

Research Article

Interventions Aimed at Alleviating Loneliness and Social Isolation among the Older Population: Perspectives of Service Providers

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Background. Older people are one of the groups particularly vulnerable to loneliness due to factors such as deteriorating health, widowhood and death of friends/family, fewer confiding relationships, and being more likely to live alone. In the United Kingdom, services to alleviate and/or prevent loneliness can be classified as foundation services, direct interventions, gateway services, and structural enablers. Service managers and personnel involved in the delivery of interventions for older people are well-positioned to report on the mechanisms that contribute to the effectiveness of interventions. This study aimed to elicit from the perspective of a range of service providers, the barriers and facilitators of successful service provision, and the reduction of loneliness among older people. **Methods.** Semistructured interviews were conducted with 23 service managers of services providing an intervention to older people in Northern Ireland. Services were eligible for inclusion if they reported a goal of preventing or reducing loneliness and/or social isolation among older people. Transcripts were analysed using thematic analysis. **Results.** Eight themes were produced representing barriers or facilitators of successful service delivery, including characteristics of the service (person-centred approach, empowerment of service users and staff/volunteers, personal qualities of staff and volunteers, and funding for service provision) and characteristics of the wider community where services were located (hard to identify and/or reach lonely people; education and awareness of services; family and community structures; and accessible, affordable, and safe public transport). **Conclusion.** Developments in this area should prioritise integrated, systemic solutions that harness capacity and partnership working within communities, grounded in the principles of empowerment, inclusion, self-determination, and collective action.

1. Introduction

Older people are one of the groups at increased risk of experiencing loneliness because of health-related and social factors associated with older age including deteriorating physical health and disability, death of family and friends, loss of confiding relationships, and being more likely to live alone [1, 2].

Although the terms are sometimes conflated, loneliness and social isolation are not highly correlated [3]. Social isolation is an objective concept referring to the absence of relationships, contacts, or ties with other people [4], whereas loneliness is a negative feeling that occurs due to the gap between desired and actual quality of relationships or social

contacts [5]. Loneliness and social isolation are both associated with increased mortality [6, 7] and morbidity [8, 9], including symptoms of depression and anxiety [10].

Systematic reviews have reported very little high-quality research into the effectiveness of interventions to alleviate loneliness in later life [11–14]. Despite this, there is sustained investment in interventions for loneliness, and an expanding workforce of paid and unpaid personnel who support and deliver such services [15]. In the United Kingdom (UK), services to alleviate or prevent loneliness are provided by both the statutory, and community and voluntary sectors. These services can be categorized using the Campaign to End Loneliness (CTEL) framework [15, 16] as follows: (1)

services to reach, identify, and support older people (foundation services), e.g., social prescribing initiatives; (2) services to enable individuals to build connections whilst addressing their practical and psychological needs (direct interventions), e.g., befriending services; (3) services providing transport and technology to promote access to other services (gateway services); and (4) neighbourhood-level responses which help to improve and harness the community's own capacity to combat loneliness (structural enablers). Service personnel such as managers are likely to provide well-informed evidence about the mechanisms that contribute to the effectiveness of interventions to reduce loneliness [17], yet there is little research representing the voices of this group (e.g., [18, 19]).

This study aimed to elicit, from the perspective of service providers, the barriers and facilitators of successful provision of services, and the reduction of loneliness among older people.

2. Materials and Methods

2.1. Design. The study reported here was part of a larger realist evaluation of loneliness services [18]. This paper reports the findings of a qualitative exploration, using semistructured interviews, of the barriers and facilitators associated with the successful provision of services and the reduction of loneliness among older people. Data collected using the TIDieR (Template for Intervention Description and Replication) checklist [20] is also presented to describe the services that participated. The TIDieR was developed to provide a standardised framework for describing interventions in order to ensure a consistent approach to intervention delivery [20, 21].

2.2. Eligibility Criteria. Services were eligible for recruitment if they satisfied the following criteria:

- (1) The service is currently providing an intervention(s) to older people in Northern Ireland. There was no specific age range applied, as these vary considerably [22]. It was only necessary that the service described themselves as supporting “older people.”
- (2) The service has a primary or secondary goal of preventing or reducing loneliness and/or social isolation among older people.

2.3. Identification and Recruitment of Eligible Services. A range of methods was used to identify eligible services, including Internet trawls, contacting key stakeholders known to the research team, and snowball sampling. Subsequently, from this list, services were purposively selected in order to maximise variation in the following (publicly available) service characteristics: type of service as defined by the Campaign to End Loneliness framework [16] including foundation services, direct interventions, gateway services, and structural enablers; geographic catchment area (rural and urban); characteristics of service users targeted by the service (e.g., physical and psychological health problems); and mode of delivery of the intervention (in-person versus remote). Contact was made with

the manager of the identified services to explain the purpose of the study and to agree their participation. The manager identified a key informant who was knowledgeable about service characteristics and delivery. All interviewees provided informed consent to participate in the study. The study was approved by (IRB name, ref 19.23).

