



SOCIAL ISOLATION, GENDER AND SEXUAL ORIENTATION

Research Findings Report

“Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill.”

Marmot (2010) Fair Society Healthy Lives Final Report.

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Social Isolation and Gender – Executive Summary

Bristol is a member of the English Partnership of 6 local authorities who are working with the Marmot team to address health inequalities. Bristol's Marmot project is about tackling social isolation. Social isolation has been included as one of ten key priorities in Bristol's Health and Wellbeing Strategy. As part of this commitment, some research was undertaken looking at social isolation within the city (Social Isolation in Bristol 2013: Initial Findings – available on request). This briefing update looks in more detail at the relationship between social isolation and gender and sexual orientation. Initially, however, it will look at the concept of social isolation in more detail.

- Gender difference and its relationship to issues of social isolation and loneliness has been researched quite extensively in recent decades. Unfortunately, the findings have often proved ambiguous or even contradictory – some studies identify women as more isolated than men, others that men are more isolated than women and some that there is no significant difference between the sexes.
- There appears to be some interaction with gender, lack of spouse and loneliness. It has been suggested that the loss of a spouse may be more detrimental to men than women because males' life satisfaction after losing a spouse declined more dramatically than that of women.
- Women's tendency to outlive male partners and other family members, and their traditional social roles, are often cited as contributing to isolation and loneliness in old age. Women are more likely than men to be widowed, to live alone, to be unable to access transportation, to be concerned about issues of personal safety, to be dependent on other people and be the caregivers for other people, all of which can contribute significantly to social isolation.
- In their 2011 study, 'Power Lines', the Royal Society of Arts (RSA) found that, in general, female respondents were less isolated. However, while women were well-connected in general, unemployed women were markedly more likely to be isolated. Developing and encouraging neighbour to neighbour relationships are key to breaking the link between social isolation and unemployment.
- One possible explanation for the range of complex and contradictory findings is that not all studies have defined 'loneliness' in the same way. Some studies treat loneliness as 'unidimensional' – ie. that loneliness is unitary, varying only in intensity, and is the result of deficits in a variety of relationships. Other studies treat loneliness as 'multidimensional' ie. that it contains a number of 'subtypes'. One commonly used 'multidimensional' definition of loneliness draws a distinction between 'emotional loneliness' (an absence of a close, intimate emotional attachment) and 'social loneliness' (the lack of an engaging social network - meaningful friendships, integration within local community etc).
- It is also important to consider wider definitions which incorporate 'gender role'. While gender, per se, is only a biological indicator, gender roles (namely, masculinity and femininity) contain more implications that are social.
- Young and/or single mothers on low incomes are at particular risk of social isolation. A 2012 survey conducted by parenting club Bounty UK on behalf of the charity Family Action highlighted that nearly a third of new mums from low-income households lack local support networks to help them through pregnancy and are unaware of services to help with depression. A number of the same problems are faced by single parent fathers, so it is important that any support services are made accessible for both men and women.

- In a 2002 study on social isolation and domestic violence (DV) among female drug users, it was found that women reporting indicators of social isolation were more likely to have been physically abused by their most-recent sexual partners than non-isolated women. There are also particular issues of social isolation for women who experience DV if they come from BME communities.
- For men in mid-life, loneliness is recognised as a very significant cause of their high risk of suicide, and there is a need to help men to strengthen their social relationships. Suicide prevention strategies in the UK and Ireland acknowledge social isolation and disconnection as a risk factor, yet they have not developed the promotion of social connectedness as a suicide reduction measure. Building men's 'social connectedness' should be integral to suicide prevention for men in mid-life. Interventions which build on men's 'non-talk' based intimacy with other men may be helpful. Community-level initiatives directed at men and encouraging positive activities, socialisation and interaction, may be important, particularly in deprived socio-economic contexts, where there may be a lack of hope, vision of a future and opportunity.
- LGBT youth often face issues of bullying and social isolation. This isolation reaches all areas of life, from the possibility of homelessness when coming out to family members, to a higher rate of mental health issues due to homophobia, and the inability to freely express oneself. Social relationships are built on trust earned through perceived commonality and experiences. Therefore, when LGBT young people and children of LGBT families cannot divulge their identities and home life to peers, their relationships suffer, leading to further social isolation.
- A 2012 Canadian study of Ontario found that rates of suicide and attempted suicide were significantly higher in the transgender-population — and transgender-youth were especially at risk. It was noted that survey respondents were not suicidal because they were transgender; rather, it was the social shame and isolation that they found difficult to cope with. Similarly, research by the University of California in 2012 found that the rejection transgender people encounter is significantly harsher than the negative attitudes experienced by lesbian, gay and bisexual (LGB) people.
- Issues of social isolation are not just confined to LGBT youth. The American organisation 'Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders' (SAGE) note that LGBT older people are twice as likely to live alone, twice as likely to be single, and 3 to 4 times less likely to have children—and many are estranged from their biological families. Their research has also indicated that LGBT elders face higher disability rates, struggle with economic insecurity and higher poverty rates, and many deal with mental health concerns that come from having survived a lifetime of discrimination.
- According to a 2008 study by the Commission for Social Care Inspection (CSCI) only seven per cent of older people's care homes had worked specifically on equality around sexual orientation. However, a 2009 study conducted by the University of Brighton found that 85% of older LGBT people say that they would give information regarding their sexual and/or gender identities if they believe the service is LGBT friendly and the data is kept confidential and anonymous. Some 60% of LGBT respondents to a separate study said they would move out of their current home and into accommodation for older lesbians and gay men given the choice.

What is social isolation?

Some research draws a distinction between 'social isolation', defined as an objective measure of the number of social interactions a person has with other people, and 'loneliness' which is seen as a more subjective feeling of dissatisfaction with the number (or quality) of existing social contacts. Other research has not drawn such a clear distinction between the 'objective' and 'subjective' aspects of isolation.

For our purposes we are interested in both dimensions and would argue that many people involved in delivering services related to tackling the issue, whether they label it 'loneliness' or 'social isolation' or indeed some other term, are all essentially seeking to address situations where people have:

'few social contacts and few social roles, as well as an absence of mutually rewarding relationships with other people.'

What factors contribute to social isolation?

