Loneliness and ageing: Ireland, North and South

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Acknowledgements

Executive summary

The purpose of this research is to contribute to an enhanced understanding of the concept of loneliness and to identify the most effective policy and/or service interventions to prevent and tackle loneliness amongst older people in Ireland, North and South. It is based on desk research and interviews with number of key stakeholders in the areas of ageing and social inclusion.

Key points

1. Chronic loneliness affects approximately 10% of older people.

2. Factors that influence loneliness include health, depressive symptoms, a range of individual factors (e.g. age, gender education, poverty, personality) as well as environmental factors (e.g. low population density in a rural location, impoverished neighbourhoods).

3. Factors that protect against loneliness include both social participation and social resources. Positively, the majority of older people have developed successful strategies to cope with loneliness.

4. There are few policies or strategies that explicitly address loneliness among older people across the island of Ireland.

5. Knowledge of which services are most effective is limited as among the services that do address loneliness many remain unevaluated. The most popular approach to tackling loneliness has been befriending services but more recent evidence suggests that the provision of opportunities for older people to participate in social and community activities outside of home may be more effective in terms of addressing chronic loneliness.

6. Those designing services for older people should carefully consider the evidence base in relation to what is known to work or not; and build evaluation in from the start of any intervention designed to tackle loneliness.

Theories of loneliness

The three key theories that collectively provide the most comprehensive understanding of loneliness were identified as follows:

- **A social needs approach** which focuses on the need for contact and how this need continues throughout adult life.

- **A cognitive approach** which is predicated on the recognition that loneliness will be experienced when a person perceives that his or her social involvement is less than what they would want it to be terms of quantity and quality.

- **An existential approach** which focuses on the human condition and on an awareness of one's own mortality.

The subjective nature of loneliness poses challenges for its measurement with no one measure currently capable of capturing all the different dimensions of loneliness. While the nature of the relationship between age and loneliness is contested some evidence exists at a European level to suggest that loneliness levels may follow a U-trajectory over an individual's lifetime - generally higher in teenage years, low during family formation and working age and rising again in older age.

Loneliness is influenced to a greater or lesser extent by a range of individual factors (*e.g.* age, gender, health, socio-economic status, sexual orientation, personality, personal circumstances, membership of an ethnic/minority community) and wider societal factors (*e.g.* the presence or absence of pre-existing social networks, cultural factors, as well as wider environmental factors). Some groups are more vulnerable than others with some evidence of a social class gradient. There are few specific policies to combat loneliness in either jurisdiction on the island of Ireland. However, loneliness does appear to be rising up the agenda in Northern Ireland (NI). For example, Belfast City Council runs a grants scheme designed to support initiatives that tackle loneliness. In the Republic of Ireland (ROI), several voluntary and community sector organisations led initiatives and projects specifically established to combat loneliness (*e.g.* ALONE and CareLocal). There has been limited external evaluation of the value and impact of services designed to combat loneliness on the island of Ireland. In terms of the approaches used to prevent and tackle loneliness, the research found that some voluntary and community organisations have adopted a befriending approach (using personal and or phone contact) which, whilst popular and economical, may not be the most effective in terms of tackling chronic loneliness. Other approaches focus on the provision of opportunities for older people to participate in social and community activities outside of home (*e.g.* Engage with Age, NI).   At a European level (*e.g.* Mona Lisa, France) it is suggested that the best way to tackle loneliness is through the use of a number of different, complementary, well-targeted methods which includes older people defining their own needs.

Background

The aim of this policy-focused research to contribute to a greater understanding of the issue of loneliness and the most effective policy and or service interventions to prevent and or tackle loneliness amongst older people in both parts of Ireland. Its specific objectives are to:

1. Provide a review of the literature on the risk factors and impact of loneliness on older people and identify groups at potential risk of loneliness. Review key data on loneliness amongst older people in Ireland, North and South.

2. Undertake an assessment of government policy and services to prevent or address loneliness amongst older people in Ireland, North and South.

3. Review international best practice in the area of preventing and/or tacking loneliness amongst older people.

4. Analyse the literature, data and international best practice to identify which older people are at most risk of experiencing loneliness.

5. Determine what are likely to be the most effective models for preventing and addressing loneliness amongst older people and how these models may apply to particular groups of older people.

6. Set out a framework for understanding loneliness which can aid policymakers and practitioners in effecting change in this area.

7. Provide policy considerations and recommendations.

Methodology

This research was carried out through a combination of desk research and interviews with selected policy-makers, practitioners and members of the academic community. The work was carried out over the period February - July 2015.

Recommendations

1. **Develop and foster a better understanding of the concept of loneliness**

   While social isolation, social inclusion and loneliness are related and often used interchangeably they are distinct concepts. Loneliness involves both a psychological state and a subjective experience (*i.e.* a negative emotion associated with a gap between the quality and quantity of relationships an individual has and wants). Tackling loneliness and particularly chronic loneliness requires a complex response based on an understanding of the various (affective, cognitive and subjective) components of loneliness.

2. **Identify chronic loneliness as a social health priority**

   While loneliness is both a social and a wider (social) health issue, the absence of an adequately resourced social inclusion policy framework means that for pragmatic reasons loneliness needs to be identified as a prominent and clearly defined priority and field of work within the wider health policy arena.

3. **Ensure that loneliness interventions are based on evidence**

   Those designing services to combat loneliness need to carefully consider the evidence base of what is known to work. There is evidence to suggest that services designed to tackle chronic loneliness work best where they use a multiplicity of methods and approaches (communal socialisation is generally just one of a number of approaches used). These services also need to be designed in such a way that they can accommodate individuals who may otherwise be unable, for health, social or geographic reasons, to take advantage of them.

4. **Establish services and initiatives to tackle chronic loneliness**

   Chronic loneliness is linked to a wide range of mental and physical health and quality of life outcomes. Therefore it may be argued that there is a need for services/initiatives both to tackle chronic loneliness and to identify and support individuals at risk of chronic loneliness. These services and initiatives need to involve both statutory bodies and voluntary and community organisations and appropriate resources.

5. **Support the development of a strong evaluation culture**

   Evaluation needs to be included as a core element of all of projects, services initiatives funded to tackle loneliness. Supporting the development of an evaluation culture and evaluation expertise among and between statutory and voluntary organisations would be an important initiative in this context. Over time this could be extended to ensure information, news and examples of good practice are circulated widely on both parts of the island.

1   Defining 'loneliness': nature, characteristics and dimensions

This chapter provides the backdrop to the emergence of the concept of loneliness. It examines the different definitions, theories and conceptual underpinnings as they relate to loneliness in general and loneliness among older people in particular. The various factors that influence loneliness and the groups at particular risk of loneliness are examined. The final section contains an examination of the impacts of loneliness.

1.1   Emergence of the concept

While the history and experience of loneliness may be long (with a concern about isolation and loneliness found in a range of ancient writings), conceptual and psychological studies of loneliness are relatively recent. The social observer Rowntree made direct connection with older age and loneliness in 1947 when he described loneliness as *'a distressing feature of old age'* and stated that *'all who have done welfare work among the elderly have found it the most common, if not the most imponderable of the ills from which the aged suffer'* (Rowntree, 1947).

In a ROI context, the emergence of policy interest in the concept and existence of loneliness specifically among older people can be traced to Brian Power's 1980 all-island baseline study *Old and alone in Ireland* (Power, 1980). This research also followed the establishment in Ireland of the organisation A Little Offering Never Ends (ALONE) a response to multiple deaths from hypothermia of older people living alone in Dublin (Bermingham, & O'Cunaigh, 1978). ALONE's publicity, which shocked the authorities at that time into action (a housing task force for the elderly was established) may have had the unintended effect of creating popular image of older people as *'infirm, ill, lonely, resigned and passive'*, although over time this gave way to a more positive image of older people as active, healthy and involved (Ruddle, Donoghue & Mulvihill, 1997). Another organisation from this time was Care for Old Folk Living Alone (later CareLocal, now part of Crosscare). The UK wide organisations, Help the Aged and Age Concern, were established in the 1960's and 1970's respectively providing a range of support services for older people including local older people's groups. In this period in NI, children and families were the primary focus of anti-poverty campaigners (Evason, 1974).

1.2   Theories, definitions, and conceptual underpinnings

Loneliness carries a significant social stigma, as lack of friendship and social ties are socially undesirable, and the social perceptions of lonely people are generally unfavourable. Lonely people often have very negative self-perceptions, and the inability to establish social ties suggest that the person may have personal inadequacies or socially undesirable attributes (Lau & Gruen, 1992).

1.2.1   Theories used to understand loneliness

A variety of theoretical approaches and hypotheses have been used to explain loneliness. These include: existentialism, interactionalism, phenomenological, privacy, psychodynamic, sociological, systems, behavioural self-regulation theory (linked to personal and social resources) cognitive discrepancy theory (Scheier & Carver, 1985, Peplau & Perlman, 1982 & Bolton, 2012). Some of these approaches are theory-based definitions, while others focus on empirical hypotheses as understandings of loneliness. The interactionist approach, for example, is based

on loneliness being multidimensional meaning that there are different kinds of loneliness, including emotional and social loneliness, with emotional loneliness defined as a loss or absence of confiding in and forming an attachment to a special and beloved person; and social loneliness defined as the absence of meaningful friendships (Heylen, 2010; Van Baarsen *et al.,*2001; Holmen, Ericsson, & Winblad, 2000).

More recently, there has been a move towards empirical theories, with researchers focusing on data collection to support their theories of loneliness. This resulted in the main theoretical approaches being narrowed down to a smaller number of theories that could be supported by data leaving the research field of loneliness with a number of key constructs:

- **An affective component**: encompassing the negative emotional experience of loneliness. Within this component the focus is on how loneliness is experienced and what kind of loneliness is involved (Sonderby, 2013).

- **A cognitive component** focusing on perception and evaluation of social relations and encompassing the discrepancy between achieved and desired social relations (Heinrich & Cullone, 2006; Lasgaard, 2010a).

- **A subjective component**: recognising that loneliness is a subjective experience and focusing on describing the feelings of loneliness and on how tragedies and negative events impact life (rather than on the degree or kind or loneliness).

These different components of loneliness are guided by a number of theoretical approaches:

- **A social needs approach;**

- **A cognitive discrepancy approach;**

- **An existential/subjective approach**

   (Lasgaard, 2010).

The **social needs approach** is grounded in psychodynamic theory with a focus on the **affective component** of loneliness (Marangoni & Ickes, 1989). This approach focuses on the infant's need for contact and how this need continues throughout adult life. This approach is in line with attachment theory as well as psychodynamic theory (Lasgaard, 2010a) with the focus on how loneliness is experienced and what kind of loneliness is involved. The application of this approach in practice means that individuals with a stable and loving childhood can be expected to experience less anxiety, less loneliness, higher self-esteem and better peer relationships than individuals who had a difficult childhood (Hojat, 1989; 1998).

The cognitive (discrepancy) approach predicts that loneliness will be experienced when a person perceives that his or her social involvement is less than what that person would want it to be. The model proposes that individuals develop a "comparison level" for their entire network of social relationships. This comparison level represents the quantity or quality of social contact the person desires and is used by the individual to evaluate the adequacy of his or her current social network. Thus, the cognitive discrepancy model hypothesises that satisfaction with social relationships and feelings of loneliness are jointly determined by the person's current social relationships and by comparison level for social relationships. Social comparison (comparison with individuals perceived as being similar) is identified as a key shaper of comparison levels. Testing of this model found that the relationship between the discrepancies between the

person's actual interpersonal relationships and desired or expected relationships and their level of loneliness may not be linear and that near a person's ideal comparison level, a unit increase or decrease in the quantity or quality of 'close' relationships may be especially important to the individual in terms of determining their level of satisfaction and loneliness (Russell *et al.*, 2012).

