriously as a public health issue.

What can be done? Simply increasing social contact may not work in addressing loneliness as the nature of the contact needs to be right for the individual to perceive it as what they desire.
Professor Brennan asked: why do we have segregated care? Who benefits-is it the segregated groups or the structures offering the care, and is this the right emphasis? De-segregation of care supports increased inclusivity through normalisation of exposure to different groups in society. Promotion of volunteering with all of its associated health benefits was suggested as a useful strategy especially to those more at risk of loneliness and isolation, who may form groups usually considered recipients of services e.g. elderly, disabled. Volunteering may be an opportunity for those living with loneliness to tackle these feelings while forming social contacts that have the mutuality needed for this to be effective

Links:

Presentation slides:
http://www.befriending.co.uk/befriendinglibrary_more.php?id=602
Hello Brain:
http://www.hellobrain.eu/en/
Video clip:
https://www.youtube.com/watch?v=fx9jTkZacGc

Marcus Rand
Director, Campaign to End Loneliness

Marcus gave the background to the Campaign, explaining that the objective was to 'make loneliness everyone's business', as society as a whole needs to come together to address the issue The campaign aims to reduce loneliness in older age by creating the right policy and funding conditions for groups and individuals working to address the issue. Work is undertaken with a wide range of organisations to seek the following change:

1. Higher quality, and more effective, services and activities
2. Better use of existing support, especially by the most lonely
3. More commissioning and/or development of services and activities targeting loneliness.

Studies since the 1940s have shown that approximately 6 – 13% of people aged 65 and over feel lonely all or most of the time. However, the *number* of people who feel chronically lonely will increase as our population ages, with recent projections estimating the number of people aged over 65 to reach 19 million in the UK by 2050. Research – including from academics, Office for National Statistics, Public Health England – all consistently show that likelihood of experiencing loneliness increases with age. Additionally, a recent Campaign to End Loneliness survey of over 1200 people revealed that 20% of people who experience loneliness feel they have **no-one that they can turn to**.

Marcus pointed out that it is important to distinguish between loneliness and isolation - they are related but distinct concepts and experiences: loneliness is a completely **subjective** experience and is experienced differently by everyone. It can be:

- **social** (missing a group or network of friends/relations)
- **emotional** (missing a particular loved one – after bereavement for example),
- **transient** (comes and goes),
- **situational** (lonely at a particular time such as birthdays, Christmas, Sundays, bank holidays)
- **chronic** (severely lonely all or most of the time)

Isolation is an **objective** state –it only looks at the *quantity* of relationships – the number of contacts that take place on a day to day basis.

The Campaign uses a definition based on cognitive discrepancy theory which defines loneliness as "…a painful, unwelcome feeling that occurs when there is a gap between the quantity and quality of relationships we want, and those we have".

People often use isolation as a proxy for loneliness. This can be inadequate and it is crucial to make a clear distinction. For example, carers and care home residents are not isolated, but evidence shows that many of them will be lonely. A good way of putting it is that you can be **lonely** in a crowded room but you are not **isolated.** Therefore isolation isn't always a helpful proxy for loneliness.

Marcus acknowledged that Local Authority budgets are under enormous strain and there is a need to outline a clear case for preventing loneliness and isolation at a local level. We know that loneliness is a seriously harmful to our health, e.g.:

- it poses an equivalent risk for early death as smoking 15 cigarettes a day
- it increases the risk of high blood pressure
- it increases risk of cardiovascular disease

Lonely and isolated people are also more likely to smoke, be overweight, eat fewer fruit and vegetables, and skip medication.

Preventing and alleviating loneliness helps older people to remain more independent. 76% of GPs report 1-5 patients a day come to their surgery because they are lonely. The cost of being chronically lonely to the public sector on average is around £12,000 per person, based on costs associated with GP and A&E visits. Research in Cornwall and Devon found a third of patients admitted to A&E had very infrequent meaningful social interactions– less than once a month, or never.

Reducing loneliness can boost independence and reduce costs by resulting in:

- fewer GP visits
- lower use of medication
- fewer days in hospital
- improved ability to cope after returning from hospital
- reduced inappropriate admission to care homes
- increased contribution of older people to society:
  sharing skills, knowledge and experience

Marcus asserted that solutions need to focus on driving meaningful connections, which means:

- significant, not superficial
- active, not passive
- respectful, not pitying
- inclusive, not selective
- enduring, not short-lived

The Campaign's aim is that all these goals are at the heart of what should happen across the whole of the UK. Action should be taken to address loneliness in the same way as action on diabetes or smoking. The Campaign aims to mobilise people to take action, particularly those organisations which don't currently recognise it as a priority. He reminded delegates that the Campaign is free to join, and is a national forum for collaborating and sharing best practice.

Links:
Presentation slides:
http://www.befriending.co.uk/befriendinglibrary_more.php?id=611
Website:
http://www.campaigntoendloneliness.org

Dr. Kellie Payne
Learning and Research Manager, Campaign to End Loneliness

Measuring your impact on loneliness in later life

The Campaign to End Loneliness has a research hub made up of over 100 academics and researchers from across the UK and abroad, meaning that the latest research is directly accessible to those organisations working directly with lonely people. Kellie indicated that the Campaign has a bulletin four times a year and a monthly newsletter to which all organisations can sign up. There is no agreed definition of loneliness, but there are many characteristics of loneliness which can be used to help define and measure it.

Kellie went on to explain that loneliness is described as a negative, unwelcome and painful feeling, not just caused by a lack of friends and acquaintances (social isolation) but also the quality and depth of our relationships and social networks. It is important to be aware of both of these factors in order to prevent loneliness.

Loneliness is also not a static experience: it may come and go over the course of a week or a month, and is a shifting feeling which can make it difficult to quantify and identify.

Measuring loneliness is a very important task for members in the learning network, and the Campaign has put together a guide and created their own measurement scale.

The Promising Approaches report published with Age UK shows that there is a lack of robust evidence demonstrating what services and activities can support and effectively address loneliness. Kellie emphasised that those who are providing services should measure what they are doing and what impact they are having on loneliness, in order to provide evidence to show which interventions work. There is a growing awareness of the negative consequences of loneliness for our mental and physical health: it increases our chances of dying earlier and is linked to chronic conditions including depression and dementia.