Social isolation most commonly occurs to individuals, though for some recent migrant communities, for example, social isolation may be experienced on a wider, community level. Social isolation may first occur in childhood and may be a lifelong issue. For others, it will be linked to a specific life event, such as being made redundant, getting divorced or the death of a partner or spouse. Gender, plays a role also. Women generally tend to live longer than men, so it is often women who are left alone in later life, but with divorce rates rising nationally, social isolation is increasingly an issue for men from middle age onwards. There is also some research to indicate that men and women experience social isolation/loneliness differently – for men, social isolation is commonly linked to the loss of a partner/spouse, whereas for women the absence of wider social networks can be of equal concern.

Individual experiences are nonetheless influenced and shaped by wider factors. Most people are integrated within their families and communities to some degree, but opportunities for interactions can be affected by such trends as changing family structures (more people of all ages are living alone than in previous decades for example and families are more mobile and more likely to live apart) and changing access to social resources (the government's welfare reform programme will undoubtedly have an effect for a significant number of people, as will the on-going cuts to public sector budgets). Likewise, physical location may impede or prompt interaction. People's desire to go out and see other people may be influenced by such factors as the accessibility of local shops, for example, or the condition and accessibility of pavements and benches, or how safe they may feel in their neighbourhood.

At the community level, social isolation will be less likely if mutual assistance is a principle in the community and if reciprocity is the norm, so a sense of community cohesion is important. Personal social skills obviously also influence the experience of isolation. These are more developed for some people than others, and are determined partially by the individual's cultural background, social class and gender.

Social isolation, therefore, is influenced by factors on three levels - the individual level, the community level and at the wider societal level (see diagram on next page). It is a multi-dimensional issue, encompassing both people and the places where they live. It can be more or less severe, and

has a life-course dimension; that is, it could be permanent or episodic if related to particular life events.

Why is tackling social isolation important?

Social isolation can have physically and emotionally damaging effects resulting in depression, poor nutrition, decreased immunity, anxiety, fatigue, and social stigma. Reducing social isolation can have tangible health benefits, with research highlighting the influence of social relationships on the risk of death as comparable to well-established risks such as smoking and alcohol consumption. Weak social connections carry a health risk that is more harmful than not exercising, twice as harmful as obesity, and is comparable to smoking 15 cigarettes a day or being an alcoholic.

There are studies that indicate that socially isolated older adults, for example, have longer stays in hospital, a greater number of physician visits and are more dependent on homecare services. There is therefore an economic as well as a health related case to be made for tackling social isolation. Early intervention to tackle the issue is likely to have longer term cost benefits if it helps improve people's health and wellbeing. Some valuable research has already been done in this area within Bristol. Dr Richard Kimberlee from the University of West England (UWE), for example, conducted a social and economic evaluation on a LinkAge hub in Whitehall and St George and calculated that for every £1 invested in the Whitehall and St. George Hub there is a Social Return on Investment of £1.20. The report added that this figure is "probably an underestimation of the potential return in the medium term."

Other examples from around the country include Brendon Care Friendship Clubs for older people - for every £1 invested it was estimated that there was a £1.40 is saved to society at large; Craft Café; a pilot programme from Impact Arts in Scotland that seeks to reduce the isolation and loneliness experienced by older people – analysis showed that overall the Craft Café pilots have created a social return on investment of £8.27 for every £1 spent and Stay Well at Home (Age Concern: Kingston Upon Thames) - which is estimated to have had a social return on investment of 12:1 – £12 of value for every £1 spent. The savings in public sector expenditure were estimated to be £240,000 – around three times the investment made by NHS Kingston in funding the pilot.

Yet economic evaluations of interventions to tackle social isolation are not routinely undertaken and it is suggested that more work needs to be done on this in future, integrating evaluation measures into any proposed intervention and highlighting the potential longer term economic benefits of the intervention as well as the estimated cost of not intervening.

Social Isolation: A Contextual Overview



Social Isolation and Gender

Gender difference and its relationship to issues of social isolation and loneliness has been researched quite extensively in recent decades. Unfortunately, the findings have often proved ambiguous or even contradictory. A number of studies have highlighted loneliness and isolation as a particular issue for women, for example, whereas several studies have found no significant gender difference and others have shown that males were lonelier than females. To some extent, the results can depend on the questions asked. Borys and Perlman (1985) found that when loneliness was measured using the direct self-labelling measurement (e.g. 'do you often feel lonely?'), females reported higher level of loneliness, but males were lonelier when the UCLA Loneliness Scale was used (the UCLA Loneliness Scale uses a range of less-overt statements such as 'I lack companionship' and asks people to rate to what extent they agree with the statements used). It has been suggested that this may be because the negative connotations and social consequences of being lonely may inhibit people from admitting that they are lonely, and this may be more so for men.

A number of studies have suggested that men may feel lonely more often than women because they are not as well socialized in the social-emotional area and, as a result may deal with their loneliness in ways that alienate them even further from social contact. Alternatively, females may more successfully buffer loneliness, especially in the social-emotional areas of life. A study of American university students, for example, found that among 'freshman' (1st year) and 'sophomore' (2nd year) students, men were less likely to be in a romantic relationship and to know how to make friends, and these same men were more likely to drink more alcohol and to regard themselves as 'losers' relative to female students. Such coping styles are likely to put them at even greater risk of loneliness.

There also appears to be some interaction with gender, lack of spouse and loneliness. Chipperfield and Havens (2001) suggest that the loss of a spouse may be more detrimental to men than women because males' life satisfaction after losing a spouse declined more dramatically than that of women. Carr *et al* (2000) found also that dependence on a male spouse for male typed tasks (instrumental support) is a strong predictor of anxiety for widowed women. Women's tendency to outlive male partners and other family members, and their traditional social roles, are often cited as contributing to isolation and loneliness in old age. Women are more likely than men to be widowed, to live alone, to be unable to access transportation, to be concerned about issues of personal safety, to be dependent on other people and be the caregivers for other people, all of which can contribute significantly to social isolation.