The existential/subjunctive approach focuses on the human condition and how individuals come to terms with it. It focuses on living an authentic life and being aware of one's own mortality of life (Jacobsen, 2007).

Measures of loneliness

Measurement methods for self-rated loneliness include the De Jong Gierveld in Europe and the Social and Emotional Loneliness Scale for Adults (SELSA) and the University of California Los Angeles (UCLA) Loneliness Scale in the United States (Cacioppo, & Hawkley, 2006). Some of these scales are uni-dimensional (*e.g.* UCLA scale measures how lonely a person is) while others are more multidimensional (*e.g.* the SELSA scale measures how lonely a person is and what kind of loneliness they are experiencing) which enable a differentiation to be made between different kinds of loneliness.

Other researchers have used open-ended questionnaires (Rubenstein & Shaver, 1982) to explore the language individuals use to describe: how loneliness feels, the reasons or causes of loneliness and individuals reactions to loneliness (p. 210).

1.2.2 Defining Loneliness

For many people loneliness is a transitory and or periodic condition that often occurs in association with a particular life event (*e.g.* after a relationship breakdown or bereavement). For others loneliness can be a lasting and chronic condition.

Cacioppo & Patrick (2008) describe loneliness as a prevalent, common, and disconcerting social phenomenon and other recent estimates suggest that up to 32% of adults experience loneliness and that up to 7% report feeling intense loneliness (Hawkley *et al.*, 2010). Cattan defines loneliness, as the 'subjective, unwelcome feeling of lack or loss of companionship or meaningful relationships, emotional and social by nature, relating to opportunities to socialise, social networks and support from friends or allies in time of distress' (Cattan *et al.*, 2003).

Rokach (2012) argues that loneliness has become 'an almost permanent and all too familiar way of life to millions of North Americans: the single people, divorced individuals, adolescents, housewives, and the scores of people who call suicide prevention centres and hot lines. It is so widespread and aversive, that a billion-dollar loneliness industry has been developed to meet the desire of those who do not know what to do about their loneliness'. He argues that this industry 'tempts us with an array of relational possibilities, social skills upgrading, and semi-forced joined activities', with many lonely people engaging in these activities to 'become unlonely'. He argues that 21st century lifestyle is contributing to this loneliness by creating isolation and by failing to equip individuals with the skills to deal with this.

While loneliness is frequently associated with old and older age (with age-related losses and decreasing health, linked to the loss of social contact, which in turn is expected to increase the risk of loneliness), the reality is that loneliness affects people of all ages (Shute & Howitt, 1990).
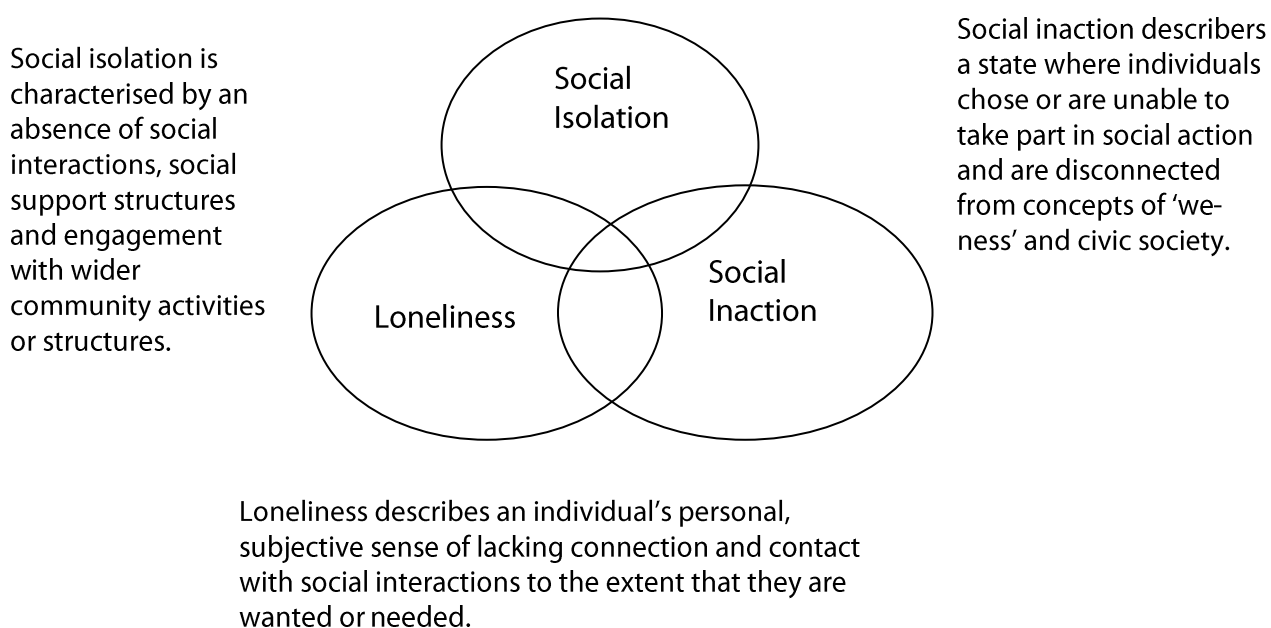
With definitions of loneliness evolving over the years, Rokach (2012) has identified three distinguishing and common characteristics of loneliness as follows:

- Loneliness is a universal phenomenon that is fundamental to being human.

- Although shared by all of us periodically, loneliness is in essence a subjective experience that is influenced by personal and situational variables (*i.e.* people can be alone without being lonely, or they can be lonely in a crowd (Beaumont, 2013).

- Loneliness, which is a complex and multifaceted experience, is generally considered very emotionally painful, severely distressing, and individualistic.

1.2.3 Living Alone v Social Isolation v Loneliness

Living alone, social isolation and loneliness are interrelated. Although social isolation and loneliness are often used interchangeably they are distinct concepts. See Figure 1 for details of the relationship between social isolation, social inaction and loneliness.

Figure 1: The relationship between social isolation, social inaction and loneliness

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures.

Social inaction describes a state where individuals chose or are unable to take part in social action and are disconnected from concepts of 'we-ness' and civic society.

Loneliness describes an individual's personal, subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed.

(Source: Henderson, 2013)

Living alone refers simply to people living in separate households. Living alone has increased markedly in the last 40 years. Living alone is, at every age group, much more common amongst women as compared with men. Being alone in contrast is simply time spent alone.

Social isolation relates to the integration of individuals (and groups) into the wider social environment. It includes quantitative 'objective' measures of the number, type and duration of contacts between individuals and the wider social environment. A key component of isolation, therefore, is the size of an individual's social network (Wenger *et al.*, 1996). In policy terms, the concept of social isolation tends to be used a lot more frequently than loneliness. Data from the Irish Longitudinal Study on Ageing (TILDA) shows that 60% of older people who reported being

isolated indicated they never felt lonely (Barrett *et al.*, 2011). One possible reason given for this is that 'loneliness relates more to emotions' and that 'there may be a view that the state has no legitimate concern with these' (Bolton, 2012).

Loneliness in contrast is both a psychological state and a subjective experience; a negative emotion associated with a gap between the quality and quantity of relationships an individual has and wants (Age UK Oxfordshire and the Campaign to End Loneliness 2011; Jopling, 2015). It is therefore possible to be socially isolated without being lonely and to be lonely without being socially isolated (*e.g.* people living in nursing homes particularly when the death of friends and loved ones takes away the companionship they need) (Wenger & Burholt, 2004).

1.2.4 The extent of loneliness among older people[1]

Victor, Scrambler and Bond (2009) estimated the prevalence of loneliness amongst those aged 65 and over is in the 8-10% range with approximately 20% classified as sometimes lonely and the majority of this population defined as 'not lonely'.

The 1980 Power report concluded that 35% of older people in NI and 39% of older people in ROI were afflicted by loneliness to a varying degree, with 7% affected by persistent loneliness (Power, 1980).

The National Council for Ageing and Older People 2005 study of loneliness in ROI measured three different types of loneliness: social, family and romantic (emotional type) loneliness (the latter indicating a lack of close friend or partner). It found:

> *The highest percentage of loneliness was identified in older people being romantically lonely, with just under 50% identifying themselves as moderately lonely in this category. 10% of older people surveyed were moderately socially lonely, less than 2% very socially lonely. The lowest report of loneliness was identified in the family category, with 7.2% of respondents indicating that they were moderately lonely. Reports of being very lonely were infrequent (Treacy et al., 2005, p14).*

More recently as part of the TILDA study on a scale from 0 (not lonely) to 10 (extremely lonely) an average score of 2 was identified for older people in ROI (Timonen, Kamiya & Maty, 2011 (p.62). This low score which was derived from four negatively-worded questions each with a three-point response scale (using a modified version of the UCLA scale) did not include older people who did not live at home[2]. There is no comparable study for NI.

Recent research has also found a relationship between education and loneliness (*i.e.* the more educated an individual is the less likely they are to feel lonely. See Table 2 for details) and a relationship between health and loneliness (*i.e.* individuals who report excellent and good self-rated health are less likely to feel lonely. (See Table 3 for details).

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[1] In this report 60 will be the general reference point for an older person, but applied pragmatically according to context and circumstances.

[2] Household-based survey designs can also be ineffective in studying hard-to-reach groups (Agadjanian & Zotova, 2012), so some of the most socially marginalised older adults may not be included in the TILDA sample.

Table 1: Mean Loneliness Score by age and education (measured using the UCLA loneliness scale)

Education Level	Age			Total Mean Score
	50-64 Mean Score	65-74 Mean Score	>=75 Mean Score	
Primary	2.3	2.2	2.3	2.3
Secondary	2	1.8	2	1.9
Third/Higher	1.8	1.8	1.7	1.8

Note: (Scores range from 0 (not lonely) to 10 (extremely lonely) with 2 being the average score for an older person)
Source: Timonen, Kamiya & Maty (2011, p.62)

Table 2: Mean Loneliness Score by age and self-rated physical health (measured using the UCLA loneliness scale)

Self-rated physical health	Age			Total Mean Score
	50-64 Mean Score	65-74 Mean Score	>=75 Mean Score	
Excellent	1.3	1.3	1.5	1.3
Very Good	1.6	1.4	1.9	1.6
Good	2.1	2	2	2.1
Fair	2.9	2.5	2.6	2.7
Poor	3.5	3.8	3.7	3.6

Note: (Scores range from 0 (not lonely) to 10 (extremely lonely) with 2 being the average score for an older person)
Source: Timonen, Kamiya & Maty (2011, p.62)

Comparative European data, on 'frequent loneliness levels' across age groups in 25 European Nations is provided in Table 4.