Kellie indicated that if services measured the difference its outputs had on loneliness, they would be adding to this evidence base and helping others who are supporting older people. Services would have a better knowledge of improvements made to people's quality of life and their health, and a better understanding as to how services are improving the way people feel about their connections. A measurement tool can provide more information than just counting the number of people someone sees in each day.

There is an issue about whether to measure social isolation, wellbeing or loneliness. Measuring social isolation and wellbeing does play a part, but if a service wants to determine its impact on loneliness, it must be loneliness which is measured.

Social isolation is the objective state, and measuring isolation would involve capturing the number or frequency of social contacts someone has, rather than how they feel about those social contacts. It is the quality of those relationships that is important, and this issue is wider than isolation: people can be in a crowd and still feel alone, e.g. those in care homes, unpaid carers or people in unhappy marriages.

Wellbeing is a broader concept which looks at our psychological state as well as our social connections. Like social isolation it is linked to loneliness, but is not a proxy measure for loneliness.

The Campaign urges professionals to measure specifically the difference their service is having on loneliness, and suggested four scales:

- The Campaign to End Loneliness measurement tool
- The De Jong Gierveld scale
- The UCLA scale
- The single item scale

The different scales use slightly different definitions of loneliness which impact how the questions are written.

Campaign to End Loneliness Measurement Tool

The Campaign has developed its own measuring tool, which is a positively worded three question scale, made to measure loneliness in old people and aimed at service providers, rather than academics. The definition used when creating the scale is:

> *'Loneliness is the distressing feeling that people experience when the amount or types of friendships or relationships that they have are less than they would like to have.'*

One of the unique things about it is that it is positively worded, unlike some of the other scales: it has been pointed out that when people experiencing loneliness are asked these questions it can ignite negative emotions, so having a positively worded scale can help to address that. It also doesn't mention the word loneliness, so is a sensitively worded scale which is easy to use and has been designed by service providers. It contains these statements:

I am content with my friendships and relationships
Strongly Disagree (4) Disagree (3) Neutral (2) Agree (1) Strongly Agree (0)

I have enough people I feel comfortable asking for help at any time
Strongly Disagree (4) Disagree (3) Neutral (2) Agree (1) Strongly Agree (0)

My relationships are as satisfying as I would want them to be
Strongly Disagree (4) Disagree (3) Neutral (2) Agree (1) Strongly Agree (0)

These questions underline the discrepancy in the definition of loneliness - the relationships that you want versus the relationships that you have.

The rating is from 4 to 0, with 0 indicating that someone is not lonely. If the score is 4 –ie. a strong disagreement to those positively worded statements, giving a total of 12- that would indicate that someone was very lonely.

Strengths:

Positive language about a tricky issue: Witten in a language which is non- intrusive and unlikely to cause any embarrassment or distress

Practical: Very practical resource for organisations to use in the field with their face-face work with older people.

Co-designed: with a number of different people and organisations to try and ensure it is appropriate for a range of users

Length: Kept as short as possible and is easy to score

Validity: has undergone academic tests to ensure it is valid and reliable

Limitations:

Newness: Not yet been used extensively by services so we do not yet know how it picks up changes over time

Only using positive language: The use of only positive worded questions could lead to respondents under reporting their loneliness

Not a screening tool: strongly advise organisations not to use these questions as a 'screening tool' to establish eligibility for their services. It has not been designed for this purpose and may give misleading results.

There is a validation report available from the Campaign which explains how the scale was put together.

De Jong Gierveld Loneliness Scale

One of the well-established measurement tools is the De Jong Gierveld Loneliness Scale, one of the unique features of which is that it looks it looks at both emotional and social loneliness, as defined by Weiss (1973).

Loneliness can be divided into two different types: emotional loneliness, when what is missing is that one individual connection, like a best friend or a partner, and social loneliness, when what is lacking is a larger social group. This six question scale can explore these two types of loneliness, is positively and negatively worded and was initially developed for researchers. When academics are putting forward a bid for research funding they will often use the De Jong Gierveld Scale as it is very rigorously tested and widely used within academic circles. It can easily be compared across different modes of research.

It uses the following statements:

I experience a general sense of emptiness
Yes (1) More or less (1) No (0)

There are plenty of people I can rely on when I have problems
Yes (0) More or less (1) No (1)

There are many people I can trust completely
Yes (0) More or less (1) No (1)

I miss having people around me
Yes (1) More or less (1) No (0)

There are enough people I feel close to
Yes (0) More or less (1) No (1)

I often feel rejected
Yes (1) More or less (1) No (0)
Answers are added for a total of 6 to 0. Three statements test social loneliness and three test for emotional loneliness.

Strengths:

Measures different types of loneliness
Designed with for use with older people
Extensively used and validated

Limitations:

Length
Training / support needed for negative answers

UCLA loneliness scale

The original UCLA was made up of 20 questions but this is a shortened three question versions. It is similar to the Campaign scale in that it looks at the cognitive discrepancy or mismatch between the relationships someone has and the relationships they want, the only difference being is that it has negative wording:

How often do you feel that you lack companionship?
Hardly ever (1) Some of the Time (2) Often (3)

How often do you feel left out?
Hardly ever (1) Some of the Time (2) Often (3)

How often do you feel isolated from others?
Hardly ever (1) Some of the Time (2) Often (3)

The higher the score, the greater the impact of loneliness on the individual. The Campaign has come across many services in England using this scale as it is established and validated, meaning results can be compared across projects.

Strengths:

Widely used

Well tested and validated

Compare to national studies and data – used in the English Longitudinal Study of Ageing (ELSA)

Limitations:

Full scale version originally developed in the USA and with students (though shorter version has since been tested withholder people)
Only uses negative wording so could lead to a "response set" where people answer without really considering the statement

Single question scale

Examples of single questions asked about loneliness might be:

How often do you feel lonely?

Hardly ever
Some of the Time
Often

During the past week, have you felt lonely:

Rarely or none of the time (less than one day)
Some or little of the time (1- 2 days)
Occasionally or a moderate amount of time (3-4 days)
All the time (5 -7 days)

Strengths:

Short and easy to insert into a broader assessment of need
Age-friendly especially where there are communication issues or cognitive decline
Academically accepted

Limitations:

May be too blunt to detect small changes over time
Ignores stigma attached to loneliness, risking underreporting

The Campaign is presenting all these tools as different ways to measure loneliness. The Campaign would like people to start using its tool, but potential users should be aware that there are other tools as well and the choice about which is most appropriate needs to be made on a case by case basis and tested out to see what works.