A Canadian study from 2009 sought to explore social isolation as a multidimensional social construct examining in particular gender and geography to try to tease out some of the complexity around the issue and its relationship to health status and the use of services. It noted that when individual characteristics like gender are considered together with broader contextual variables like place of residence, a more comprehensive and layered portrait of vulnerability among socially isolated persons begins to emerge with insights into their unique patterns of health and service use. For example, home care may be an extremely critical resource for keeping older women in their homes and out of hospital. On the other hand, among socially isolated older men, those living in rural communities may be particularly 'invisible', neither benefiting from home care nor having strong social supports. It seems plausible then that both men and women may be in need of special interventions or targeted programmes to help them to remain, or to become, more socially integrated in their communities as they age in place.

In their 2011 study, 'Power Lines', the Royal Society of Arts (RSA) found that, in general, female respondents were less isolated. However, while women were well-connected in general,

unemployed women were markedly more likely to be isolated. While just 10% of women who are not unemployed are isolated, 43% of unemployed women were isolated. The RSA stated that developing and encouraging neighbour to neighbour relationships remained key to breaking the link between social isolation and unemployment. Setting a goal of improving community's social networks is one way in which the so called 'big society' could take a big step forward towards not only becoming better defined but also delivering on the ground.

The report concludes that the government's efforts to build the big society risk exacerbating existing inequalities unless more is done to support those who are isolated within their communities. It stated that the government is currently too focused on engaging members of the public with the delivery of public services and that its efforts would be better spent trying to promote the strength of neighbour-to-neighbour relationships and a community's ability to self-organise. By fostering support and exchange through informal connections the Government could in fact 'achieve' outcomes that many public services aim for - such as increasing employment and providing social care.

Loneliness – unidimensional or multidimensional?

One possible explanation for this range of complex and contradictory findings is that not all studies have defined 'loneliness' in the same way. In brief, there are two broad perspectives concerning the 'dimensions' of loneliness. The 'unidimensional' model argues that loneliness is unitary, varying only in intensity, and is the result of deficits in a variety of relationships. This unidimensional conceptualization has guided most researchers' study of loneliness, as evidenced by the preponderance of global loneliness measures that have been developed and the widespread use of the unidimensional UCLA Scale in empirical research. The second perspective argues that loneliness is 'multidimensional'. It has been argued for example that the UCLA loneliness scale only emphasized a subjective lack of connection and failed to include other kinds of loneliness, particularly pathological types.

Among the multidimensional perspectives, Weiss's classification has been used widely in research. Weiss (1973) identified two types of loneliness: the 'loneliness of emotional isolation' and the 'loneliness of social isolation'. According to Weiss (1973), emotional loneliness is related to absence of close, intimate emotional attachment, whereas social loneliness results from a lack of an engaging social network (such as meaningful friendships, collegial relationships, or other linkages to a coherent community).

Studies examining gender difference using the two factor loneliness approach, based on Weiss's typology are fewer in number, but have developed in recent decades. Wittenberg, for example (1987), using the Revised UCLA Loneliness Scale measuring global loneliness and a self-compiled scale measuring social and emotional loneliness, found males had significant higher scores on global, social and emotional loneliness than females had. In the 1990's, more work was undertaken by researchers to develop valid scales be produced to assess the two distinctive dimensions of loneliness. One of these was the Social and Emotional Loneliness Scale for Adults (SELSA) developed by Enrico DiTommaso and Barry Spinner. Using SELSA, DiTommaso and Spinner (1993) reported no sex differences on family emotional loneliness, but they did find that males were lonelier than females on social loneliness and romantic emotional loneliness.

Gender roles

The inconsistent results of the relationship between gender and loneliness can also lead to consideration of wider variables such as 'gender role'. While gender, per se, is only a biological

indicator, gender roles (namely, masculinity and femininity) contain more implications that are social. Traits like assertiveness and dominance are often viewed as masculine, whereas qualities such as emotionality and understanding are more likely to be regarded as feminine (Bem, 1981).

Masculinity and femininity may help prevent loneliness via two independent sets of social attitudes: the masculine set (including assertion and dating skills) and the feminine set (including providing advice and guidance, conflict resolution, and more positive perceptions of others), both of which are important in alleviating loneliness (Wittenberg & Reis, 1986). Comparing the masculine/feminine set and the definitions of social and emotional loneliness suggests that it is likely that masculinity may be negatively associated with social loneliness and femininity may be associated with emotional loneliness more.

For decades, masculinity and femininity were conceptualized as bipolar ends of a single continuum (from high levels of masculinity to high levels of femininity); therefore, an individual was seen as either masculine or feminine, but not both. However, the American psychologist, Sandra Bem has argued that individuals might possess both masculine and feminine traits - a significant revision to the traditional gender role conception. Based on this, she designed the Bem Sex Role Inventory (BSRI) which is a measure of masculinity-femininity and gender roles. It assesses how people identify themselves psychologically and offers four different possible resulting categorizations: masculine, feminine, androgynous (a high degree of both feminine and masculine traits) and undifferentiated (a low degree of both feminine and masculine traits). Following this new focus, a number of researchers have examined the functions of gender roles and gender role types, especially the role of androgyny (being high in both masculine and feminine characteristics).

For example, in 1998, Cramer and Neyedley assessed the magnitude of sex differences in loneliness after accounting for the influence of two covariates: masculinity and femininity. The 256 participants in their study (principally White, somewhat affluent, and middle-class university students) completed both the UCLA Loneliness Scale and the Bem Sex Role Inventory. Their initial findings were that males tended to be lonelier than females, but the results were not statistically significant. However, this difference did become statistically significant after accounting for masculinity (not femininity) embedded in participants' loneliness scores. The researchers noted that their findings tended to support the hypothesis that males appear more reluctant to admit to feelings of loneliness. In general, studies have tended to show that androgynous people possessing both masculine and feminine characteristics were less likely to be lonely than other types of individuals. Jones *et al* (1990) found that undifferentiated individuals (low degree of both feminine and masculine traits) were the loneliest among the four gender role types identified by Bem.

Issues for Women

Young and/or single mothers on low incomes are at particular risk of social isolation. A 2012 survey conducted by parenting club Bounty UK on behalf of the charity Family Action highlighted that nearly a third of new mums from low-income households lack local support networks to help them through pregnancy and are unaware of services to help with depression. The survey questioned more than 2,200 women in the early stages of pregnancy through to mothers with a youngest child aged two. It found that a fifth of women do not have friends or family nearby who they can turn to if they feel isolated through pregnancy or immediately after the birth of their child. This rose to a third among women in the lowest income group. Thirty per cent of the women said they were not aware of local services to support them through feelings of isolation and depression during pregnancy and immediately after birth. A quarter of women who responded said they were not always comfortable bonding with their babies.