Table 3: Prevalence of Frequent Loneliness across age groups in 25 European Nations

Country	Sample Size	% of frequent loneliness		
		<30 years	30-59 years	>60 years
Group 1				
Bulgaria	1400	5.6	8.1	18.9
Hungary	1519	9.6	13.3	21.1
Latvia	1897	7.8	10.9	18.8
Poland	1721	5.5	11	20.1
Romania	2139	11.5	10.7	18.8
Russia	2437	11.3	15.4	24.4
Slovakia	1766	8.8	10.5	19.6
Ukraine	2001	15.3	19.8	34..0
Group 2				
Belgium	1768	6.2	6.5	8.7
Denmark	1505	3.4	1.9	3.2
Finland	1896	2.6	3.7	6.1
Germany	2915	5.1	4.4	7.0
Ireland	1800	4.1	5.0	5.4

Netherlands	1888	3.4	3.3	6.0
Norway	1750	2.2	2.6	5.0
Sweden	1927	6.0	3.7	7.4
Switzerland	1803	1.3	2.6	4.8
United Kingdom	2394	6.3	5.5	7.4
Group 3				
Austria	2405	9.5	6.4	10.5
Cyprus	995	3.7	5.8	10.2
Estonia	1517	6.1	5.6	14.0
France	1986	8.2	8.8	11.4
Portugal	2222	6.5	9.0	14.9
Slovenia	1476	4.6	5.0	15.2
Spain	1876	4.4	6.5	11.5

Source: Yang & Victor (2011)

Overall, loneliness tends to be lower in social democratic countries and higher in countries with less well-developed social security systems, suggestive of the importance of welfare regimes (including pensions, social security schemes and health care) (Fokkema, T.de Jong Gierveld, J & Dykstra, P, 2011;Jacobsen, 2015).

This data, while promoting the view that for most nations (with the exception of Denmark) loneliness levels are higher in older age, challenges the common stereotype of loneliness as an experience almost exclusively confined to older people finding loneliness across the age spectrum (Yang and Victor, 2011). There is some evidence (which this data supports to suggest that loneliness levels may follow a U-trajectory over an individual's lifetime, being generally higher in teenage years, low during family formation and working age, rising again in older age (Victor, 2005).

A UK publication by the Mental Health Foundation (2010) reported finding an almost flat distribution of loneliness across the age groups with little evident relationship between age and loneliness. Nevertheless, life transitions linked with loneliness occur more frequently with increased age, including retirement from work, children growing up and leaving home, the increased prevalence of chronic illnesses, the increased risk of bereavement (in general and bereavement of a spouse in particular) and entry into long-term care.

1.3   Factors that Influence Loneliness

Loneliness may be considered as having three distinct components (affective, cognitive and subjective). This means that loneliness may be influenced by a range of often interrelated factors at an individual and at a societal level.

1.3.1 Individual factors

Health status of the individual
Health has been found to have a significant indirect effect on loneliness, through its potential to impact on social resources and social participation. Burnholt & Scharf (2014) specifically found that the *'increasing numbers of chronic conditions can be considered as a precipitating event, which leads to a decrease in achieved levels of social interaction'* (p320). According to Timonen *et al.*, (2011) individuals over fifty who report *'excellent, very good and good self-rated health are also less*

likely to feel lonely' (p62). This concurs with an earlier finding by Dykstra *et al.,*2005 that declining health can be a predictor of increased loneliness but that loneliness can abate if the individual's health recovers or if they can make new social ties (Beaumont, 2013). It is also the case that particular health conditions (*e.g.* blindness) have been found to increase levels of loneliness (Pocklington Trust, 2010). A study of people aged 65+ on the island of Ireland also found an independent association between loneliness and emergency hospitalisation (Molloy *et al.,*2010).

The socio-economic status of the individual
Loneliness has been found to be least evident among those on higher incomes with access to transport. Scharf emphasises the social class gradient to loneliness making a connection between loneliness and poverty with higher levels of loneliness linked to low economic and social opportunities and poor quality of life (Scharf *et al.*, 2002). His view concurs with that of Peter Townsend, author of *The family life of old people, 1865-1957*, who wrote that desolation, rather than isolation, was the fundamental cause of loneliness in old age (Townsend, 1957).

Changing personal circumstances (linked to life transitions)
Changing personal circumstances includes; partner status, level of contact with children and relatives and caring responsibilities (Drennan *et al.*, 2008). According to Distel *et al.,*(2010) *'Marriage, children and siblings are associated with lower loneliness'.* A Belfast study found that loneliness was higher for divorced or separated people, lower for married and lowest for single people (Boyle, 2010). Widowhood in particular has been identified as a powerful predictor of loneliness (Beal, 2006; Golden *et al.*, 2009; Savikko, Routasalo, Tilvis, Strandberg, & Pitkala, 2005) and more so among men than among women (Pinquart, 2003). Other life stage transitions that can influence loneliness among older people in particular, include: retirement, unemployment, bereavement, becoming a carer, moving to a new area (to be closer to family), loss of mobility, sensory impairment, moving into a care home, loss of cognitive function. Some older people recover from this type of loneliness, so it is not necessarily a path of deterioration (Cattan, 2005). For others the onset of loneliness can be gradual, while for some loneliness can be temporal, changing in intensity varying daily, weekly and seasonally. Self-efficacy and coping skills, including the capacity to deal with stressful and negative events across the life cycle can mitigate the effects of loneliness (Singh & Misra, 2009).

1.3.2 Membership of an ethnic or minority group or community
Other factors that may influence loneliness include membership of an ethnic or minority group or community who have particular values and cultural norms (different to the majority) and perhaps differential access to wider societal resources (Victor, Burholt & Martin, 2012).

Sexual orientation and gender identity
Sexual orientation and gender identity (*e.g.* gay, lesbian bisexual, transgender or straight) may also have an influence on loneliness). In a 2011 survey, 31% of LGBT adults said they felt lonelier as they aged (Higgins *et al.*, 2011).

Advancing age
The extent to which age and gender may have an influence on loneliness is not clear. The 2005 National Council for Ageing and Older People baseline study and a 2001 ESRI study for example found that loneliness was most evident among the 'oldest old' (80+), single or widowed women living alone, with lower education, lower socio-economic status, in rented accommodation, few transport connections and were more likely to be rural. In contrast, a TILDA report found no significant correlation between advancing age and loneliness suggesting the relationship between old age and loneliness may not be straightforward (Barrett, *et al.*, 2011).

Gender

According to Karki (2009) loneliness affects men and women differently. Men are less likely to experience social loneliness than women, given that women tend to have a greater number and are more reliant on their social networks and therefore experience a greater sense of loss when these break down. Male dependency on a single key relationship can in contrast be very significant and the loss of that relationship through bereavement or separation can be devastating and a cause of deep emotional loneliness (Karki, 2009).

1.3.3 Wider physical, societal and cultural factors

Social networks

The presence or absence of pre-existing social networks may also be an important influence on loneliness. According to Heylen (2010) 'the higher the satisfaction with social relationships and the better the appraisal of the number of good friends, the lower the risk of social loneliness' (p. 1190)
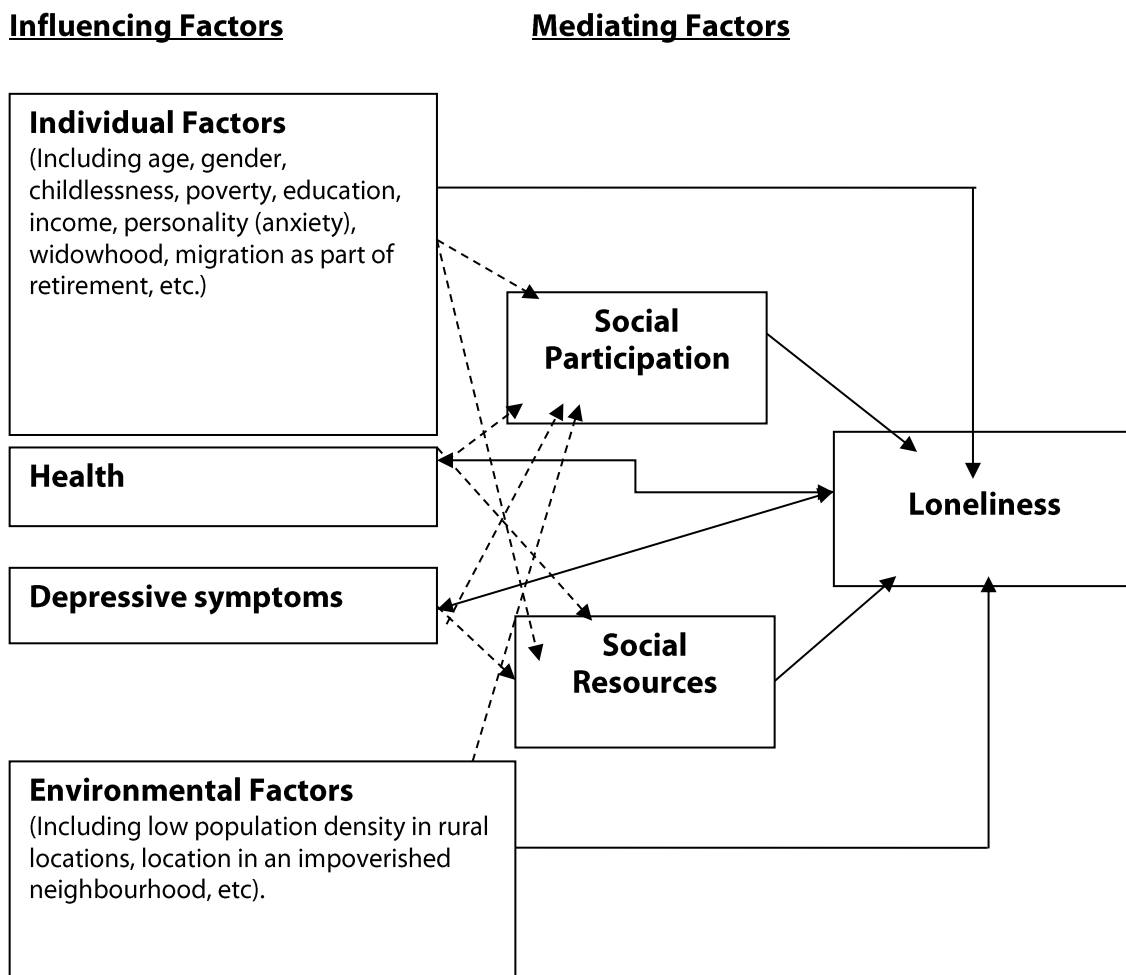
Cultural factors

Research has found that emotional loneliness is likely to be higher in more individualistic countries (such as North American countries) than in more collectivistic countries (*e.g.* eastern- and southern European countries (Rokach & Bauer, 2004). Rokach (2007) argues that various cultural structures can be connected with individualism which influence the experience of loneliness rather that individualism directly. A more recent study of loneliness across 25 EU Nations found a North & West versus an East divide. For example those living in Russia and other Eastern European nations reported the highest percentages of frequent loneliness in comparison to Northern and Western European countries. The percentage of young people reporting loneliness in some of these nations was higher than reported by older people in Northern and Western Europe by a factor of 10-15%. Yang and Victor link these differences to the dramatic political and economic changes that have happened in Eastern Europe since 1989 suggesting that these changes have contributed to a deficit of desired social relations, with younger and middle aged people forced to move away from their social relations in pursuit of a better material life somewhere else (Yang & Victor, 2011, p 1382-3).

Wider environmental factors

The wider physical environment (including challenges in the physical environment (*e.g.* lack of public toilets or public seating), housing design and location have all been identified as influences on prevalence of loneliness (Skjaeveland & Garling, 1997). Access to public transport can also play a role as can levels of crime and fear of crime (Stanley & Stanley 2007; Jakobsson & Hallberg, 2005).

Figure 2 shows an overview of some of the factors that influence loneliness and the factors that can protect/mediate against loneliness.

Figure 2 Factors that influence and factors that mediate against loneliness

Influencing Factors   Mediating Factors

Individual Factors
(Including age, gender, childlessness, poverty, education, income, personality (anxiety), widowhood, migration as part of retirement, etc.)

Health

Depressive symptoms

Social Participation

Social Resources

Loneliness

Environmental Factors
(Including low population density in rural locations, location in an impoverished neighbourhood, etc).