Often in workshops, people have been asked to try the set questions to find out how it feels to ask these questions and also to answer them, and feedback indicates that the Campaign's tool tends to be the easiest or least distressing of these scales.

It is important that service providers consider taking the step to measuring the impact that their service is having on loneliness. It is only from those who are providing services and measuring loneliness that the Campaign can gain the base of evidence needed.

Kellie concluded with a call to action to go to the Campaign to End Loneliness website and register as a supporter, and to read the guidance. The Campaign would like to be kept informed about who is using the tool and their experience of it, so invited delegates to share their findings whichever tool is being used. She asked that the Campaign be updated about use of the measurement tool in order to encourage people to get involved and increase communication on this topic.

Links:

Presentation slides:
http://www.befriending.co.uk/befriendinglibrary_more.php?id=603
Video clip:
https://www.youtube.com/watch?v=QlxRjf21-Bc&t=935s

Dr. Peter Cawston
Clinical Lead, Scottish Government Links Worker Programme

Dr. Peter Cawston is a GP with Garscadden Burn Medical Practice in Drumchapel, Glasgow. He is clinical lead with the Scottish Government Links Worker Programme and a steering group member of GPs at the Deep End (i.e. those that work in general practices serving the 100 most deprived populations in Scotland). He runs the substance misuse clinic at the practice and has an interest in the impact of poverty on health.

In his presentation, Dr. Cawston used his experience of working in primary care in a deprived area to illustrate patient experience and to examine how the practice had responded to these challenges, as well as outlining the context for primary care in Scotland.

Using a real but redacted letter from a rheumatologist, which recommended a series of prescription pharmaceuticals, he posed the question that, given the patient was facing multi-morbidity, would these drugs offer a solution on their own? Loneliness was one aspect of the multi-morbidity facing the patient.

He went on to share information about a health and wellbeing survey for North West Glasgow comparing poorer with affluent areas, which showed that those in poorer areas were:

- 50% more likely to feel isolated from family and friends
- 4 x more likely to feel that they do not belong
- 18 years less of healthy life expectancy (for men)
- 38% more complex health problems (5+ long-term illnesses)
- living with twice as many combined physical and mental health problems

Dr. Cawston offered the perspective that loneliness and social isolation are features of being poor and living with complex health problems. He felt strongly that there was a core causality there and that these factors were not simply part of a set of risk indicators.
He pointed out that Scotland has one of the worst health inequalities records in Europe. He therefore felt that the Summit was about tackling social justice and health inequality, for which, loneliness and social isolation were drivers.

Dr. Cawston went on to look at how health spending priorities had changed over the last decade. He showed statistics indicating a significant rise in hospital admissions since 2007 in Glasgow. He linked this to a reduction in spending on social care, district nurses and general practice. District nurse numbers in Glasgow are still well below the level of 2007 and nationally, GP spending is a smaller proportion of the NHS Scotland budget than it was in 2005-6.

He also presented statistics to show that the number of GPs in Scotland had been dropping in the last decade while the number of consultants had been increasing. Significantly, 2007 seems to have marked the crossover point at which the numbers of consultants became higher than the number of GPs in Scotland. He stated that Public Health Consultant, Dr. Helen Irvine, whose work he recommended to the Summit, had suggested a link between the rise in hospital admissions and this reduction in community health and social care services.

In a 2016 a survey of primary care staff revealed that:

- 90% feel stressed by their work (50% higher than the NHS average)
- 80% have sleep affected by work
- 20% report a diagnosed mental health condition they associate with work
- 8% have had suicidal thoughts linked to their work

He linked this to Sabina Brennan's presentation point stating that those who care need to look after their own wellbeing in order to be able to care well.

He then demonstrated that life expectancy and comorbidity increase sharply between more affluent and less affluent areas, while funding remains relatively static across these areas. He argued that therefore general practice is not funded to meet need.

He drew these points together by returning to his patient from the beginning of his presentation and concluding that not only is the person living in an area where the multi-morbidity issues, including loneliness and social isolation are more prevalent because of poverty, but the GP practice the person can turn to is struggling. He concluded that the line

of least resistance for a GP in this situation would be to follow the rheumatologist's prescription for pharmaceuticals.

He spoke about a study by Professor Mercer on patient perception of GP consultations and stated that for the least affluent areas:

- consultations were shorter and patients report less enablement
- those reporting lowest enablement are living with psychosocial problems
- GPs are perceived as less empathic

He pointed out that the system is therefore failing those most at need.
To conclude this section of his presentation he pointed out that people who are lonely and socially isolated rely heavily on community based services. Cuts to these services over the last decade have led to a costly and unsustainable rise in hospital admissions, most acute in deprived areas.

As a GP, he busted the myth that he is a gatekeeper to hospital admission and pointed out that anyone could get into hospital. As other options are removed for people living with long term conditions including psychosocial problems and even the GP is perceived as being less empathic, a hospital admission becomes increasingly the only option.

Dr. Cawston felt that the last decade had seen a push of resource allocation towards hospital based provision and that this now needed redressing so that care could be provided within communities. He called on the Summit to begin changing this.

Going back to his patient and the prescription received – which included two types of anti-depressant and would cost £2500 per year, he stated that the patient may feel better and he might feel his job as a GP was done, though in reality questioned whether this was the best outcome. He suggested that the evidence of increasing health inequalities indicated that this was not the case.

He cited another study by Professor Mercer which evidenced that caring for people works. GPs were given a bit of extra time and were asked to care for people. The study showed that increasing the time to care led to an improvement in patient Quality of Life, whilst continuing with the usual care approach led to a reduction.

He went on to discuss to practical examples of what improved care might look like in a GP practice. One was the Govan Ship Project which gave extra GP time, attached social workers to the practice and held monthly multi-disciplinary meetings to try and help the neediest patients. He disclosed that the most popular uses of the extra time for the GPs on the project were extended consultations and home visits.

The other project, which he was directly involved in, is the Links Worker Programme, where a Links Worker with expertise on community assets becomes part of the practice team and can support patients with psychosocial needs by social prescribing support from within the community. In addition, the Links Worker can bring their expertise to the practice team and help promote their wellbeing, improving their ability to care for others. The example given was of bringing yoga into the practice for the staff. The practice paid for this service from a third sector supplier, which therefore improved the capacity of the third sector body to offer yoga free to those in the community. Practice staff had found that accessing this community resource had contributed to stress reduction in the workplace, making them better able to care for others.
As part of the practice journey with the Links Worker Programme, there had been a shift in flagging up community engagement opportunities on the practice website – so that it became a source of support.