Family Action has highlighted figures that suggest that more than 300,000 babies will suffer due to poor attachments with their mothers. The charity has stated that tackling perinatal depression through genuine early intervention services could make a big difference for many families. In the worst cases, poor behavioural development will lead to antisocial behaviour and school exclusions. The research highlights that for the most vulnerable families intervention during pregnancy and the first year of a child's life is key to preventing future problems for children and families and highlights the need for better support services and early intervention initiatives.

“The thing that stands out for me as being the single most important thing is the dreadful loneliness of it all”, one single mother wrote to me. There may be, as a friend put it “no-one to share those precious, unique moments with”. If your child or children are very small there may also be no-one who responds verbally to you (something I found very difficult). Mothering alone is universally a lonely occupation. And long-term loneliness is a definite risk to physical health. Judith Shulevitz, *The Lethality of Loneliness*.

A Social Issues Research Centre report from 2011, entitled ‘The Changing Face of Motherhood’ noted that main source of advice on child rearing for today's mother is her own mother and that other female friends, especially those with children of their own, are more important in this context than the husband/partner. Their research also indicated that communication was predominantly via phone calls and texts rather than face to face meetings. However, it would be unwise to infer from this that mothers are less in contact with their support networks than in previous times. Texts, in particular, often serve to create opportunities for additional ad hoc face-to-face meetings – occasions that may have been difficult to arrange at short notice in the past.

The Changing Face of Motherhood report indicated that, for those with access to the internet, sites such as ‘Mumsnet’ could assist in empowering mothers, allowing them to keep in touch with a wider network. Yet, despite the availability of such networks and more immediate support in the family and community, many mothers stated that they felt socially isolated, especially those aged between 35 and 44. For those mothers who had been in work prior to having children the profound change in lifestyle that came with the birth of their children took some adjustment. This participant also recognised the value of networks in combating feelings of isolation.

“Also it is such a different lifestyle if you have had a career. I was in my mid-thirties and suddenly I had a child. Even people who lived in the same street, and I probably never even realised that they were there because I was probably always out. Suddenly you have a baby and you see this different life. It is such a role reversal and I think it is really nice to be able to go to a group. NCT, things like that, some of whom plug you in when you are pregnant, so before you even have the baby you have this kind of patch already set up. You might decide after a year that you don't really like a particular group or that you are not going to do this or you are not going to do that, but you have established by then a network of people that you like and friends for the children. It is really important otherwise you would be so isolated I think.”

Just over half (58%) of the 5.41 million people providing some level of unpaid care in England are female, according to 2011 census data. This higher proportion of female carers is consistent across all regions. Female carers are representative of 11.9% of the total female population of England and Wales, and male carers are representative of 9% of the male population. Ten years ago these figures were 11.5% and 8.8%. The greatest burden of care nationally falls to 50–64-year-old women. The ONS suggest that this could be because women are more likely than men to leave work at an earlier age to provide unpaid care for family members, boosting their numbers in the 50-64 age bracket.

With regard to the health and wellbeing of women who are carers, a 1999 Australian study (Schofield *et al*) examined differences between women family carers of people with chronic illnesses or disabilities and a group of women 'non-carers' in self-reported physical health, psychological wellbeing, life satisfaction, social support and feelings of overload. The research found higher rates of self-reported ill-health and use of medication, more negative effect, and less life satisfaction and perceived social support, among carers than among women in the comparison group. Even though the latter were more likely to be caring for one or more children, compared with the carers they reported less overload. Irrespective of carer status, women without partners expressed less life satisfaction, and more social isolation and negative effect. The research concluded that the poorer health status and emotional well-being of carers compared with non-carers among women, and associations between overload, social isolation, negative effect and health problems within carers, point to a number of practical interventions such as promoting an awareness in GPs and other health professionals of the impact of caregiving on the health of their patients; informing them about relevant community services; and encouraging appropriate referrals.

A 2010 report, 'Family Caring in Ireland' also highlighted that caring responsibilities often limit the time available to for carers to have a life of their own. It noted that many carers do not have access to the support that would allow them to take significant time off from their caring duties to enjoy a social life or participate in the community and wider society and that social isolation was a widely reported problem. In their 2004 study, *Hearts and Minds: The Health Effects of Caring*, the Social Policy Research Unit and the University of York noted that although the end of caregiving can bring relief from day-to-day caring activities, social isolation and other sources of stress are not easily remedied. Some carers experience traumatic grief and prolonged depression following the death of the person they were caring for. Admission of the care recipient to a residential care or nursing home may also be stressful for carers, especially when associated with feelings of guilt or failure. Loss of a significant role, and a need to fill the void left by caregiving with meaningful alternatives, can undermine a sense of self-worth and identity.

In their 2002 study on social isolation and domestic violence (DV) among female drug users, Farris and Fenaughty found that women reporting indicators of social isolation were more likely to have been physically abused by their most-recent sexual partners than non-isolated women. They recommended that providers who have contact with female drug users should be aware of the high domestic violence rates and work to counterbalance the isolation these women may experience. The research identified that isolation from friends and community may decrease women's ability to access the emotional support and health resources necessary to address effectively the abuse in the relationship as well as their current drug use. Physically abused women who receive social support from informal support networks such as friends, state that this support played an important role in their ability to leave the relationship, and substance-abuse treatment outcomes are also associated with levels of received social support and perceived social support for abstinence. So, it is a truly significant loss for women who do not have access to an informal support network—a possibility that is unfortunately often a reality for drug-using women who experience domestic violence.

Given the relative lack of contact that physically abused, drug-using women have with friends and the community, the report noted that people who do have contact with this dually disadvantaged population have an added responsibility to provide immediate support and resources. While it is clear that both drug-using women and women subject to domestic violence are isolated from informal support (and even more so for those women who experience both), there is evidence that these women do access formal systems. Women who experience DV and women drug users' access emergency departments and doctors at disproportionate rates and drug users have been found to access gynecological services at rates similar to the general population. In addition to providing

resources directly tied to the alleviation of violence and drug use in women's lives, these formal points of access may also be able to counterbalance the isolation from informal support systems.