Source: Burholt and Scharf (2014)

1.4   Groups at risk of loneliness

1.4.1 Groups at risk

This section explores various groups identified as being at particular risk of loneliness.

Members of the Lesbian, Gay, Bisexual and Transgendered (LGBT) community

A 2011 study by the Gay & Lesbian Equality Network on the needs and experiences of older Lesbian, Gay, Bisexual and Transgender (LGBT) people in ROI identified *'loneliness and isolation as issues for* 30.9% of its ageing community (Higgins *et al.*, 2011). Loneliness and isolation were seen to be particular issues *'for those living in rural areas and for those who had not come out'* (Higgins *et al.*, 2011, p.24). The study also suggested that *'because LGBT people are less likely to be 'socially embedded' than their heterosexual counterparts, they are, as a result, more likely to experience loneliness'* (p.29). Other reasons cited as to why LGBT people may have a higher risk of experiencing loneliness were linked to the fact that older LGBT people are more likely to:

- Live alone

- Be non-partnered

- Not have children

- Lack family support in times of need

- Face barriers to local community involvement due to the heteronormative culture

- Feel excluded from many LGBT organisations and activities due to their youth-focused nature

- Be reluctant to access formal health and social support services for fear of discrimination and anti-LGBT bias

- Lack extended 'families of choice', *i.e.* LGBT networks in whom they could confide, be themselves with and share stories. In many cases, the lack of LGBT friends was the result of coming out late in life and not having developed LGBT friends in the early years of life, when many lifelong friendships are formed

Individuals living with dementia or cognitive impairment

Individuals living with dementia are more at risk of loneliness than the general population (Alzheimer's Society, 2013). This risk increases if the person with dementia lives alone. As many as two-thirds of people with dementia live in the community with a significant and increasing number of them living on their own. According to the Alzheimer's Society UK (2013) 62% of those living alone with dementia said that they felt lonely and a third of all respondents (35%) reported having lost friends after receiving a diagnosis. A variety of factors have been found to contribute to the loneliness of these individuals including a reluctance to leave the house due to the fear of getting lost or confused in public, loss of confidence, and the stigma surrounding the condition which can leave people feeling they have been 'written off' by society (Campaign to End Loneliness, 2014).

Individuals with a physical disability/ mobility issues

Individuals living with a physical disability and or mobility issues can find themselves physically isolated, marginalised and lonely (Russell, 2009). Individuals with dual sensory loss, as a result of their decreased vision and/or hearing loss, frequently experience communication breakdown. With limited ability to improve communication this can result in poor psychosocial functioning. It can also be difficult for the individual involved to adjust to the sensory loss and this is turn can be a trigger for depression, anxiety, social dissatisfaction all of which are linked to loneliness (Heine & Browning, 2002).

Individuals with an intellectual disability

Research has found *'some level of loneliness was a common experience'* among adults with an intellectual disability in Ireland (McCarron, *et al.*, 2011, p.47). Women with intellectual disabilities are almost 20% more likely than men to report feeling lonely (53% female versus 34% male), a little more likely to 'feel left out' (28% female compared to 24% male) and having difficulty making friends (28% female versus 27% male). *'Levels of reported chronic loneliness were low and broadly comparable with the general population'* (McCarron, *et al.*, 2011 p47). Older adults with an intellectual disability living independently or with family were found to have lower levels of emotional or mental health problems, and were less likely to feel lonely than individuals with

intellectual disabilities living in more communal settings (Burke *et al.*, 2014). These higher levels of loneliness have been linked the fact that individuals with intellectual disabilities have significantly less meaningful relationships with people who do not have intellectual disabilities, and are not either relatives or carers (Roberston *et al.*, 2001). Tackling loneliness among individuals with intellectual disabilities clearly requires interventions to assist these individuals develop meaningful relationships and exercise control over their lives from an early age (Kelly, 2010; CARDI, 2015).

Individuals who are caring for a family member or friend
The loneliness experienced by carers is caused by a range of circumstances including a lack of time or energy to sustain contacts/relationships with friends or wider family (Ekwall *et al.*, 2005). It is also the case that when an individual's caring responsibilities end this too can generate feelings of loneliness (Victor, Scambler & Bond, 2009). Tackling the loneliness of carers requires reaching out to carers and providing them with practical and emotional supports to help break the loneliness that many carers experience (Campaign to End Loneliness, 2014).

Individuals from ethnic minority/minority communities
Within ethnic minority populations, households are often perceived to have more 'traditional' family structures and therefore at lower risk of loneliness. There is a danger that the support needs of older members of these communities in relation to loneliness may be underestimated. Language can be a barrier for individuals from minority communities, with research showing that individuals from this community experiencing dementia often lose whatever second-language ability they had (Campaign to End Loneliness, 2014).

1.5   The Impact of Loneliness

Although the experience of loneliness clearly affects health and quality of life, it is not clear whether loneliness causes these, or indeed whether poor health and a declining quality of life are triggers for loneliness. What is known is that loneliness has been linked to a wide variety of mental and physical health outcomes, such as depression, nursing home admission, and overall quality of life for older people (Timonen, *et al.*,2011).

1.5.1 The links between loneliness and physical health
It has been suggested that loneliness affects physical health and is affected by physical health in a number of ways:

- **Lonely people have higher cortisol (stress hormone) levels:** persistently high cortisol levels can become dysfunctional and can lead to early organ deficit. Loneliness can also affect gene expression in immune cells making the person more prone to viruses (Bolton, 2012);

- **Loneliness can increase the risk of heart disease. and recovery rates from stroke** (Ong et al., 2012 & Boden-Albala et al., 2005) ;

- Lonely people have more **disrupted sleep** because they are more prone to wake up during the night, perhaps because they do not feel safe and protected (Cacioppo et al,. 2002).

1.5.2 The links between loneliness and mental health

Loneliness has been associated with a broad range of adverse psychological conditions including anxiety, depression, substance abuse, social deviance, lower social skills, a more critical view of self, and perfectionism (Perlman & Peplau, 1984; McWhirter, 1990; Hughes, Waite, Hawkley & Caccioppo, 2004; Arslan, Hamarta, Ure & Osyesil, 2010). Loneliness has also been linked with suicidal behaviour and poor self-regulation behaviour, for example in alcohol abuse and eating disorders (Sønderby, 2013). The large scale SLÁN study of Irish adults found that *'positive mental health is predicted by lower levels of loneliness and higher levels of social support'* (Van Lente *et al.*, 2012).

Loneliness affects both cognition and relationships with lonely people more preoccupied with social threats and self-preservation and less attentive to what others are feeling and what they might need. Loneliness has also been linked to cognitive decline and dementia in older people with evidence that socially engaged older people experience less cognitive decline and are less prone to dementia (Conroy, *et al.,* 2010, James *et al.,* 2011). The question of whether loneliness is a "side effect" that appears in connection with other mental disorders, such as depression or whether it is a condition with its own set of distinct causes, responses and reactions remains an open one, Burnholt and Scharf (2014) have suggested that depressive symptoms influence cognitive process, which in turn interfere with judgements particularly in relation to the adequacy of social interaction.

1.6   Conclusions

A wide range of theories have been used to explain loneliness. These theoretical approaches include a social needs approach (which focuses on the infant's need for contact and how this need continues throughout adult life), a cognitive approach (which is predicated on the recognition that loneliness will be experienced when a person perceives that his or her social involvement is less than what they would want it to be) and an existential approach (which focuses on the human condition and on being aware of one's own mortality). The subjective experience of loneliness poses challenges for its comprehensive measurement with different measures useful for different purposes. The UCLA Loneliness scale measures how lonely a person is, the SELSA scale measures how lonely a person is and what kind of loneliness they are experiencing, while more qualitative measures explore the language individuals use to describe how loneliness feels, the reasons and causes of loneliness as well as individuals reactions and responses to loneliness.

The concepts of living alone, social isolation and loneliness are interrelated but distinct concepts.

While the nature of the relationship between age and loneliness is contested there is some evidence to suggest that loneliness levels may follow a U-trajectory over an individual's lifetime, being generally higher in teenage years, lower during family formation and working age, rising again in older age. Other contributing factors include a range of individual factors including gender, sexual orientation and identity, socio-economic status and ethnicity as well as wider societal factors and environmental factors including access to social networks and transport.

Groups identified as at greater potential risk of loneliness include members of the LGBT community, individuals living with dementia or cognitive impairment, individuals with a physical disability, individuals who are carers (for family or friends) and individuals from ethnic/minority communities with restricted friend and family networks.

Although a direct causal relationship is difficult to establish loneliness has been linked to a wide variety of mental and physical health outcomes, such as depression, nursing home admission, and overall quality of life for older people.

2   Government policies

This chapter examines government policies in ROI and NI, at an all-Island and at a European level. Initiative and programmes led by non-governmental organisations are also examined with conclusions drawn in the final section.

2.1   Northern Ireland

Policies in NI operate within the broad UK framework for social policy as adjusted by the principal government department responsible; the Office for the First Minister and Deputy First Minister (OFMDFM); the NI Assembly; and implementation bodies in the areas of health and social care. In NI there is a policy relating to ageing and older people *Ageing in an inclusive society - strategy for promoting the social inclusion of older people* (OFMDFM, 2005) but this contains no specific mention of loneliness. It is currently under review with a consultation document issued in 2014 (OFMDFM, 2014) with a view to a new policy being issued in 2016. The consultation document contained reference to representations by the Campaign to End Loneliness in England which highlighted the need to tackle loneliness among older people and associated health issues including depression, lack of physical activity and poor diet. It argued for better access to services to allow older people to fully participate in society. No further references or mentions of loneliness were made, nor is loneliness mentioned or measured in the principal social profile of older people undertaken by the statistical and research agency (NISRA, 2014).

Current NI strategies which make reference to loneliness include:

— The **social inclusion** strategy Lifetime Opportunities (OFMDFM, 2006) which includes the following goal: 'By 2020, [to] ensure that every pensioner lives in a decent, warm, secure home in a community where they experience reduced levels of isolation and loneliness';

— The **health and social care** strategy Transforming Your Care (DHSSPS, 2011) makes a brief reference to loneliness stating that 'there is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing and that one to one interventions such as befriending and outreach can reduce loneliness and depression and are cost effective' (DHSSPS, 2011).

— The **public health** strategy Making Life Better-A Whole System Strategic Framework for Public Health (2013-2023) identifies loneliness and social isolation among older people as 'a growing problem' (DHSSPS, 2014). The framework also makes specific reference to the importance of healthy active ageing (p61) and the establishment of 'age friendly environments'.

The Public Health Agency (PHA) has developed an *Older People's Thematic Action Plan (2014-2015),* which contains an objective focused on reducing the risk of older people becoming socially isolated (PHA (NI), 2014). This plan is linked to the current regional priority for the establishment of an overall health service framework for older people. Actions under this objective include:

• A small grants programme to support local groups to create arts and health opportunities for older people.

- An arts and health festival that will engage older people in arts and health programmes, delivered with ArtCare NI.

- Development of *'a shared approach'* with the Health and Social Care Boards (and their five Local Commissioning Group Committees), Trusts and other partner organisations to address the wider local health and social needs of older people and in particular those experiencing social isolation and loneliness.

Other NI initiatives

In 2011 a **Commissioner for Older People** (COPNI) who acts as a champion for older people's issues was appointed. The Commissioner has spoken out on several issues concerning services for older people relating to loneliness including free transport for those over 60 and meals-on-wheels services.