He summarised the impact of the Links Worker Programme to date:

- >2000 referrals to Links Workers across 7 practices over the first 2 years
- 75% engagement had been achieved over the first 2 years
- 60% of patients self-reported improved wellbeing after 1 year

From a practice perspective, the 7 practices showed an improvement on all indicators on the Safety Climate survey, completed by all GP practices in Scotland compared to those not in the programme.

He went on to suggest that for the NHS to survive it would need to invest in well-connected teams of health and social care generalists to provide compassionate, unconditional long-term person centred care . He proposed that both the Govan Ship Project and Links Worker Programme provided a glimpse as to what this could look like.

A key aspect of the Links Worker Programme had been the setting aside of protected learning time for staff. Dr. Cawston described how at Garscadden Burn this had been used to engage with a patient group to try and identify any health issues currently being under addressed. The patients identified loneliness and were asked by the practice staff to help them learn what loneliness meant to them to improve understanding. The patients' words included:

"Loneliness seeps into your very being, blackening your world and transforming your thoughts into thoughts of despair, eroding your self-worth till you feel worthless…."

"Loneliness changes positivity to negativity, happiness to sadness, hope to despair….You look upon life as a burden instead of a pleasure. It's Hell……"

The patients were also asked what would achieve a change for them. The answer was to slowly allow them, through a caring and nurturing approach, to "melt the wall of loneliness" and allow the individuals to find their feet at their own pace. Listen, surround by kindness, and make the person feel valued.

Dr. Cawston commented that as there is no quick fix, this makes the issue uncomfortable for policymakers and doctors.
The patient group had evolved into a friendship group as the individuals recognised they were all living with loneliness. Barriers were being broken down between individuals the group was being supported by a practice receptionist. The group now has ambitions to invite others to join them and is hoping to build a coffee shop and have a drop-in centre.

Dr. Cawston concluded that for secondary and tertiary health services to work, it was first important to get it right in the community, as this is where he felt the initiatives that would tackle loneliness would emerge and needed support.

Links:

Presentation slides:
http://www.befriending.co.uk/befriendinglibrary_more.php?id=610
Video clip:
https://www.youtube.com/watch?v=EbWKW-yI_V0

Interviews

Befriending Networks interviewed a sample of delegates, asking these questions:

- why is loneliness of concern to you?
- what (if anything) does your organisation currently do to tackle loneliness?
- what would you like to see happen as a result of today's summit?

Links to the interviews are below:

Martin Malcolm, Head of Public Health Intelligence, NHS Western Isles
https://www.youtube.com/watch?v=ep0b_eec200

Antony Gardiner, Head of Prevention and Protection, Scottish Fire and Rescue Service, Highland
https://www.youtube.com/watch?v=03v_5gQjMQk&t=2s

Diane Wilson, Senior Development Officer, Voluntary Action Fund
https://www.youtube.com/watch?v=UgmmPo2SO90

Emily Beever, Senior Development Officer, Youthlink Scotland
https://www.youtube.com/watch?v=SzMuYHoiRoQ

Linsey Drever, Adult Befriending Coordinator, Voluntary Action Orkney
https://www.youtube.com/watch?v=plxxinQL9uI

Heather Sloan, Health Improvement Lead –Mental Health, NHS Greater Glasgow and Clyde
https://www.youtube.com/watch?v=gcyfzZAF6uU

Amy Dalrymple, Head of Policy, Alzheimer Scotland
https://www.youtube.com/watch?v=cR-AxIKvCsk&t=18s

These interviews provide insight into how a range of services are approaching or intend to approach the topic of loneliness in the communities they support.

Workshops

Five workshops were held simultaneously, and the same three questions put to each workshop:

- how do we determine which interventions are most effective in tackling loneliness?
- how do we ensure that any national effort to tackle loneliness and isolation recognises the ubiquitous nature of this problem rather than focusing on its impact on certain groups within society (such as older people)?
- what concrete steps need to be put in pace to take forward a national commitment to tackling loneliness?

The discussions were wide ranging, encompassing a number of associated questions and points. The summary below is an attempt to capture the main themes from the workshops, rather than reproduce every detail raised.

As the workshops occurred simultaneously, there are some contradictory statements recorded in the summaries, which reflect what different participants felt about the same point. Befriending Networks has avoided trying to editorially iron out these differences of opinion, in favour of recording a more accurate reflection of delegate input from the day.

It was felt that the high profile of this conference had to be a good thing: it is an issue whose time has come. There was a discussion about the language used: whether the term 'intervention' is helpful, the terms 'effective' and 'loneliness' are both subjective, and the word 'lonely' could be regarded as stigmatising. It was pointed out that, when considering the therapeutic aspect of dealing with loneliness, we may not yet have got the narrative right: identifying loneliness as negative may be stigmatising a natural process, but what's needed is a distinction between transient feelings of loneliness, which are normal (e.g 'empty nesters') and can be a driver to effect change, and longer term chronic loneliness that actually makes it harder to seek company. It was recognised that, in the case of chronic loneliness, support would be needed to alleviate and prevent health impacts.

There was a discussion around negative language, e.g. 'tackling' loneliness, the stigma around acknowledging loneliness, and its association with 'losers'. Delegates agreed that no intervention should be regarded as a 'fix' for loneliness, and that awareness-raising was needed to counter the attitude that this was possible: rather, societal change is necessary to address the issue.

The Campaign to End Loneliness (CTEL) was thought to be very positive, but it was felt by some that campaigning should be toward positive goals, such as happiness. The CTEL scale was believed to be useful for assessing problematic, chronic loneliness.

There was much discussion about the **role of community** in tackling loneliness. A question was posed as to whether we are over-complicating the issue, whether the growth of public services has disempowered people, and whether communities need to reclaim this responsibility. Creating space within a community to discuss loneliness may help community members to understand the issue, and give them confidence just to knock on their neighbours' door. It was suggested that a focus on what's happening in communities is more likely to field a successful public campaign, with a focus shifted from dependency on individual services. Services may be funded for short periods only, whereas peer-led approaches can be sustained and cost-effective.