However, intervention cannot be aimed singularly at social isolation, as isolation is likely to be tied closely to experiences of violence and drug use. The researchers recommended that a more active clinical approach in which providers consider the totality of women's experiences may enable women to begin an exit from these harmful situations. As they went on to state 'unless providers recognize and address the pressing needs of drug-using women who experience domestic violence, these women will continue to be isolated not only from informal support but from formal support as well, the consequences of which will be far reaching'.

There are particular issues of social isolation for women who experience DV if they come from BME communities. For BME women suffering from domestic violence, especially from Asian Sub-Continent and parts of Africa, the lack of knowledge of their rights, restrict them of their personal freedom outside the family home. In addition, they lack English language skills and this possibly is the greatest contributory factor to social isolation. This makes it extremely difficult for some of the women to seek help from outside agencies, on their own, without assistance of their key worker. BME Network systems of extended family are strong, therefore, once they flee domestic violence, they are isolated from family and the community, and for the first time seek additional support.

Issues for Men

In general there is noticeably less social isolation research which focuses specifically on men. However, it can be said, that with regard to the social isolation and loneliness faced by single parents – this can be as much an issue for single parent fathers as it is for mothers. Some 400,000 families were headed by lone fathers in 2012, representing 13.5% of all single-parent households in the UK according to the Office for National Statistics (ONS) so it is important that some single parent support is targeted towards single parent fathers.

The Samaritans have written a number of reports on men and suicide risk. In their 2012 report 'Men and Suicide- It's a Social Issue', they note that men in mid-life (30s-50s) remain overwhelming dependent on a female partner for emotional support, yet recognise that in modern society men are less likely to have one life-long partner and more likely to live alone, without the social or emotional skills to fall back on. For men in mid-life, loneliness is recognised as a very significant cause of their high risk of suicide, and there is a need to help men to strengthen their social relationships. There are a number of recommendations in the report which are of relevance to work around tackling social isolation:

- **Suicide prevention policy and practice must take account of men's beliefs, concerns and context – in particular their views of what it is to 'be a man'.** Men as a group are often criticised for being resistant to seeking help or talking about their feelings. We need to move from blaming men for not being like women, to recognising their needs, and how societal expectations of the way men should behave, shape their actions. Agencies must remove the barriers to men engaging with services and design these to be more effective for them.
- **Recognise that for men in mid-life, loneliness is a very significant cause of their high risk of suicide, and enable men to strengthen their social relationships.** Services should encourage men to develop their social relationships. Access to relationship counselling should be provided, to lessen the harmful aspects of relationship breakdown. The shift to involved parenting for fathers needs to be supported.

- **Support GPs to recognise signs of distress in men, and make sure those from deprived backgrounds have access to a range of support, not just medication alone.** GPs are the most likely formal support service to be consulted by this group of men, and can make a profound difference to their lives. Further forms of support may be more acceptable to men if they are 'practical' rather than 'talking therapy' and are provided as part of wider skills training. Interventions for men should address social problem-solving, managing stress and the expectations of others.

Although the figures fluctuate from year to year, there has been a general downward trend in suicide rates since the mid 1990s across generations from teenagers to the elderly, except middle aged men. According to the Office for National Statistics (based on 2012 data), the rate among men among men in their early 40s currently stands at 25.9 per 100,000 people, almost two and a half times the national level. A quarter of all suicides in Britain involved men aged between 44 and 59, among whom the rate now stands at 23 per 100,000 – 26 per cent higher than it was nine years earlier. It is also important to consider that even though the issues facing middle aged men may only in a relatively small number of cases actually end in suicide, the issues of loneliness and social isolation can still have long term detrimental health effects if no preventative interventions are undertaken.

Professor Rory O'Connor, who leads the Suicidal Behaviour Research Laboratory at Glasgow University, has stated that there has been a 'step change' in suicide patterns in recent years with middle aged, rather than younger men, now most at risk. In part, he notes, this can be ascribed to the decline of the traditional role of the male breadwinner, particularly in communities once dependent on male dominated industries. Yet, changing social habits also play a role. There is a greater openness among women and younger men to talk about problems and seek help if needed – a change that many middle aged men have not, on the whole, embraced. Professor O'Conner has noted that society has moved on but middle aged men are not as well equipped as they should be to deal with changes in their role in society.

Another 2012 Samaritans report, 'Men, Suicide and Society' explores some of these issues in more depth, particularly the issue of 'gender roles' as outlined earlier. It notes that men's loneliness, the actual or perceived lack of people who care and to whom they matter, can be profound. The likelihood of social disconnection among men in mid-life – particularly if unemployed and without a partner – and the fundamental role this plays in their high risk of suicide, needs to be recognised. The American government's public health arm defines as its strategic direction to prevent suicidal behaviour 'building and strengthening connectedness or social bonds within and among persons, families, and communities' (Centres for Disease Control and Prevention, 2008). The report notes suicide prevention strategies in the UK and Ireland acknowledge social isolation and disconnection as a risk factor, they have not developed the promotion of social connectedness as a suicide reduction measure. Building men's 'social connectedness' should be integral to suicide prevention for men in mid-life.

Services may provide 'surrogate' social support for men for a period: there is evidence that ongoing maintenance of contact with a suicidal person, nondirective telephone-based support, befriending and setting up informal networks of support reduce suicidal feelings and behaviour (Leitner, *et al*, 2008). Services should also spend their contact time with men building social skills and encouraging them to develop sustainable sources of support in their own lives and communities. Interventions which build on men's 'non-talk' based intimacy with other men may be helpful. Community-level initiatives directed at men and encouraging positive activities, socialisation and interaction, may be important, particularly in deprived socio-economic contexts, where there may be a lack of hope, vision of a future and opportunity.

Issues for the Lesbian, Gay, Bisexual and Transgender (LGBT) community

A 2010 report by LGBT Youth Scotland (Challenging Homophobia Together) noted that young people who experience homophobic bullying can suffer:

- feelings of isolation and exclusion resulting from low level bullying behaviour such as name calling, going unchallenged by teachers and senior education staff;
- fear of attending classes resulting in truanting or persistent absences and lack of support from families, especially when young people are not out to their families.