In 2014 Belfast City Council introduced the *Age-friendly reducing isolation small grant scheme.* The scheme is open to organisations who tackle social isolation and loneliness. To date it has awarded 18 grants in the range €3,700 to €9,900 to voluntary and community organisations for local projects including befriending and visiting programmes, arts and leisure activities and other forms of support. An evaluation of the scheme is planned to measure its impact (Belfast City Council, 2015).

UK policy

As mentioned earlier, policy in NI is informed by developments at the UK level as a whole. There is some evidence that loneliness is being recognised featuring more strongly on the government agenda:

 In 2010 the Minister for Pensions announced that the UK government would provide a **£1m fund to help older people most at risk of longer-term loneliness and social isolation**, with 459 initiatives subsequently being funded (Department of Work and Pensions, 2015).

The *Caring for Our Future: Reforming Care and Support* **white paper** identifies loneliness and social isolation as problems that society has failed to tackle, while the Minister for Care and Support has spoken very publicly about an *'epidemic of loneliness'* (Department of Health, 2012). It identifies up to 16% of older people in the UK as lonely potentially leading to poor physical and mental health, including depression. The paper aims to tackle loneliness and social isolation by supporting people to remain connected to their communities and to develop and maintain connections to friends and family. It details the steps needed to support these aims and makes a commitment to develop, with local government, suitable measures of loneliness and isolation for inclusion in the Adult Social Care Outcomes Framework (ASCOF) and the Public Health Outcomes Framework (PHOF).

The *Public Health Outcomes Framework 2013-2016* likewise makes a clear link between loneliness and poor mental and physical health (Department of Health, 2012).

Healthy Lives, Healthy People (the strategy for public health in England) acknowledges that approximately 10% of older people experience chronic loneliness, with higher percentages in deprived areas, with the commitment to addressing this framed in the following terms: *'local*

government and central government will work in partnership with businesses, voluntary groups and older people in creating opportunities to become active, remain socially connected, and play an active part in communities – avoiding social isolation and loneliness' (HM Government, 2010).

2.2   Republic of Ireland

ROI has had three over-arching strategies specifically for older people: *Care of the Aged* (1968); *The Years Ahead* (1988) and *The National Positive Ageing Strategy* (2014).

The Years Ahead cited research showing that loneliness was a problem among older people, especially those living alone and that clubs for older people were valuable in providing opportunities for socialisation, but that was its principal comment on loneliness.

The present ***National Positive Ageing Strategy***, in contrast, makes a number of references to ageing and loneliness. In the section *Changing mindsets to promote inclusion* the reference is as follows:

> *'Other older people may be financially vulnerable in their later years, or may be prone to social isolation and loneliness brought about by family circumstances or as a consequence of where they live'.*

In the section *Cultural and social participation* it highlights the health risks associated with loneliness:

> *'Research has found that the health risks associated with lower levels of social integration are comparable to those of smoking, high blood pressure and obesity. Research has further found that loneliness results in adverse mental and physical health conditions, increasing the risks of depression and cognitive decline. Engagement through activity can help to maintain quality of life, promote social contact, combat loneliness and isolation and maintain people as active members of society'.*

It also includes reference to the important role that access to transport plays:

> *'Being able to drive has been associated with higher levels of life satisfaction, better adjustment, less loneliness and better perceived control'.*

While recognising the issue the strategy does not identify any specific measures or commitments to address loneliness in older people.

Other relevant ROI policies and national reports include:

— The national **health policy**, *Healthy Ireland - a framework for improved health and well-being 2013-2025*, has a specific section on *Positive and healthy ageing* but no mention of the issue of loneliness among older people (Department of Health, 2013). In addition, there is no reference to the issue in the HSE *Primary care operational plan* (2014) or the HSE *National Service Plan* (2015).

— The Equality and Human Rights Commission examination of older people in long-term care also does not make reference to loneliness and ageing. It is also absent from the Irish Medical Organisation position paper on care of older people (Mangan, 2002; IMO, 2006).

— The **National Carers' Strategy** *Recognised, Supported, Empowered* (2012) and the *Irish National Dementia Strategy* (2014) both make reference to the isolation of older people who have dementia and older carers (Department of Health, 2012; Department of Health, 2014).

Local authorities have traditionally played a role in the development of services related to loneliness. The 1960s saw the establishment by local authority health services of day centres which were seen at the time to offer *'an escape from an otherwise lonely and tedious existence'* (Convery, 1987). A 2006 Society of St Vincent de Paul study (*op cit*) highlighted their value in providing companionship, services and activity for older people. They were complemented by the establishment of meals-on-wheels services which, whilst primarily concerned with nutrition, had an important secondary function of combating loneliness (Harvey, 2006).

Other services while not explicitly designed to combat loneliness may in practice fulfil such a role implicitly include public health nurses visiting or arranging visits to older people. Older people may also be assisted by the Social Inclusion and Activation Programme developed by Pobal. In recent years an initiative for age-friendly counties has developed, where local authorities take a pivotal role in developing a comprehensive range of responses to the needs of older people. Here, issues around loneliness featured in the pilot project in Co Louth and in strategies for other counties in the first wave, such as Kildare and Kilkenny, but cannot be said to be prominent (Netwell Centre, 2007; Ageing Well Network, 2007). This is matched in NI by the development of age-friendly communities, most prominently Belfast, Derry and Newry.

These examples illustrate the way in which services for older people have developed and have moved up the agenda of the health services and local authorities. Loneliness has been one of a number of many drivers of these developments, but we have little or no evidence as to the degree to which these initiatives have impacted on loneliness.

2.3   At an all-island and at European level

There is the potential for stronger cooperation between the governments of ROI and NI on social policy (Building Change Trust, 2013). Although the North-South Inter-Parliamentary Association made a review of policies for older people in Ireland, North and South in 2013 it did not address the issue of loneliness (North-South Inter-parliamentary Association, 2013).

Policies for health and ageing are primarily the responsibility of member states, but at European level the Commission Directorate General for Health and Food Safety has responsibility for older people. The Commission works through the European Innovation Partnership on Active and Healthy Ageing which has a *Strategic plan, Operational plan* and Communication *Taking forward the strategic implementation plan* (COM 2012/83). This plan contains only a brief mention that loneliness affects older people. The most recent examination of the situation of older people in the EU made only brief mention of loneliness (the two principal instances being in the Greek national report), so it cannot be seen as a prominent issue (European Commission, 2014). However, ageing and older people have been the subject of dedicated promotional programmes including in 1993 The Year of Older People and Solidarity between Generations (http://ec.europa.eu/employment_social/soc-prot/ageing/intro_en.htm) and 2012 was declared the Year for Active Ageing and Intergenerational Solidarity (http://ec.europa.eu/archives/ey2012/).

2.4   Voluntary and Community Sector influencing policy agenda

Sections 2.1 and 2.2 outlined the policies of the two governments to loneliness. Loneliness was a prominent driver of the development of voluntary organisations in ROI, the principal examples including ALONE, Friends of the Elderly and CareLocal. Across the island, it was also an important consideration in the role of the Society of St Vincent de Paul (*op cit*). In recent years, loneliness has become a more prominent issue in the voluntary and community sector in NI. Although loneliness was not cited in Age Concern NI's 2008 agenda for government the following year the UK-wide Age Concern organisations, including Age Concern NI highlighted loneliness as a key issue for older people, citing 11% of older people always feeling lonely, risk levels being higher in urban areas, over 80s and ethnic minorities (Age Concern NI, 2008). It made a recommendation that *'Local government must invest in programmes such as befriending schemes and peer-to-peer telephone clubs to provide support for isolated older people and prevent the need for care in the future'* (Harrop & Jopling, 2009). In Britain, the Big Lottery Fund allocated £20m to befriending projects, with £10m for the Silver Dreams Fund to pioneer ways of assisting older people, with the De Jong Gierveld loneliness scale suggested as an indicator for their impact.

Some actions which may have prompted the increasing prioritisation of loneliness and ageing as an issue by the non-governmental sector may include:

— The 2004 Joseph Rowntree Foundation *Building a good life* report identified loneliness as a significant problem among older people, one leading to frailty and depression. It found loneliness especially evident in sheltered accommodation, with lonely people very dependent on their care workers (Joseph Rowntree Foundation, 2004).

— The formation in 2011 of the Campaign to End Loneliness coalition by Age UK Oxfordshire, Counsel and Care, Independent Age and the Women's Royal Voluntary Service and their publication of *Safeguarding the Convoy* detailed a range of policies for government and managed to achieve media traction (Campaign to End Loneliness, 2011). This initiative was followed by others such as Friends of the Elderly (Friends of the Elderly, 2014).

— The Westminster All Party Parliamentary Group (APPG) on Housing and Care for Older People (HAPPI) highlighted the importance of sheltered housing design which was believed to reduce loneliness through the provision of spaces for companionship (Best, 2012).

— The establishment of Engage with Age in Belfast in 2010 with a specific focus on loneliness (Boyle, 2010). A report commissioned by Engage with Age (*op cit*) proposed:

Government policy and funding streams should recognise the value of innovation and 'thinking outside the box' in the field of preventing or overcoming loneliness, for example in social networking between older people themselves, self-help, as well as service provision, like befriending schemes. Recognition should be taken of the barriers experienced by older people in getting out and about. Consideration should be made in relation to the accessibility of public transport, more door to door transport and more buddying schemes.

There has been recognition across the non-governmental sector that loneliness among older people is a key health issue and an integral part of the suite of primary care, preventative health policies and services - indeed, not doing so is more costly for lonely older people will need more expensive care later (Scharf, 2014).

2.5   Conclusions

An examination of government responses to loneliness in ROI and NI shows that it is not yet seen as a policy priority within health policy or elsewhere. At best, loneliness has achieved sporadic mention as an issue but without specific accompanying policies. Initiatives where they exist to tackle and address loneliness among older people are funded under more general actions to support older people. It has no presence at an all-island level and little within European Union policy. To date most of the initiatives and programmes to tackle loneliness have been developed within the voluntary and community sector. On a more positive note, there are indications that there is increasing recognition of loneliness as a key health and social issue in the UK which is likely to have an impact on policy thinking and approaches in NI.

3 Approaches and practices

This chapter looks at examples of approaches in responding to loneliness both from within and outside the island of Ireland.

3.1 European Union

According to Age Platform Europe which brings together NGOs concerned with older people across Europe, loneliness and social isolation are among the most serious challenges facing older people, but *'so far, older people are not directly targeted by national social inclusion strategies in most EU countries'*. It also highlighted the issue in its manifesto for the 2014 European elections (European Age Platform http://www.age-platform.eu/age-work/age-policy-work/social-inclusion). Age Platform Europe has also pressed for the issue to be moved up the agenda of the European Union and those of the member states. There are few transnational comparisons of policies or services for older people across Europe either in general or focused on loneliness in particular. Very few services or examples are uniquely focused on loneliness making an analysis of loneliness outcomes difficult. Results, outcomes and their impact on loneliness are scarce, so we are obliged to look for initiatives, projects, services and best practice in which loneliness is an aspect or component. Even then, there is a general lack of evaluation and assessment. As a result, this chapter is able to give only indications, rather than proof, of what may constitute good practice, so the examples given here must be treated with caution.

As far back as 1993 the European Commission tried to create an inventory of good practice in services and projects working with lonely older people including Carcavelos Community Centre and the Support programme for the elderly in Almeirim (Portugal), the Greek Red Cross home help service (many locations); Antenne Andromede (Belgium) and the Senior Joint Housing Scheme (Denmark). The elements of these services included home care by volunteers (*e.g.* accompaniment, companionship, social events, self-help groups), professional home care services (information, medical care, nursing, physiotherapy, equipment, housework, shopping, meals, social work, psychological support) and the development of common services and facilities in social housing, including their design by older people themselves. More recent research has identified the most typical responses to loneliness as being points of contact in the neighbourhood, home visit programmes, shared housing communities and intergenerational housing concepts (Stula, 2012).