It was suggested that cultural change needs to be effected in communities: the Community Empowerment Act is evidence that change can happen. Community empowerment doesn't require top-down, evidence- based solutions: asset-based approaches using co-production may provide a solution. Problems may be solved by changing the relationship between the citizen and the state, rather than an interventionist approach-mutuality doesn't require

interventions. It was further suggested that consideration needs to be given to the barriers, or perceived barriers (often mythical), created by legislation-e.g. health and safety, PVG, environmental health concerns or safeguarding; that fear of risk in respect of children or vulnerable adults impedes community based solutions. There needs to be a combination of informal solutions to prevent loneliness, and more formal approaches to help people deal with existing chronic loneliness. The Meal Makers initiative was mooted as an example of successful circumvention of potential barriers: the service is regarded as donations of food between neighbours, which means it is not subject to restrictive regulations.

A view was expressed that volunteering was becoming too formalised-that PVGs, core training, and induction may deter people from volunteering, and that 'community activism' which was about informal relationships, could address this.

The concept of 'intervention' was further discussed: it was suggested that communities should help themselves, and should be 'doing' rather than 'done to'. Small changes within our communities could make a huge difference at minimal cost, if better use was made of already available services and resources. Work could be done within communities to identify assets which already exist, and where there are gaps. An example was given of Tesco in Maryhill, which has evolved organically as a community hub-i.e. the private sector can provide part of the solution.

It was pointed out that intervention will depend on the demographics and needs of individual communities, and that solutions for e.g. urban areas will not have the same impact in rural areas, where there may well be specific challenges in, for example, transport or web connectivity. Localities plans and community councils need to be engaged in this cultural change. The point was made that we should create space to interact with and learn from one another, either in terms of other cultures within our communities or in respect of specific issue such as participatory budgeting. Peer-led engagement or training is empowering, and in terms of building community assets, some people who receive a service (e.g. via community connectors) go on to become volunteers, which can improve confidence and reduce isolation. Communication and safe spaces to talk are important in communities, as within services there is rarely time to do this-the point was made that decision-makers in public and statutory services should recognise that cost-saving now may mean generating future need for interventions.

There were differing views expressed as to whether national guidelines (on loneliness and social isolation) were needed, one opinion being that they may drive out small scale community measures which work, and that the focus should be on the non-stigmatising issue of social and emotional health. The issue needs to be placed in a wider context of reducing health inequalities, with the involvement of Health and Social Care partnerships,

an understanding of local need and knowledge of local provision, but fundamentally it has to be about human engagement, and avoiding putting people in 'boxes'.

Policy/strategy

There was a view that loneliness and social isolation needs to be built into a range of national and local strategies, as it doesn't neatly fit into one policy area. There was a suggestion that a Loneliness (or Isolation) Impact Assessment tool could be developed, and that it was relevant to e.g. housing, education and transport policy areas. The issue should be included within both new and current health and social care policies and planning documents. If the public sector could understand and align thinking around the issue, this would be a great achievement. There was a suggestion that the Scottish Government's (SG) priorities need to be looked at in order to see how the issue can be linked to them. Loneliness is linked to many other issues, such as poverty. It was pointed out that there should be 'joined up thinking' in some SG policy areas, and that some national strategies are completely ostracising.

Opinions differed as to whether a national strategy on loneliness would be helpful, but there was general recognition that it was a complex and multi-layered issue with no single, effective, 'one size fits all' intervention, and that appropriate responses would depend on whether a preventative approach or a crisis driven intervention was necessary. The most prevalent view was that a National Strategy would be helpful, provided that this was underpinned by work within communities, in order that communities can grow and develop.

Measure/evaluate/research

General statements:

- a number of measurement tools were talked about in some depth, including those which had formed part of the presentations taking place during the morning.
- well-being scales are regularly used
- some organisations do not undertake a great deal of measurement
- need to acknowledge the different starting points for measurement/evaluation – community (loneliness prevention) different to service intervention (loneliness assessed as present and seeking to reduce) - both could be regarded as "early intervention" but approaches would vary and clarity provides context.
- the report by the Calouste Gulbenkian Foundation "Loneliness across the life course" was mentioned and it was discussed how this flags up vulnerable transition points in life where services may wish to focus an assessment of loneliness for individuals.

- use of research materials as a resource to share good practice. An example is "Promising approaches" which collated information on initiatives tackling loneliness
- loneliness plays a significant role in the lives of many younger people – more research is required in this area
- why does so much research focus on older adults? Are younger people more comfortable dealing with this issue?
- longitudinal studies all concentrate on older people. There may be an intergenerational aspect that if individuals are lonely in childhood does this reflect a similar pattern in older age?
- IRISS - a good website for sharing learning

Concerns around monitoring/evaluation:

When it has been widely recognised that something is effective, such as peer led approaches, do we need to continue exploring the value of this on a regular basis? If we know what works then can we just measure how much of it we do? Do we have to justify what works and why we do it?

There was a general acceptance that it can be difficult finding time to measure effectiveness of interventions whilst trying to run a service, and that we should be spending more time doing things rather than simply measuring our activities.

National guidelines can be very important as they raise the profile of an issue such as loneliness, but trying to gather this information can be a difficult and time consuming addition to someone's responsibilities.

There was a view that we need to guard against throwing too much resource into evidence, impact of activity/intervention etc. There was a feeling from third sector delegates that no matter how much is produced, it is never enough/right. Creating conditions where people flourish is not about using the same methods of evaluation, but we should instead be concerned with what we can learn from our experience to make things better for people. Loneliness is universal- it affects everyone- so strategies to reduce it are the right thing to do. It was pointed out that drawing from the science should save the NHS money.

The question was asked whether, in the evaluation process, we are trying to convince funders or service users of efficacy, and whether we needed evaluation evidence for funding or to achieve goals. Statistics and the use of quantitative data, it was suggested, is not the most compelling way to attract new clients. Another opinion was that there is currently little evidence base for effectiveness: case studies were used, but not enough measurement. Resources are needed to enable services to measure, and a measuring toolkit is useful but can be intrusive. A need for a logic model was suggested.

It was pointed out that many funders appreciate case studies rather than relying on quantitative data. Funders may have very robust measures which need to be adhered to: they can, at times, ask for 'new' and 'novel' measurement methods, requiring information which can constrain services in their evaluation process.