The report noted that homophobic bullying creates additional physical and mental health risks for those who identify as LGBT, including increased rates of substance abuse, lack of adequate sexual health knowledge, physical violence, and isolation. This isolation reaches all areas of life, from the possibility of homelessness when coming out to family members, to a higher rate of mental health issues due to homophobia, and the inability to freely express oneself. Social relationships are built on trust earned through perceived commonality and experiences. Therefore, when LGBT young people and children of LGBT families cannot divulge their identities and home life to peers, their relationships suffer, leading to further social isolation.

A 2012 Canadian study of Ontario found that rates of suicide and attempted suicide were significantly higher in the transgender-population — and transgender-youth were especially at risk. It was noted that survey respondents were not suicidal because they were transgender; rather, it was the social shame and isolation that they found difficult to cope with. Similarly, research by the University of California in 2012 (Norton and Herek) found that the rejection transgender people encounter is significantly harsher than the negative attitudes experienced by lesbian, gay and bisexual (LGB) people.

Research in Britain has shown that in schools with clear anti-homophobic bullying policies or programmes, LGB pupils are 60 per cent less likely to experience bullying and more than twice as likely to enjoy attending school (Hunt and Jenson, 2007). However, where procedures for reporting homophobic bullying are in place, there can still be stigma attached to LGBT identities and this can lead to under-reporting.

In their report on LGBT bullying, LGBT Youth Scotland highlighted interviewees from Finland, Sweden and Belgium who spoke of the importance of questioning the norms and values which underpin society when teaching about issues like sexuality. Traditional approaches seek to advocate tolerance and acceptance of those considered to be 'outside of the norm', but, no matter how benign the intent, the focus remains on those perceived to be 'different'. A 'norm-critical' approach, rather than focus on those who are considered different from the norm, seeks instead to explore the often unexamined 'rules' that control who is perceived as 'normal' versus 'abnormal'. It is stated that such a method can raise awareness and cause people to question *why* certain people are discriminated against. Using a norm-critical approach requires all participants to examine their personal biases and analyse how this influences their actions. In Sweden, the national guidelines for education state that education should employ a 'norm critical' approach.

Issues of social isolation are not just confined to LGBT youth. The American organisation 'Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders' (SAGE) note that LGBT older people are twice as likely to live alone, twice as likely to be single, and 3 to 4 times less likely to have children — and many are estranged from their biological families. Their research has also indicated that LGBT elders face higher disability rates, struggle with economic insecurity and higher poverty rates, and

many deal with mental health concerns that come from having survived a lifetime of discrimination. Location-related barriers, coupled with stigma and discrimination, can make it difficult for LGBT older people to find the LGBT-friendly community supports they need to age successfully and avoid social isolation.

SAGE have noted that LGBT older adults often face harassment or hostility when accessing ageing programs and when frequenting centres for older people, volunteer centres or places of worship. Few ageing service providers plan for, or conduct outreach to, the LGBT community— and few are prepared to address acts of discrimination aimed at LGBT elders by staff or other older people. This makes many LGBT older adults reluctant to access mainstream ageing services, which increases their social isolation and negatively impacts their physical and mental health.

According to a 2008 study by the Commission for Social Care Inspection (CSCI) only seven per cent of older people's care homes had worked specifically on equality around sexual orientation. However, a 2009 study conducted by the University of Brighton found that 85% of older LGBT people say that they would give information regarding their sexual and/or gender identities if they believe the service is LGBT friendly and the data is kept confidential and anonymous. Some 60% of LGBT respondents to a separate study said they would move out of their current home and into accommodation for older lesbians and gay men given the choice.

Several Stonewall reports have explored this issue, including *Lesbian, Gay and Bisexual People in later life* (2011) and *Working with older lesbian, gay and bisexual people: A Guide for Care and Support Services* (2012). The former report makes a number of recommendations, both for local authorities and those delivering frontline services:

- Local authorities and other commissioners of care services should ensure through their contract management that adequate care and support is provided to older lesbian, gay and bisexual service users.
- Local authorities and other commissioners of care services that directly employ frontline care staff should provide mandatory training that includes how to provide good quality care for older lesbian, gay and bisexual people.
- Those conducting assessments should be knowledgeable about the needs of older lesbian, gay and bisexual people so that these are considered during the assessment process and so that adequate advice and information, such as knowledge of local support groups for older gay people, is provided during assessments.
- Local authorities and other commissioners of care services should support opportunities for older lesbian, gay and bisexual people to meet and socialise, as they do for other members of the community.
- Local authorities and other commissioners of care services should make sure information is widely visible and available to older lesbian, gay and bisexual people on relevant advice services, social groups and other resources.

Bristol Statistics

Population Change

The population of Bristol local authority for mid-2012 is estimated to be 432,500. Since 2001 the population of Bristol Local Authority is estimated to have increased by 42,400 people an increase of 10.9%, this compares to an England and Wales increase of 8.0% over the same period. This follows a trend of a more or less stable population in Bristol throughout the 1990s. If recent trends continue, Bristol's population is projected to increase to 472,900 by the year 2021.

Bristol 2012 Population Estimates by Broad Age Band

Source: Population Estimates Unit, ONS: Crown Copyright 2013

Broad Age Band	Males		Females		Persons	
	number	%	number	%	number	%
0-15	41,000	19.0	39,700	18.3	80,700	18.6
16-24	33,300	15.4	33,500	15.5	66,800	15.5
25-49	84,200	39.0	79,700	36.8	163,900	37.9
50-64	32,100	14.9	31,800	14.7	63,900	14.8
65 and over	25,200	11.7	32,000	14.7	57,200	13.2
All ages	215,800	100.0	216,600	100.0	432,500	100.0

Life Expectancy

Bristol's life expectancy estimates continue to increase, but for men is significantly worse than the England average (though 2nd highest of Core Cities). For Bristol female life expectancy is statistically similar to England average, and is the highest of the Core Cities.

Bristol's 2009-11 average male life expectancy is 78.0 years, and the average female life expectancy is 82.6 years. Looking at longer term trends, men in Bristol now live 4.6 years longer than 20 years ago, and women live 3.3 years longer than they did.