A 2014 study of best practice for social innovation for healthy ageing is available from a Belgian study of 20 initiatives across Europe (Kesselright, Smith, Dobner, Schrammel, 2014).[3] Tackling loneliness was an element of these approaches. The focus within the study was on inventory rather than analysis or evaluation so its value in informing good practice is difficult to extract. Other organisations that have attempted to provide Europe-wide interventions against loneliness include:

— **The Red Cross** provides a variety of visiting services and group activities (*e.g.* exercise) (http://www.redcross.org.uk/About-us/News/2009/January/A-friendly-lifeline-for-isolated-older-people).

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[3] The examples were Good gym (London, physical exercise); Kindred by choice (Salzgitter, Germany; new type of public space); Pari Solidaires (Paris, France; intergenerational living); Passion for life (Sweden, life cafés); Knitting social fabric (Rotterdam, Netherlands; social enterprise); Siel Blue (Ireland, exercise programmes); Kineage (Bilbao, Basque country; new technologies); and Silver thread (Rome, Italy; telephone service).

— **V2me** is a Europe-wide network for organisations working against loneliness among older people, which encourages older people to make contact with others and create friendship circles with the help of a virtual coach (http://www.aal-europe.eu/projects/v2me/). There is a similar programme in Italy run by the **Eldy Association** (http://www.eldy.eu/en/about-us/eldy-association/).

— The **Friendship Enrichment Programme** in the Netherlands has worked with older people to help them upskill their friendship-seeking skills (http://knowledgex.camh.net/policy_health/mhpromotion/mhp_older_adults/Pages/friendship.aspx).

Policies, programmes and projects to address loneliness have also been a feature of some national policies, notably the Netherlands and Germany, the two leaders of European policy and practice for older people (Acheson & Harvey, 2008). The following section explores some notable initiatives in European countries:

Germany

Research has found that loneliness affects 9% of older Germans. It is the country with the longest and most advanced set of initiatives to combat loneliness among older people, such as telephone befriending and crisis lines (*e.g.* Berliner Seniortelefon)(http://www.bagso.de/). Germany also imported the Eden alternative approach, an American concept developed in 2003 by Dr William H Thomas, designed to change the culture of nursing homes to 'small intentional communities' (generally 7-10 people) that provide private and informal communal living and personalised care, preventing loneliness from arising. Evaluations show improved social interaction, reduced depression and weight loss, improved domestic functioning, albeit no specific impacts in the area of loneliness. It won awards for design intervention (http://seniorenzentrum.goettingen.de/).

France

In France, the Mona Lisa organisation (*Mobilisation Nationale contre l'isolement des âgés* http://www.monalisa-asso.fr/) was specifically formed to combat loneliness among older people. Its working methods include contact, listening platforms, café seniors based in socio-cultural centres. It arose from an initiative by the Minister responsible for older people, Michèle Delaunay, who in 2012 convened a working group under the guidance of the Petits Frères de Pauvres [Little Brothers of the Poor] which led to the establishment of the Mona Lisa association of institutions and organisations concerned with loneliness among older people. It is funded by the national fund for solidarity and autonomy and combines a mixture of citizen volunteers (including young people in civic service) and public authorities. Procedures for evaluation were launched in January 2015, but are not yet available. The Petits Frères de Pauvres already has 10,300 volunteers in 200 teams helping lonely older people in difficulty, trying to reduce their isolation and ensure their access to services, rights and assistants, also providing 18 holiday homes (https://www.petitsfreresdespauvres.fr/).

Spain

A similar large-scale approach is evident in Spain in Catalonia's FATEC, a federation of 580 voluntary organisations providing senior citizen centres, retirement homes, community centres and others services to, *inter alia*, combat loneliness, reaching 345,000 older people (http://www.emil-network.eu/fatec-works-to-promote-greater-intergenerational-solidarity-in-spain/).

Portugal and UK

The Gulbenkian Foundation funded 18 projects in Portugal and Britain to address isolation and loneliness. They covered such areas as digital exclusion, intergenerational activities, befriending and village design (http://www.gulbenkian.org.uk/). The scoping phase of the programme found that loneliness was one of the key overlooked contemporary issues that affected older people, 10% of them, with a negative impact on physical and mental health.

Switzerland

In Switzerland, the theme of getting older people out of their home was evident in the *Autour d'une table* initiative, set up by the Institution Genevoise de Maintien à Domicile with community action bodies (http://www.imad-ge.ch/fr/index.php). It followed a study by the Health and Social Action Department of Geneva which found that meals-on-wheels tended to contribute to isolation and reduce self-care. This initiative, run in cooperation with local restaurants, involved volunteers bringing older people to weekly lunches out as an alternative (Ville Geneve, 2014).

Denmark

In Denmark specific initiatives to combat loneliness have been put in place in various locations for the immigrant community and older men. DaneAge, the national voluntary organisation concerned with older people in Denmark, set up a multi-lingual coffee shop for older immigrants who were believed to be especially vulnerable to loneliness (http://www.aeldresagen.dk/om-os/in-english/sider/default.aspx). DaneAge has also run a pilot project to combat loneliness among older men, with eight volunteers leading activities such as cooking and dinner clubs, textile craft shops, blacksmithing, wood shop, computer workshops, swimming, fitness and motor-cycle training for 140 men aged 60-85 (Ældre Sagen, 2007).

Belgium

The Maison Bioba Huis in Brussels, Belgium is a multicultural centre which includes a service for lonely older people (http://www.maisonbilobahuis.be/).

3.2   Northern Ireland

Several voluntary organisations in NI have developed specific services to address loneliness among older people. Older people's clubs were funded by the Community Relations Council from the 1970s. Voluntary services in NI focus on befriending services with quite a number of *Morning call* - type local telephone services (*e.g.* Magherafelt, Dungannon) some being funded though Health and Social Care Trusts. More recently, a model much more focused on social activities for older people has emerged.

Some of the voluntary and community initiatives are explored below:

Engage with Age was founded in response to loneliness among older people in Castlereagh and adjacent areas of south and east Belfast in 2010 (Boyle, 2010). Engage with Age bases its work on a distinctive model based on the positive objective of social wellbeing. Rather than setting down the negative objective of averting loneliness, it sets a positive one of social wellbeing. Its approach is to proactively identify those individuals who might be most isolated or engage individually initially with each individual linking them to whatever community activity or support that might most suit them (http://engagewithage.org.uk/). Its HOPE (Hubs for Older People's Engagement) project approaches loneliness through increasing people's confidence to participate in community activities, providing a range of meaningful activities identified by older people themselves (*e.g.* dance, music, outings, quizzes, art and craft, healthy eating, social media, lifelong learning, health and wellbeing, cinema, sailing, barbeques, visits, furniture restoration). So far HOPE has established six 'hubs' in Belfast (north, south, east, west Belfast, Shankill and Castlereagh) with over 200 older people and 22 volunteers (HOPE, 2013). The principal beneficiaries have been older people living in their own home (more than those in sheltered housing), with strong demand coming from older men. Although HOPE includes an individual befriending element, the thrust of the project is to encourage older people to get out and join social activities with others. HOPE has been evaluated and the STAR subjective, self-assessment tool indicated an improvement, over three months, of 1.0 (out of ten, or 10%) with gains in social connections reported by focus groups (Engage with Age, 2014)[4].

Other projects in NI have found new ways of addressing loneliness and social connectedness, although the issue of loneliness may be implicit rather than explicit. **The CLARE (Creative Local Action Response and Engagement)** pilot service set up by Mount Vernon Community Development Forum, Belfast reaches out to vulnerable older people, encouraging them to assess their own needs and then ensure that they get the services that they need (http://clare-cic.org/;O'Hara, 2015). Its approach was facilitated by a change in social care from 2012 in which clients could help decide on what services this package should be spent (*e.g.* meals on wheels, volunteer visitors). **The Later Years Working Together Subgroup of the Western Local Commissioning Group** is a local initiative targeting isolated older people in their area. The project, which was piloted in 2014, involved targeting and visiting about 500 older people. As a result, individual action plans were developed with the older person, the purpose of which was to connect them to the various local public and community services and activities open to them.

Me Unlimited is a social economy initiative commissioned by the PHA to provide tailored personal development programmes to support older carers, including older carers of people with dementia and isolated older male carers (http://meunltd.org/). Other initiatives which target social isolation (and loneliness) in the wider community and which include older people include Men's Sheds (CARDI, 2014).

3.3   Republic of Ireland

Statutory, voluntary and community organisations have provided services for older people containing elements relating to loneliness for many years at national and local levels. The first examination of them was by the Economic and Social Research Institute (ESRI) which made the striking finding that the proportion of older people actually reached by services for them - such

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[4] STAR (Self Assessment Tool and Report) is a tool on a range 0 to 10 that measures staying well, keeping in touch, feeling positive, being treated with dignity, looking after yourself, feeling safe and managing money.

as home assistance, meals-on-wheels, laundry, social workers and home help - was very small about 2% (Whelan & Vaughan, 1984).

The National Council for Ageing and Older People later identified six types of intervention that might combat loneliness: group activities (*e.g.* active retirement); visiting and befriending; day and social centres; initiatives to enable older people to stay in their own homes (*e.g.* home help, home care, meals-on-wheels); interventions to provide alternative, suitable accommodation (*e.g.* sheltered housing); and rural transport; with the riders that such services be planned, coordinated, consistent and involve older people themselves (Treacy *et al.*, (2005).

As is the case in NI, several voluntary organisations in ROI have specifically addressed the issue of loneliness including:

ALONE describes itself as a service for older people who are 'lonely and would like someone to visit them on a regular basis'. The specific aim of its befriending service is 'to provide older people with a weekly visit that may bring a whole new quality to their life ultimately decreasing the likelihood of loneliness for that person' and to alleviate loneliness and isolation for older people through visits (http://alone.ie/). Other organisations providing services befriending for lonely older people nationally are the **Society of St Vincent de Paul and Friends of the Elderly**.

At a local level initiatives include **Galway Connect; Carers Association**, Newbridge Co Kildare; **Droichead na Daoine**, Sneem, Co Kerry; **Making Connections**, Clonkseagh, Dublin**; Durrow Befriending Group**; and telephone services **Third Age Senior Helpline, Good Morning South Tipperary, Good Morning Claremorris, Leitrim Calling, Good Morning Donegal**; Northside **Family Resource Centre** Ballynanty, Co. Limerick; **Good Morning Drogheda; Friendly Call Longford and Care Call** (Crosscare, Dublin).

Other organisations may, albeit indirectly, play an important role in preventing loneliness or enabling a recovery from loneliness after retirement, widowhood or bereavement including **Active Retirement Ireland**, the **Age and Opportunity** *Ageing with confidence* **programme** and the **GAA Social Initiative** (Harvey, 2011, 2014).

In 2014 a study entitled *Only the Lonely* was carried out for **Age Friendly Ireland** by Professor Brian Lawlor, Trinity College Dublin. It was a randomised study of volunteer visiting services for older people. Lawlor *et al.*, examined an unspecified, unidentified volunteer visiting programme by older volunteers for older people experiencing loneliness (scoring 3 or more out of 5 on the De Jong Gierveld scale) comparing it with a control group. There were a hundred participants, the criteria being that they be over 60, community dwelling and have no significant memory problems (three controls and nine intervention participants dropped out due to illness and death). There was a definable reduction in loneliness after three months in the programme and he concluded that such a volunteer-based intervention was a promising, low-cost intervention. The programme was successful in prompting some older people to join local clubs and even more successful in establishing a social connection with the older person (Lawlor, 2014).