Some services have a particular challenge as their outcomes are not defined in terms of reducing the impact of loneliness. They therefore have to explore methods of exploring the effectiveness of interventions in this area and integrating them within the measurement of their other activities

How can we encourage people to report when they are experiencing feelings of loneliness?

- the measurement scale doesn't support identification of people 'at risk of loneliness' and therefore it is difficult to evidence prevention of people becoming lonely, as opposed to a reduction in loneliness in those who are already living with the issue.
- finding out who is at risk is important - e.g. those at transitional points in their lives.
- people may not realise or be able to articulate their levels of loneliness.
- apps can be used for volunteers to provide information following each visit which result in an ongoing, regular, light touch approach instead of distributing long questionnaires on an annual basis
- if we want to consult with service users and volunteers we should look at the ways in which they would prefer to provide feedback
- people volunteer for their own reasons-'to meet people' etc. There was an interest in the loneliness measurement tools described in the presentation, and it was suggested that this could be done with volunteers. There should be a recognition that volunteering can be an approach to reducing loneliness, so measuring its impact should have validity in this context – the impact on volunteers of service involvement is often overlooked or of lesser interest to funders and commissioners.

Working together/Consistency:

The following points were made:

- the things we can measure should be measured like for like to give us a good overall picture.
- organisations who have partnership arrangements should consider joint measurement and evaluation tools. This could also include linking with GP partnerships
- there needs to be a national well-being index/indicator of loneliness, which should be tracked over time

- measures identifying loneliness should be positive rather than negative (as discussed in the morning session)
- need to move from a 'pledge' to considering what agencies can do.
- encourage partnership and collaborative working and through this have joint campaigning initiatives
- lots of good work being done in Scotland-pick out the best & replicate
- loneliness is subjective but an individual may not know what they need or want. This could be where the third sector comes into play. Someone to be in an informed position of what is and isn't available to signpost or identify gaps.
- the need to know what is out there so we can begin to "socially prescribe".
- an asset map with commitment to learning exchange
- vision & creativity needed. Stop working in silos. Be inclusive: however, the Government is designed to work in departments. It would be useful to find ways of demonstrating that it does us good to 'live well'.
- youth work- cross-cutting political example. Look at principles of youth work-is there a parallel with loneliness? People need to buy in to listen to one another-now refer to "youth sector"- not voluntary/statutory youth sector – so a real sense of working together has been achieved.

Awareness raising

- there needs to be greater emphasis on educating people as to what is meant by loneliness. Public awareness of the issue needs to be raised
- we should create a "call for action" or "social movement" with real momentum. Could the Campaign to end Loneliness be this?
- there is a need to destigmatise the word "loneliness" and incorporate it into everyday language as has been done with mental health, raising awareness of the importance of identifying and seeking to alleviate it among the general public - otherwise it's always seen as someone else's business.

It was felt that action should be taken to engage and inform local and national politicians, and the following suggestions were made:

- hold a parliamentary event focusing on loneliness
- feedback the information on the impact of loneliness to elected representatives as a method of raising awareness
- as the Scottish Government assisted in funding the Loneliness Summit, feedback from the event should be collated and be used to inform the government and all political parties
- contact elected representatives to inform and discuss issues

Intervention approaches

Discussions took place about intervention approaches, and the following points were made:

- we should promote the benefits of learning and volunteering. Volunteering improves the physical and mental health of individuals
- encourage personal contact, which can be more persuasive than media articles in persuading individuals to assist in tackling issues
- trying to change culture within the NHS -not 'what's the matter' but 'what does matter' (ie the social rather than medical model of health)
- loneliness is related to inequalities in health/available resources. We need to aim to narrow the gap through encouraging participation and social engagement
- there are ways of presenting the intervention to be more appealing and less stigmatising- e.g. Big Lunch, Men's Sheds. Food is a great social vehicle.
- interventions must be person centred-coming from a voluntary/non voluntary position; non judgmental; in partnership.
- there has been increased use of tele-health and tele-care in both communication with and consulting with people. There is greater use of electronic platforms to engage with individuals
- transitions are a key point for loneliness. It needs to be communicated that it's okay to feel that way at times. If we recognise this, it may help people to talk about it and with prevention.
- on back of Big Lunch Tour 2014, a workshop was developed and piloted in Mental Health week and attended by home care workers, which changed perceptions of what the workers can do.
- improve access to and endorsement of social prescribing – need to bring more primary care practitioners on board with this
- see Big Lunch model-right at beginning of loneliness journey.
- befriending: Fife Council have funded 11 befriending services for 3 years, and are collating evidence, supported by Evaluation Support Scotland, to determine their impact.
- other comments: befriending is a reciprocal arrangement –if it was a paid service, it would devalue the relationship.
- befriending services- volunteers coming on board as a direct result of 'John Lewis' ad. A lot of referrals to services are of young people. Volunteers are shocked by this, but respond to the young people as befriendees
- befriending support is also required for those in care or nursing homes.
- connecting individuals by e.g. befriending is important. We must realise that this can be a slow process but results will become apparent. We have to accept the length of time it takes to building relationships that will actually combat loneliness.

- some services such as befriending can be resource intensive, but cost effective as a preventative measure. Because of this they do not always have to involve additional expenditure.

Summaries

Main points:

- Prevention
- Community assets
- Loneliness as part of life –transition
- Change narrative-not 'tackle loneliness'
- Education
- Myth-busting
- Person centred solutions
- Safe space to discuss /have conversations

Demand social participation as a human right.

Change expectations-e.g. of benefits/burden of volunteering

Approach needs to be cultural change, not just education/awareness-raising.

More subtle campaign-ask people in e.g. care homes 'have you helped/smiled at someone today?'

Come together again & identify good practice

Government and beyond responsibility-it lies with individuals too.

Concluding statement

It is hoped that the report captures useful information from the first National Summit event on Loneliness in Scotland. Befriending Networks is grateful to the Scottish Government for supporting such an event and feedback from delegates suggested this was a welcome move in drawing people together across sectors to begin sharing knowledge and developing approaches. Our thanks to all our wonderful and inspiring speakers and to all our stallholders who showcased their current work in this area for delegates.

The date of the Summit, 6th September 2016, coincided with the First Minister announcing as part of the Plan for Government for 2016-17 that a National Strategy on Social Isolation

will be developed. This was greeted with great enthusiasm by delegates and provided a fitting end to the plenary session.