However, life expectancy estimates highlight health inequalities within Bristol. The average life expectancy in the 10% most deprived areas in Bristol is 9.4 years lower for men and 5.8 years lower for women, compared to the 10% least deprived areas (the 'Slope Index of Inequality'). The gender difference varies across the city – in Inner City areas it can be as high as 8 years (mainly due to low male life expectancy) but in more affluent areas the gender gap is 1-2 yrs.

Carers

There are over 40,000 unpaid carers in Bristol, including over 9,000 providing care for over 50 hrs/wk. Young Carers (under 18) and Parent Carers (of disabled children) are groups with specific needs, and it's estimated there are 1,500–2,500 Young Carers locally.

LGBT

It is estimated that there are some 26,060 Bristol residents who are lesbian, gay, bisexual, or transgender (LGBT) - approximately 6% of the total population of the city. Evidence from the Bristol Youth Links Needs Analysis of 2012 indicates that LGBT young people often feel isolation and emotional distress following rejection by family or friends and can suffer from mental health problems linked to difficulties coming to terms with sexual orientation or gender identity.

Suicide

Annual rates for suicide and undetermined injury fluctuate widely from year to year and whilst those fluctuations may appear pronounced, they can often be explained by the comparatively small numbers of suicides. Bristol's average mortality rate from suicide and undetermined death for the period of 2007-2009 was just above the national average (Bristol: 9.49; England & Wales: 7.90 deaths per 100,000 of the population). Recent data for 2010 indicates a similar heightened incidence in Bristol.

Harassment

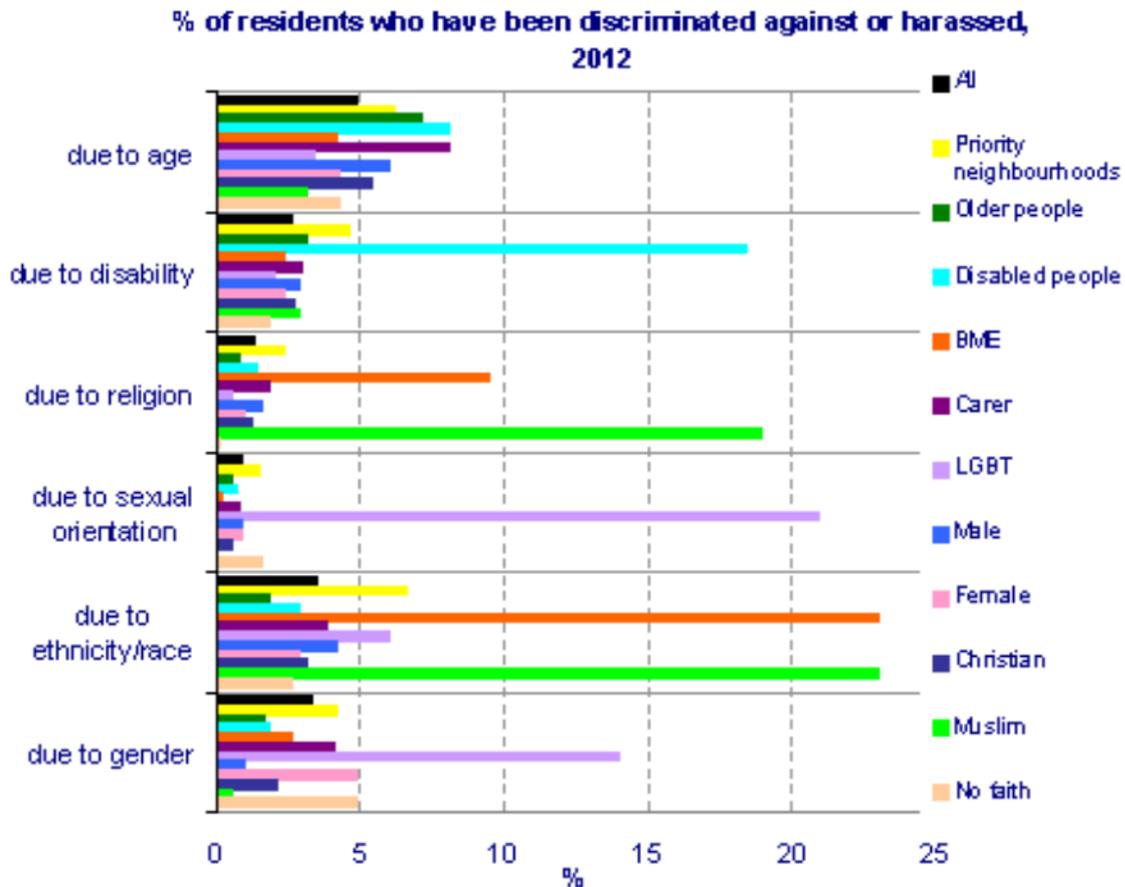
In recent years Bristol has undergone a major demographic change, more so than any other city in Britain, making it one of the most diverse cities outside London. There were 1,584 hate crimes reported to the police and partner agencies in Bristol in 2012/13, an overall reduction on 2011/12 figures. Bristol has the second highest hate crime rate, when compared with Core Cities.

Persistent discrimination and harassment can affect quality of life, perception of safety in the community and can have longer lasting effects, such as increasing feelings of social isolation and depression.

The annual quality of life survey asks a question about whether or not people feel they have been the victim of discrimination and harassment. The question has six sub-indicators - residents are asked about discrimination and harassment in relation to age, disability, religion, sexual orientation, ethnicity/race and gender. This indicator was first measured in 2006. Between 2006 and 2012 a very small proportion of the total population said they have suffered different types of discrimination and harassment (5% or less). Of the sub-indicators, all have remained stable each year, apart from discrimination and harassment due to sexual orientation and this has decreased/improved.

Some residents in certain wards tend to suffer more discrimination and harassment, particularly in Lawrence Hill. Generally men, compared to women experience more discrimination and harassment, except for gender discrimination.

Results shown in the graph below showed people of Muslim faith, black and minority ethnic groups, lesbian, gay, bisexual and transgender people and disabled people experienced discrimination and harassment. Further analysis (not illustrated here) suggests that carers are also exposed to discrimination and harassment disproportionately.