The **CONNECT** (Community Operated Network for the Elderly of Castlemaine Town) project was set up by the Maine Valley Family Centre, Castlemaine, Kerry to alleviate loneliness among older people. The project provided 15 volunteers to bring 1hr weekly visits to 30 older people, assisted by a part-time coordinator. Older people interviewed welcomed the volunteer visits, especially

the conversation, but the evaluation was inconclusive as to whether loneliness had been alleviated or not, partly because of client awkwardness with the term 'lonely' (Quirke, 2012).

The **Cúltaca** project developed by the Netwell Centre in Dundalk, Louth was a volunteer visiting service also designed to encourage older people to design their own service needs. It was based on the *Omtinker* service developed in the Netherlands, which reversed the traditional model whereby the health service designed its response to the older person (supply-led) to one in which the older person defined his or her own needs (demand-led). Like Engage with Age, it encouraged them out of the home into men's groups, women's groups and other social activities. Many of those assisted were isolated, lonely, hard-to-reach older people living on their own. The evaluation was not specifically focused on loneliness but recorded significant gains in improved mood, physical activity and new circles of friends (Harvey, 2013).

3.4   Effective models and their application

Although programmes, projects and even entire organisations have been developed to combat loneliness, information on models or their effectiveness is scarce, we lack information on their effectiveness, which is an important issue. As the Campaign to End Loneliness noted 'because of the importance of loneliness as a problem for older people, a range of services to combat loneliness have been developed, but few have shown that they actually achieve this aim' (Campaign of End Loneliness, 2013, *Research Bulletin* 6). Several analysts have devoted attention to trying to assess the outcomes of these approaches to loneliness. A notable study by Cattan & White *Developing evidence-based health promotion for older people - a systematic review and survey of health promotion interventions targeting social isolation and loneliness among older people* examined intervention strategies concentrating on loneliness.

The study examined 680 interventions to combat loneliness from the period 1970-2002 including home visiting, one-to-one and group activities. The most common services examined were, in descending order, social activities, befriending, social support and companionship, low-cost meals, drop-in cafés, lunch clubs, advice and information and physical activity or exercise. Some also included outreach services. Only 4% (30) of the interventions had been evaluated with the United States accounting for half, half being randomised control trials (Cattan & White, 1998). The researchers noted that one-to-one support was very common, despite the lack of published evidence to demonstrate its value. Lay people and practitioners considered many interventions effective, despite the absence of evidence. Many evaluations were short-term, focused on one-to-one services, while some forms of intervention had never been evaluated at all (*e.g.* drop-in, transport, physical activity groups). Interventions focused on individual change, not on policy or service interventions.

The study found that while some group interventions were effective 'the majority of one-to-one interventions (including those concerning services) were unable to demonstrate a significant effect in reducing social isolation and loneliness'. The authors recommended that 'programmes that enable older people to be involved in planning, developing and delivering activities are most likely to be effective'. Their conclusions were that effective interventions to combat loneliness had the following characteristics: they should be targeted, both for those lonely and specific groups therein (*e.g.* women, widows); long-term (possibly built on short-term pilots); multi-faceted, using several methods (most projects ran several activities); have an element of participant control; and involve group activities (Cattan *et al.*, 2005; Qualter *et al.*, 2015; Zebhauser *et al.*, 2015).

According to Findlay (2003), the few studies that have been done were flawed by weak methodologies and future programmes aimed at reducing social isolation should have evaluation built into them at inception (Findlay, 2003). One problem here is that we have little in the way of the informed view of older people as to what *they* themselves consider effective in tackling loneliness. Older people can be reluctant to admit being lonely in the first place and when they do they tend to suggest a number of different elements of a service that might address loneliness, such as 'someone to talk to', visitors, clubs and day centres. Other services recommended were social groups (*e.g.* walking groups), cafés and befriending services (with some practical assistance) as well as accessible transport (Kane & Cook, 2013).

UK think tank Demos looked at what makes for effective interventions under the heading *What works in tackling loneliness?* It found that the evidence base is currently under-developed; many interventions have not received a robust evaluation to measure their impact in reducing loneliness; and among those that have been evaluated, many interventions have failed to demonstrate a quantifiable impact. Demos notes that interventions break into three: home visiting and one-to-one interventions; structured group interventions (*e.g.* exercise); and community-based participation, with rising levels of effectiveness (Bazalgette, Cheethan & Grist, 2012).

Turning to specific forms of intervention Age Research Knowledge (NI) (ARK) carried out an assessment of one-to-one befriending programmes (Devine, 2014). These were one of the most common, popular forms of intervention with older people, generally undertaken on a one-to-one basis, normally face-to-face but also at a distance (phone, e-mail), either as a stand-alone service or part of a package. Such services were found to be effective in reducing loneliness and depression but did not address root causes of disadvantage and were less effective than group activities. They may work best if combined with social activities, assistance into other services, advocacy, phone support, combining volunteer and professional support. Similar evaluation in the Netherlands of the *Loneliness* and *In good company* projects found their impact in reducing loneliness to be limited (Strümpel, Charlotte & Billings, Jenny (eds), 2008). Some lateral thinking was also evident in the provision of animal-assisted therapy (the visitor normally being a dog) and even robot befrienders. However, specific information on these outcomes was not found for this research. In Gateshead, England, the HENPOWER project introduced hen-keeping to older people in residential care homes as a means of improving their wellbeing (Cook *et al.*, 2013). Although a small project, it was evaluated, the outcome showing an improvement in social interaction, but little impact on loneliness.

Befriending services counter that they are effective when run to high standards with consistency, quality, training, vetting, evaluation and accountability. Volunteer befriending services require skill, good practice guidelines, resources, networking, evaluation, all of which require professional investment (Befriending Networks, 2014). Looking at new technologies a report carried out for Friends of the Elderly (UK) *The Future of Loneliness (2014)* spoke of the '*huge potential*' of technology to make a positive impact on loneliness, notably internet, mobile phone, smart phones, social media, though it acknowledged that '*no single strategy for reducing loneliness could possibly work for everyone*'(http://www.fote.org.uk/wp-content/uploads/2014/07/2014_03-FOTE-Future-of-loneliness-Report-low-res-without-crops.pdf). There is some evidence that new and remote technologies may facilitate greater social contact (telephone befriending, internet, e-mail, mobile phone, Skype) (Kaspar, 2004). However, these new approaches remain in their infancy and as yet are unevaluated.

3.5   Conclusions

A review of good practice in relation to tackling loneliness among older people reveals that there is a lack of a strong comparative, analytical or evidence base for approaches currently being used. Inventorying approaches is easier than determining their effectiveness. Cattan *et al.,* found that the level of evaluation was extraordinarily low (4%). Whilst a multiplicity of services to meet the needs of the lonely older people might, intuitively, be desirable, they raised serious questions about the value of befriending services, which they contend is unproven. The value of befriending services is probably the principal point of contention in this research and those providing them have made a strong defence for them. Recent research points to better targeting of interventions as well as recommending a long-term; multi-faceted approach involving group activities and informed by older people themselves. In summary, a stronger evidence base is required for loneliness interventions in order to assess effectiveness and to help explore new approaches to tackling the issue.

4 Conclusions and recommendations

This final chapter first outlines how one might develop a response to loneliness. The conclusions of the research are then summarised before recommendations are made.

4.1 Developing a response

4.1.1 Policy

There has been little analysis of policies (as distinct from services) to combat loneliness in ROI and NI. In the UK, the Campaign to End Loneliness is a marked exception. Its study *Safeguarding the Convoy* made such an analysis and was unambiguous in outlining what it considered to be the respective responsibilities of national government (e.g. pension levels, housing adaptation); local government; health services (e.g. public spaces, preventative services); and voluntary and community organisations e.g. campaigning, appropriate services) (http://www.campaigntoendloneliness.org/wp-content/uploads/downloads/2011/11/Safeguarding-the-convey.-A-call-to-action-from-the-Campaign-to-End-Loneliness.pdf).

This delineation of responsibility highlights an important, unresolved and rarely discussed issue about the respective responsibilities of individuals, the voluntary and community sector and the state in relation to loneliness. In general initiatives against loneliness have come from the voluntary and community sector. It has also has played a significant role in promoting loneliness as a policy issue. One interviewee for this project noted: *'It's not the role of government on its own to "solve" loneliness or to be held responsible if an individual is ever lonely. We all have responsibilities at personal, individual, familial and local level. But it is the responsibility of government to put policies and funding in place to ensure that initiatives to address loneliness are supported. And it is definitely the duty of the state not to take decisions that exacerbate loneliness, such as closing public services that are socially important for older people'*. The role of the state was, as shown in chapter 2, largely reactive compared to proactive initiatives by the voluntary and community sector.

An important role of this review was to identify what approaches to loneliness were held in common and what were different in the two parts of the island. Loneliness was not identified as a significant feature of or priority in health and social service policies of either jurisdiction, achieving little more than 'also mentioned' status in NI's *Active Ageing Strategy 2014-2020 Consultation document* and ROI's *National Positive Ageing Strategy*. Loneliness was mentioned in the PHA (NI) plan but no mention was made in the HSE plan (RoI). It is likely, though, that loneliness will remain an issue within the orbit of the respective departments of health and their executive agencies for some time, especially their primary and continuing care functions and that this will be its policy home. Provided that these departments and their agencies take a broad, social approach to their role, this should not of itself inhibit the development of more prominent policies concerned with loneliness.

A first step in developing a response to address loneliness must be to see the issue obtain a more prominent place, status and priority in government policy, thinking and funding. As noted earlier, both jurisdictions provide health and related social services that, *inter alia*, implicitly respond to loneliness, but combating loneliness is generally not a defined objective, so their capacity to impact on loneliness cannot be extracted. Loneliness must be a defined, stated, explicit, measured priority within health and social services with both governments charging their health service delivery bodies (Health and Social Care Trusts in NI, HSE in the ROI) to make

community support for older people who are lonely or at risk of loneliness a priority. There is a good case to be made for specific funding strands to be made available by health services for voluntary and community organisations to provide measures and services that specifically respond to loneliness. Likewise, the research showed how related areas of policy including transport, especially in rural areas must be aligned with measures to tackle loneliness.

The National Council for Ageing and Older People identified what it considered to be key *desiderata* in a framework to respond to loneliness (Treacy *et el, op cit*). These included income support (pension and ancillary schemes); support of voluntary services designed to break loneliness (*e.g.* help lines, volunteer befriending services); and specific health services (falls prevention, mental health strategies). Transport was also identified as a key public dimension in the response to loneliness ('people who have no access to transport report significantly higher levels of loneliness'), vital in facilitating social contact and was specifically cited as one area where government could do most to make a difference. In the Council report, older people themselves identified the key elements in combating loneliness as the continued visiting and caring of family and friends; and participation in social activities, ranging from church to hobbies or personal interests, although this may overlook the problem of lonely older people without family or friends.

4.1.2 At a practical intervention level

The lack of evidence on the effectiveness of different interventions to prevent or tackle loneliness among older people was the key finding of this research. The Campaign to End Loneliness in the UK reported 'a growing gap between the understanding of what constitutes a 'loneliness intervention' demonstrated in the academic literature and those delivering interventions' (Jopling, 2015, p8). Services continue to be provided and funded in the name of combating loneliness with no certainty that they are actually successful. Practitioners continue to focus on befriending schemes while ancillary services like meals-on-wheels are also considered to have an important secondary function in addressing loneliness. Befriending services have the advantage of low cost, practicality; media appeal and offer a clearly defined role for volunteers. However, their value as a means of combating loneliness has with some exceptions (*e.g.* Lawlor) been difficult to prove. In contrast, community-based activities have been found to have more positive outcomes in addressing loneliness but are often more costly and complicated to establish.