Befriending Networks looks forward to working with partners to contribute to the development of this strategy and to ensure that chronic loneliness remains on the agenda as a public health issue which should be addressed to improve national wellbeing.

For those interested in learning more about current research into loneliness, BNs recommends visiting the Campaign to End Loneliness website at:

www.campaigntoendloneliness.org

Jeane Freeman MSP, Minister for Social Security, visits the Befriending Networks stall before addressing the Summit

Appendix 1 – delegate list

Name	Job title	Organisation
Aileen Grant	Community Health in Partnership Officer	Aberdeenshire Voluntary Action
Alan Silcock	Development Volunteer	Scottish Men's Sheds Association
Alison Clyde	National Development Manager	Generations Working Together
Alison Love	Head of Support & Development Scotland	Royal Voluntary Service
Alison Roy	Director of Services	Equal Futures
Ally Irvine	Board Member	Befriending Networks
Amy Dalrymple	Head of Policy	Alzheimer Scotland
Andrena Coburn	Funding Manager	Life Changes Trust
Andrew Findlay	Project Coordinator	Interest Link Borders
Andy McCann	Chief Inspector, Harm Prevention Unit	Police Scotland
Angela O'Brien	Housing and Independent Living Team	Scottish Government
Anne Clarke	Assistant Director Public Health	NHS Ayrshire & Arran
Anne Connor	Chief Executive	Outside the Box
Anne McIlvain	Development Officer - Befriending	East Dunbartonshire Voluntary Action
Anne Nixon	Manager	Home Start Leith & North East Edinburgh
Annie Brown	Volunteer Coordinator	EAV
Antony Gardner	Head of Prevention & Protection, Highland	Scottish Fire & Rescue
Bernadette Reilly	Senior Community Link Officer	Renfrewshire Council
Billy Singh	Development Officer	Walking Football
Brian Sloan	Chief Executive	Age Scotland
Calvin Little	Public Health Coordinator	NHS Grampian
Cameron McFarlane	Development & Engagement Officer, ALLISS	Health and Social Care Alliance (Scotland)
Caroline Scott	Strategic Lead - Health & Social Care	CVO East Ayrshire
Caryn Kerr	General Manager	Big Hearts Community Trust
Cat Campbell	Information and Advice Volunteer Development Worker	Age Scotland
Catherine Chiang	Consultant in Public Health Medicine	NHS GGC
Cathy Steer	Director of Health Improvement	NHS Highland
Chris Gourley	Learning and Evaluation Lead	Health and Social Care Alliance (Scotland)

Claire Stevens	Chief Officer	Voluntary Health Scotland
Daren Borzynski	Volunteer Engagement Project Lead	West Dunbartonshire CVS
Denise Bailey	Partnerships Manager	Campaign To End Loneliness
Derek Harper	Community Network Developer	The Big Lunch
Derek Young	Senior Policy Officer	Age Scotland
Diane Beckett	Development Manager	Scottish Churches Housing Action
Diane Wilson	Senior Development Officer	Voluntary Action Fund
Dianne Williamson	Senior Health Promotion Officer	NHS Fife
Dr. Katharine Logan	Executive Committee Member	Royal College of Psychiatrists in Scotland
Elaine Wilson	Strategic Support Manager	Lloyds TSB Foundation for Scotland
Eleanor McCallum	Engagement Officer	N Ayrshire Health & Social Care Partnership
Eleanor Muniandy	Events and Volunteer Coordinator	Get2gether, The Thistle Foundation
Emily Beever	Senior Development Officer-Policy & Research	Youthlink Scotland
Emily Watts	Scotland Country Manager	The Big Lunch
Emma Black	Project Leader	Mealmakers
Emma Whitelock	Chief Executive	Lead Scotland
Evelyn Devlin	Community Living Manager	S Lanarkshire Health & Social Care Partnership
Farzana Beg	Senior Caseworker - Family Circles Support Service	Roshni
Fergus McMillan	Chief Executive	LGBT Youth Scotland
Fiona Couper	Board Member	Befriending Networks
Frances Bain	Manager - Walking for Health	Paths for All
Gail Phillips	Perth & Kinross Learning Coordinator	Lead Scotland
Garry McGregor	Quality Officer (Children and Young People's Services)	Befriending Networks
Gillian Lindsay	Health Promotion Manager	NHS Lanarkshire
Gillian Munro	Digital Participation Assistant	SCVO
Gordon Brown	Executive Officer	Volunteer Centre Borders
Grahame Cumming	Strategic Programme Manager	NHS Lothian
Gus Collins	Community Engagement Manager	South Ayrshire Council
Haylis Smith	Acting Group Manager-Mental Health & Addictions	Borders Council
Heather Edwards	Dementia Consultant	Care Inspectorate

Heather Noller	Policy & Parliamentary Officer	Carers Trust Scotland
Heather Sloan	Health Improvement Lead-Mental Health	NHS GGC
Hector MacLeod	Chief Executive	Third Sector Hebrides
Helen Fleming	Representative	Scottish Volunteering Forum
Henriette Laidlaw	Knowledge & Information Manager	Dementia Services Development Centre
Helen Macneil	CEO	GCVS
Hilda Campbell	Chief Executive Officer	Cope Scotland
Hong Zhang	Development Officer - Health & Social Care Integration	PKAVS
Iain Forbes	Strategic Development Manager	Scottish Mentoring Network
Irene Gardiner	Cardiac & Respiratory Support Service	Chest, Heart & Stroke Scotland
Jacqueline Campbell	Policy & Strategy Lead for H&SC Integration	Scottish Government
Jacqui Reid	Programme Director, H&SC integration	Health and Social Care Alliance (Scotland)
James Jopling	Executive Director for Scotland	Samaritans
Jane Andrew	Researcher	University of Edinburgh
Jane Cairns	Membership Officer	Befriending Networks
Jane Walker	Board member	QNIS
Janice Kerr	Central Scotland Development Officer	Contact the Elderly
Jason Schroeder	Chairman	Scottish Men's Sheds Association
Jayne Burnett	Visiting Friends Coordinator	Argyll Voluntary Action
Jean Inglis	Befriending & Care Services Coordinator	Volunteer Glasgow
Jeanette Bates	Head of Wellbeing	Independent Age
Joanna Clark	Project Manager (Health and Care Services)	Fife Voluntary Action
Jodie Fleming	Befriending Programme Coordinator	LGBT Health and Wellbeing
John MacDonald	Director for Scotland	Community Transport Association
John Watson	Deputy CEO	ASH Scotland
Karen Windle	Chair in Ageing	University of Stirling
Katherine Byrne	Policy manager	Chest, Heart & Stroke Scotland
Kathleen Donnelly	Health and Social Care Development Officer	British Red Cross
Kay Barton	Volunteer	Home-Start
Keith Walker	Executive Director	Befrienders Highland
Kira Weir	Digital Youth Work Officer	LGBT Youth Scotland
Lauren Blair	Programme Engagement Officer	Voluntary Health Scotland