Source: 2012 Quality of Life Survey – Published May 2013

Domestic Violence and Abuse

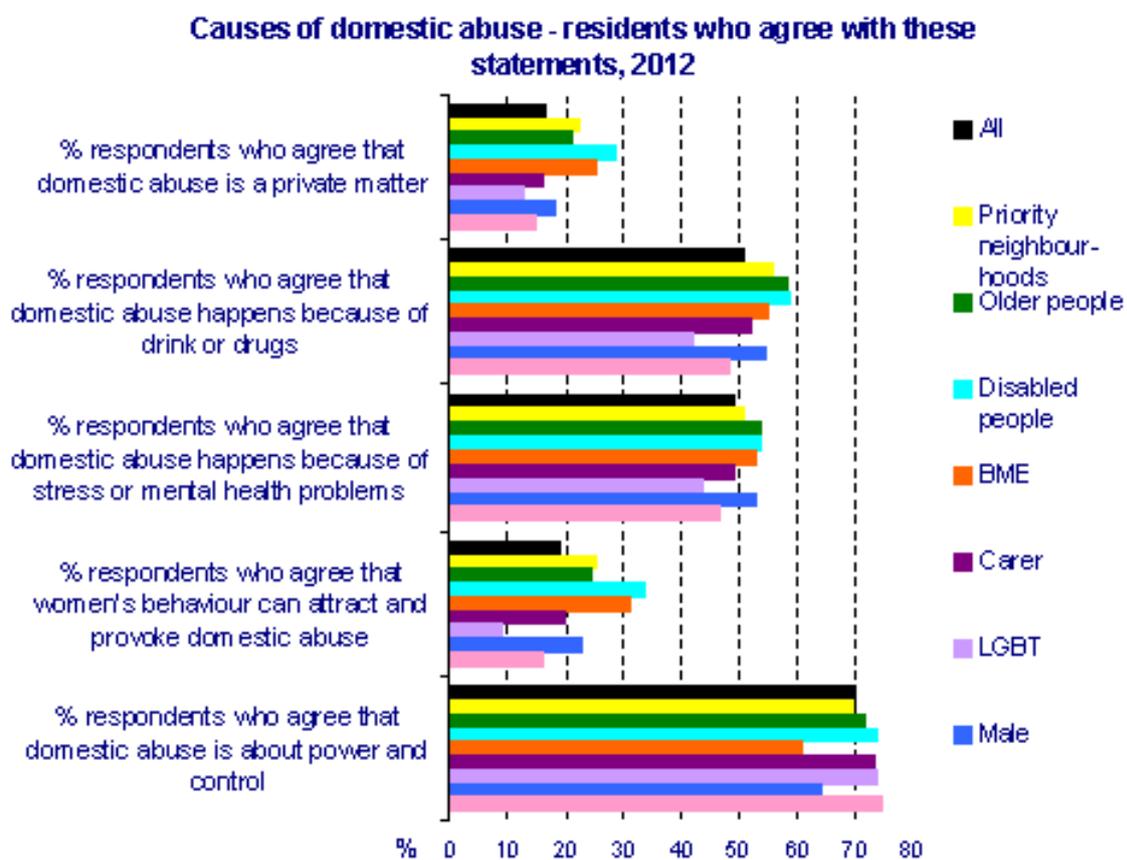
Domestic violence and abuse (DVA) has fallen by 5% in the last year, with 2,986 DVA crimes recorded in 2012/13 plus a further 3,192 incidents. Nevertheless, it is widely acknowledged that DVA is underreported by victims. The British Crime survey in 2010/11 estimated 23.5% of adults aged 16-59 experienced domestic abuse, and using this estimate, it is projected that over 33,000 adults have experienced domestic abuse in Bristol. Locations with higher levels of domestic violence are: Lawrence Hill, Avonmouth, Hartcliffe, Filwood and Cabot.

In 2008, the Quality of Life survey introduced a number of indicators of domestic abuse, and responses can help explain people’s attitudes towards this issue and why some of these crimes go unreported. In the most recent survey –

- 16% agreed domestic violence was a private matter
- 51% agreed domestic abuse happens because of drink and drugs
- 49% agreed domestic abuse happens because of stress and mental health problems
- 19% agreed women’s behaviour can attract and provoke domestic abuse
- 70% agreed domestic abuse is about power and control.

Trends since 2008 show fewer people agree that domestic abuse happens because of stress and mental health, can be attracted or provoked by women’s behaviour or is about power and control. Spatially there was little variation across the city apart from the indicator ‘agree domestic abuse is a private matter’; there were more residents from the Filwood (32%) and Lawrence Hill, Hartcliffe and St George East (all 23-24%) who agreed with this statement.

Equalities analysis suggests that more disabled people (29%), Black and minority ethnic people (25%) and Muslim people (28%) thought domestic abuse was a private matter. Furthermore, people who are older (25%), disabled (34%), men (23%), Black and minority ethnic people (31%), with a faith, with lower educational qualifications or living in rented accommodation (23%) were more likely to agree that women’s behaviour can attract and provoke domestic abuse.



Key Points to Consider

- The equalities team within the council do already focus on many of the particular issues raised in this report such as:
 - domestic abuse and sexual violence
 - men’s health
 - the needs of carers.

- Services aimed at men should take into account men’s beliefs, concerns and context. Agencies must remove the barriers to men engaging with services and design these to be more effective for them. . Interventions which build on men’s ‘non-talk’ based intimacy with other men may be helpful.
- There also needs to be an awareness of the impact of the economic downturn and welfare reform on vulnerable people as these changes may also compound their social isolation.
- All education providers must address and eliminate homophobia, promoting an inclusive environment in our schools and encouraging better reporting of homophobia whenever it occurs.
- There should be more general awareness raising to tackle the fact that LGB people often experience a lack of family support, which can be compounded by lack of support from local communities, BME communities, disabled communities etc which can result in low self-esteem and isolation.
- Bristol has produced a ‘Lesbian, Gay and Bisexual Equality and Health and Social Care guide’ – which has taken on board many of the suggestions outlined by Stonewall. The ‘Checklist for commissioners’ is particularly useful and the profile of this guidance should be raised.



If you require any additional detail on the information contained in this report, please contact Dave Clarke on dave.clarke@bristol.gov.uk or phone 0117 922 4788