2.4. Data Collection and Analysis. Feedback and sense-checking of the interview schedule were provided by one service manager, and modifications were made as a result of this pilot interview. The interview schedule included three main open-ended questions (with various prompts) as follows:

- (1) In your experience of delivering services, what are the key factors that you think contribute to the success/effectiveness of your service?
- (2) From your experience, what do you think needs to be done to prevent loneliness in your area?
- (3) What are the barriers to preventing loneliness?

Interviews were conducted by the first author at the workplace of the participants. Interviews were audio-recorded, and the data were subsequently transcribed and analysed using thematic analysis [23]. First, both authors read and familiarized themselves with the interview transcripts. Then, the first author generated codes within the data, and these were discussed with the second author and refined. The first author subsequently compared, contrasted, and combined codes to produce themes, which were subsequently reviewed with the second author to produce theme names and to select illustrative quotations.

In total, 27 services were recruited for the study. However, only 23 services were able to provide a representative to participate in an interview (22 in-person and one via telephone), and four services provided written responses. The data from these four services were excluded from the analysis presented here. Table 1 uses data gathered using the TIDieR to describe characteristics of the services included in the study. All key informants held a role within the service of manager or coordinator. Direct interventions ($n = 17$) included “good morning” services, befriending schemes, lunch clubs, activity groups, social groups, and other types of forums. Structural enablers ($n = 3$) included community arts or well-being programs and festivals. Both foundation services ($n = 2$) were social prescribing services. The gateway service ($n = 1$) was a driving scheme to support older people's mobility within their community.

3. Results

Thematic analysis produced eight themes that were identified as barriers or facilitators to the successful delivery of services and the reduction of loneliness among older people. These were categorized under 2 broad domains, each with 4 sub-themes. The first domain represented characteristics of the services: person-centred services; empowerment of service users and staff/volunteers; personal qualities of staff and volunteers; and provision of funding. The second domain

TABLE 1: Characteristics of services that participated in the study.

Type of service	
Direct intervention	73.9% (<i>n</i> = 17)
Structural enabler	13.0% (<i>n</i> = 3)
Foundation service	8.7% (<i>n</i> = 2)
Gateway service	4.3% (<i>n</i> = 1)
Location of service delivery	
Local within Northern Ireland	52.2% (<i>n</i> = 12)
Multiple locations across Northern Ireland	43.5% (<i>n</i> = 10)
UK wide	4.3% (<i>n</i> = 1)
Service personnel	
Paid staff only	47.8% (<i>n</i> = 11)
Volunteers only	17.4% (<i>n</i> = 4)
Mixture of paid staff and volunteers	34.8% (<i>n</i> = 8)
Number of service users supported	
1–50 service users	21.7% (<i>n</i> = 5)
51–100 service users	34.8% (<i>n</i> = 8)
101+ service users	43.5% (<i>n</i> = 10)
Eligibility criteria for participation in service*	
Age	100% (<i>n</i> = 23)
Gender	30.4% (<i>n</i> = 7)
Health (physical or psychological)	47.8% (<i>n</i> = 11)
Home/community environment	39.1% (<i>n</i> = 9)
Geographical location	60.9% (<i>n</i> = 14)
Goals of the service*	
Reduction/alleviation of loneliness or social isolation	100% (<i>n</i> = 23)
Improvement of client well-being	60.9% (<i>n</i> = 14)
Facilitate community integration	56.5% (<i>n</i> = 13)
Direct provision of companionship or friendship	13.0% (<i>n</i> = 3)
Promote independent living	8.7% (<i>n</i> = 2)
Provision of care and support for vulnerable older people	8.7% (<i>n</i> = 2)
Reduction of poverty	4.3% (<i>n</i> = 1)
Reduction of inequalities	4.3% (<i>n</i> = 1)
Opportunities for new interests or learning	4.3% (<i>n</i> = 1)
Improve social connectedness among volunteer befrienders	4.3% (<i>n</i> = 1)
Provision of opportunities for new interests or learning	4.3% (<i>n</i> = 1)

*Some services had several criteria or goals.

described contexts of the wider community/society within which services were located that interact with the provision of services to impact on the experience of loneliness among older people: hard to identify and/or reach lonely people; education and awareness of services; family and community structures; and accessible, affordable, and safe public transport.