Lex Baillie	Chief Inspector, National Missing Person Unit	Police Scotland
Linsey Drever	Adult Befriending Coordinator	Voluntary Action Orkney
Liz Watson	Chief Executive	Befriending Networks
Louise Andree	Fife Befriending Project Coordinator	Lead Scotland
Louise Paul	Specialist Occupational Therapist	Living Well Team, NHS Lothian
Maggie Gardiner	Programmes Manager	Voluntary Action Fund
Maire Cox	OPENspace Communicator	OPENspace Research Centre, University of Edinburgh
Margaret Campbell	Partnership Development Officer	City of Edinburgh council
Margaret Donald	Telephone Befriender	Good Morning Service
Margaret McLeod	Policy & Information Manager	Youthlink Scotland
Marie -Amelie Viatt	Performance Advisor - Link Up	Inspiring Scotland
Marie Oliver	CEO	VASA
Marion Findlay	Director of Services	Volunteer Centre Edinburgh
Martin Malcolm	Head of Public Health Intelligence	NHS Western Isles
Mary Ellmers	Influence & Service Development Officer	Parkinsons UK in Scotland
Maureen Thom	Dementia Engagement Manager	Alzheimer Scotland
Maureen Thompson	Community Occupational Therapist	West Lothian Council
Michael Harkin	Health Promotion Specialist	Terrence Higgins Trust
Michael Tornow	Senior Health Promotion Officer	NHS Health Scotland
Michelle McCrindle	Chief Executive	The Food Train
Moira Bayne	Chief Executive	Housing Options Scotland
Moira Gallagher	Manager	Silverline Scotland
Natalie Masterson	Chief Executive Officer	Stirlingshire Voluntary Enterprise
Natalie McFadyen White	Programme Manager	Impact Arts
Neil Hamlet	Public Health Consultant	NHS Fife
Neil Thin	Senior Lecturer, Social Anthropology	University of Edinburgh
Nichola Sewell	HI Lead	NHS Borders
Oliver Harding	Consultant in Public Health	NHS Forth Valley
Paul McCloskey	Development & Quality Manager, Customer Services	City of Edinburgh Council, Libraries & Information Services

Paul Okroj	Chair	Befriending Networks
Paul White	Director of Operations	Link Living
Paula Aldin-Scott	Neurological Programme	Health and Social Care Alliance (Scotland)
Peggy Winford	Board Member	Befriending Networks
Rebecca Stafford	Team Support Officer	Scottish Council for Voluntary Organisations
Rhea Long	Befriending Development Officer, Dundee	The Food Train
Roseann Logan	Community Links Manager	Health and Social Care Alliance (Scotland)
Sandra Brown	Training Officer	Befriending Networks
Sandra Robertson	Area Manager for Scotland	Independent Age
Scott McGill	Project Manager	The Food Train
Scott Neill	Partnership Development Officer	City of Edinburgh Council
Sheena Lowrie	Senior Health Promotion Specialist	NHS Lothian
Sheila Fletcher	Network Development Officer	Community Transport Association
Shelagh Young	Scotland Director	Home Start UK
Shelley Gray	External Relations Manager	Lloyds TSB Foundation for Scotland
Stacey Webster	Head of Services	LGBT Health and Wellbeing
Stephen Baird	Head of Wellbeing	Legion Scotland
Stephen McMinn	Senior Project Worker	Aberdeenshire Signposting Project
Sue Whisler	Hospital Link Worker	PKAVS
Susan High	Project Lead - Strathcarron Befrienders	Strathcarron Hospice
Susan Morrison	Partnership Officer	ACVO
Tammy Burns	Play & Early Intervention	East Ayrshire Council
Tracey Robbins	Community Programme Delivery Manager	The Big Lunch
Una Gillon	Telephone Befriender	Good Morning Service
Wilma Love	Wellbeing & Development Officer	East Ayrshire Council
Zoe Ferguson	Associate	Carnegie UK

Appendix 2 – stallholders

To find out more about the work currently being done by those who hosted information stalls at the Loneliness in Scotland summit, please visit their websites:

Organisation	Website
Befriending Networks	www.befriending.co.uk
Age Scotland	http://www.ageuk.org.uk/scotland
Scottish Volunteering Forum	https://scottishvolunteeringforum.wordpress.com
Paths for All	http://www.pathsforall.org.uk
Voluntary Health Scotland	http://www.vhscotland.org.uk/
Generations Working Together	http://generationsworkingtogether.org/
OPENspace Research Centre, University of Edinburgh	www.openspace.eca.ed.ac.uk
Interest Link Borders	www.interestlink.org.uk
Impact Arts	https://www.impactarts.co.uk
Community Transport Association	www.ctauk.org
Good Morning Service	www.goodmorningservice.co.uk
Voluntary Action Fund	www.voluntaryactionfund.org.uk
The Food Train	www.thefoodtrain.co.uk
Lead Scotland	www.lead.org.uk
SCVO (Digital Participation Team)	www.digital.scvo.org.uk
Chest Heart & Stroke Scotland	https://www.chss.org.uk
Wellbeing MOOC – University of Edinburgh	http://www.ed.ac.uk/studying/moocs/subjects/humanities-social-sciences/social-wellbeing
The Big Lunch	www.thebiglunch.com
Health and Social Care Alliance (Scotland)	www.alliance-scotland.org.uk
Scottish Men's Sheds Association	www.scottishmsa.org.uk
Campaign to End Loneliness	www.campaigntoendloneliness.org
LGBT Health and Wellbeing – LGBT Age	www.lgbthealth.org.uk
LGBT Youth Scotland	https://www.lgbtyouth.org.uk

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