The more sophisticated of the befriending services emphasise the importance of their outreach role, connections to other services, their professionalism and evaluation. In France, befriending is only one part of a broader spectrum of Mona Lisa's services, which include service-based activities and listening platforms. In Denmark, DaneAge's response to loneliness involves a multiplicity of activities. In ROI, Cúltaca provides an example of how befriending can be successfully combined with group and community-based activities.

It is clear that loneliness requires a variety of interventions at a range of levels – individual, familial, social, community, state, voluntary – and these will all work differently depending on the circumstances of the individual concerned. In NI and Britain, Cattan suggested that the most effective interventions were those that were targeted and included older people as active participants in determining the services they should receive and thereby enhance their self-esteem and personal control. Evidence was less clear as to the effectiveness of one-to-one interventions such as befriending services, volunteering or telephone advice. As in ROI, transport was also an issue, with routing, timetabling or its absence a major contributor to isolation,

especially for older women (Cattan, 2010). It is apparent that some voluntary organisations have followed the principles of evidence-based research to heart. For example, in NI, Engage with Age has focused on services that get older people out-and-about and into social settings, rather than befriending. However, in ROI and NI many voluntary organisations still see befriending services as their principal point of appeal for volunteers, funding and public support[5].

Further afield there are also some interesting examples of funders developing purpose-built programmes to carry out experimental actions to test new means of combating loneliness: the Big Lottery Fund in Britain; the Gulbenkian Foundation in Portugal and Britain. Even without such programmes, it is evident that experiments have taken place, ranging from those that use the architecture of residential homes to address loneliness (Eden, Germany), to friendship-building skills (Netherlands), or online programmes (V2me).

Finally the framework for understanding loneliness interventions developed by the Campaign to End Loneliness provides an example of four different dimensions to tackling loneliness as follows:

Foundation Services for the individual, focused on:

— Identifying lonely individuals;

— Understanding the nature of the individual's loneliness and identifying how it might be tackled;

— Supporting these individuals to access the services they need.

— **Structural Enablers**, supporting the development of new structures within the community, including work at a very local or neighbourhood level, asset-based community development, positive ageing initiatives and volunteering, supported by an ethos of social inclusion and anti-discrimination.

— **Direct Interventions**: services that support and maintain existing relationships, services that foster new connections and services that help people change their thinking about their social connections.

— **Gateway services** like transport and technology, key to sustaining, re-establishing and improving the quality of relationships, existing and new.

See Figure 3 for details of how these different dimensions relate to one another.

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[5] For example, see Friends of the Elderly advertisement, *Irish Times*, 1st July 2015, back page.

Figure 3 **Campaign to End Loneliness 2015 Framework for understanding loneliness Interventions (p11)**
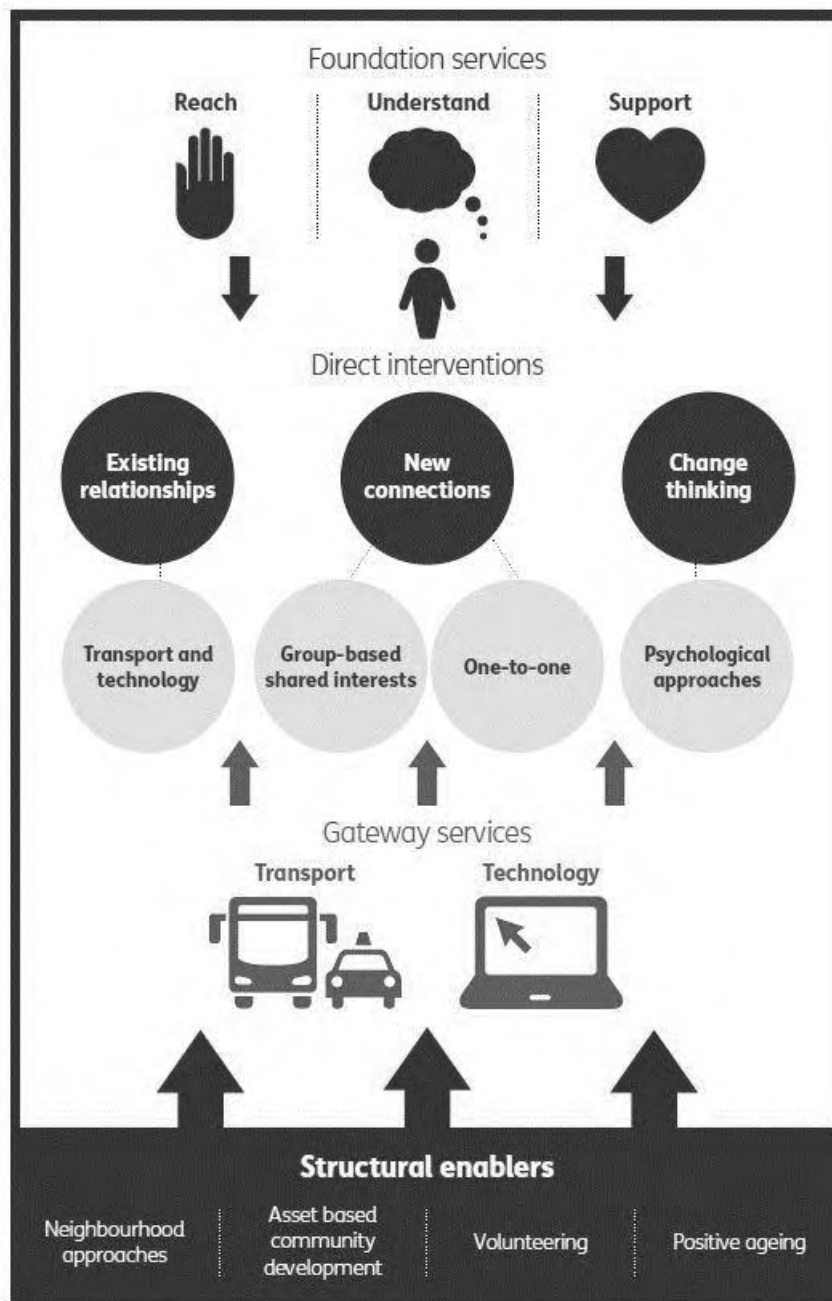
Source: Jopling, Kate: *Promising Approaches to reducing loneliness and isolation in later life.* Age UK and the Campaign to End Loneliness, (2015)

Possible gaps within this framework include the lack of consideration given to the role of income and income support in relation to loneliness and the importance of access to a range of health and social services that enable older people to live as full a life as possible and the need for measures to prevent loneliness from arising in the first place.

The lack of good evidence on the impact of different types of services on loneliness is a key challenge, with various tools available for use. The recent Campaign for Loneliness guidance on *Measuring Impact on Loneliness in Later Life* is welcome (Campaign to End Loneliness, 2015). The

guidance offers practical information and advice in choosing and using a scale to measure the impact of a service on loneliness in older age. The campaign is also encouraging services that use the various scales to share their experience and learning arising from their application. Again, it is essential that evaluations are conscious of not only measuring the outcomes of those who participate in programmes, but those who do not and take into account those who are unable, either because of social, health or geographic regions to do so but who remain lonely.

4.2   Conclusions

The concepts of loneliness and social isolation are often used interchangeably however they are distinct concepts. There is a well-established consensus as to the nature, extent, characteristics and risk factors in loneliness. Generally, chronic or severe loneliness affects about 10% of the older population but there are variations between states and welfare systems. Over the life course, loneliness affects teens and early twenties more, is least for the period of working age and is most evident from age 75 onward. The relationship between age and loneliness can be overstated as it is more likely a function of particular events (*e.g.* bereavement). Loneliness can be temporal (a function of time of day and season), dynamic (as people adapt to changed circumstances) and may be related to place (*e.g.* rurality). There is no evidence that the proportion of older people who are lonely is growing.

Some older people appear more vulnerable to loneliness than others (*e.g.* the oldest old, those with poor health or limiting disability and those who have had fewer life opportunities). Some writers have focused on the social gradient of loneliness and on such issues as low incomes (*e.g.* Scharf 2002, 2005) but connections between levels of loneliness and welfare systems remain little explored.

There is a gap between interventions being delivered and the evidence that supports them and their outcomes. Cattan *et al.*,(2005) drew attention to the low level of evaluation (4%) of interventions to combat loneliness. Examination of services in ROI, NI, UK and in other European countries suggests that a multiplicity of services is the best response. Cattan *et al.*,(2005) outlines the *desiderata* of services to combat loneliness, such as targeting; duration (long-term); method (multiple, with group activities); ethos (participant-controlled or influenced).

Although loneliness as an issue is attracting increased attention especially in the non-government sector, loneliness is not a priority issue within health policy or other related fields in either NI or ROI. However, this research showed that policy change is likely to be influenced from the activities of voluntary and community organisations for example the UK Campaign to End Loneliness, or in the Netherlands Coalitie Erbij (a campaign coalition of NGOS).

4.3   Recommendations

1.   **Develop and foster a better understanding of the concept of loneliness**

While social isolation, social inclusion and loneliness are related and often used interchangeably they are distinct concepts. Loneliness involves both a psychological state and a subjective experience (*i.e.* a negative emotion associated with a gap between the quality and quantity of relationships an individual has and wants). Tackling loneliness and particularly chronic loneliness requires a complex response based on an understanding of the various (affective, cognitive and subjective) components of loneliness.

2.   **Identify chronic loneliness as a social health priority**

While loneliness is both a social and a wider (social) health issue, the absence of an adequately resourced social inclusion policy framework means that for pragmatic reasons loneliness needs to be identified as a prominent and clearly defined priority and field of work within the wider health policy arena.

3.   **Ensure that loneliness interventions are based on evidence**

Those designing services to combat loneliness need to carefully consider the evidence base of what is known to work. There is evidence to suggest that services designed to tackle chronic loneliness work best where they use a multiplicity of methods and approaches (communal socialisation is generally just one of a number of approaches used). These services also need to be designed in such a way that they can accommodate individuals who may otherwise be unable, for health, social or geographic reasons, to take advantage of them.

4.   **Establish services and initiatives to tackle chronic loneliness**

Chronic loneliness is linked to a wide range of mental and physical health and quality of life outcomes. Therefore it may be argued that there is a need for services/initiatives both to tackle chronic loneliness and to identify and support individuals at risk of chronic loneliness. These services and initiatives need to involve both statutory bodies and voluntary and community organisations and appropriate resources.

5.   **Support the development of a strong evaluation culture**

Evaluation needs to be included as a core element of all of projects, services initiatives funded to tackle loneliness. Supporting the development of an evaluation culture and evaluation expertise among and between statutory and voluntary organisations would be an important initiative in this context. Over time this could be extended to ensure information, news and examples of good practice are circulated widely on both parts of the island.

Conclusion

Loneliness among older people is a complex and frequently misunderstood issue. However, there is growing evidence that its negative impacts on mental and physical wellbeing mean that it should be a prioritised by policymakers. This research has found that there is a need to clearly define loneliness and to align it appropriately with policy areas including health and social care. The research also indicates the need to properly assess and identify at risk groups within the

older populations as well as the need to design evidenced interventions that are based on best practice. The role of older people themselves in informing services and interventions to combat loneliness is also an area requiring attention as is proper evaluation of services and initiatives funded.

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