3.1. Service Characteristics

3.1.1. Person-Centred Approach. The importance of implementing a person-centred approach was reported across service types. Responding to service users' needs in a holistic manner and tailoring the delivery of the service to suit their individual characteristics were thought to be circumstances that could influence the level of engagement from service users.

“Being able to help individuals to identify their needs, being able to understand the person. We focus on what the individuals want and what their goals are. . . Meeting the needs of the individuals as they have outlined to you contributes to the success of the service.” (Foundation service provider)

Some direct interventions, such as befriending services, involved a comprehensive and time-consuming process of matching a service user with a befriender according to a range of needs and preferences of both parties.

3.1.2. Empowerment of Service Users and Staff/Volunteers.

The autonomy afforded to staff and service users in the design and delivery of the service contributed to its effectiveness. This empowerment triggered motivational processes and improved enjoyment and sense of well-being.

“The project is directed by the participants which gives them a feeling of not being dictated to but being included in the whole process. This gives participants a sense of empowerment, enjoyment, fun and confidence.” (Structural enabler service provider)

Autonomy was also seen as a mechanism to engage and sustain staff and volunteers in their roles.

“Because the staff have such autonomy, you can see that it positively affects their wellbeing and makes them more

motivated to do their work. They also feel more satisfied, especially when they see the positive outcomes and the difference that they can make to somebody and in somebody's life." (Direct intervention service provider)

3.1.3. Personal Qualities of Staff and Volunteers. The experiences of staff and volunteers, particularly similar experiences shared by staff/volunteers and service users, and their knowledge of the local community could aid in facilitating a better rapport with service users.

"...the coordinator's local knowledge is vital as it helps in building a rapport with service users and allows them to trust you more easily. Also, you can relate better with them." (Foundation service provider)

Personal qualities such as a caring nature were valued among staff and the notion of going "*above and beyond*" helped to build and sustain a positive and trusted reputation.

"Our drivers are very willing to compromise and do extra drives and waits... for example, if someone is a dementia sufferer, the driver will help them out of their house and into the car..." (Gateway serviceprovider)

That the staff would go beyond what was expected of them, and that they were willing to fulfill a role as a volunteer rather than a paid befriender was considered to be meaningful and valued by service users.

3.1.4. Funding for Service Provision. Service managers highlighted the role of sustainable funding for the development of new services and the ability of services to expand their reach. The ability to plan and disseminate information about services was compromised by the oftentimes short-term nature of funding models for loneliness services.

"There is a lack of funding for local communities and this affects how many people we can help and how long we can help them for." (Foundation service provider)

Unreliable funding was also perceived to inhibit the design, development, and completion of improvement projects.

3.2. Wider Community Characteristics

3.2.1. Hard to Identify and/or Reach Lonely People. Feelings of stigma and embarrassment experienced by lonely people can hinder organisations from identifying individuals and offering them appropriate support. Service providers observed individuals who are more likely to need support, such as those with physical or psychological health problems and those with reduced mobility, and sight and/or hearing loss were less likely to engage in social and community activities and were more difficult to reach.

"It is hard to reach people experiencing loneliness because they feel stigma and a sense of shame. Sometimes people feel like it indicates failure or rejection therefore do not want to admit that they are isolated." (Direct intervention service provider)

Even though loneliness has been shown to be a risk factor for increased utilisation of health and social care services, health professionals within primary care settings often fail to identify individuals who are lonely.

"Older people are more likely to visit health professionals such as doctors very frequently, however, these professionals are not recognising that these people are lonely and therefore are not referring patients to local community services... GPs and doctors are dismissing older people who express "feeling down" as symptoms of old age." (Direct intervention service provider)

3.2.2. Education and Awareness of Services. Service providers recognized that their ability to identify and reach people who are experiencing loneliness is partly dependent upon healthcare professionals and others in contact with vulnerable people being educated about the symptoms of loneliness and the potentially effective care pathways available in their communities. Positive advertising can increase awareness of available services and help to normalise the experience of loneliness, thereby reducing barriers associated with stigma and encouraging individuals to seek help.

"People don't know where to link to... If they are aware of what services are available, they are more likely to turn to these services in their times of need." (Foundation service provider)

Education, including cross-generational learning, should include an understanding of the causes/triggers of loneliness and strategies to prevent loneliness from occurring or exacerbating, including the role of staying active and the importance of building and maintaining relationships into older age. If symptoms of loneliness can be identified early, there are opportunities to intervene and improve health outcomes.

"More education, for example, on how to recognise signs of loneliness or how to support someone who is lonely or isolated. This will help people to become more confident in reaching out to those in need of help." (Direct intervention service provider)

3.2.3. Family and Community Structures. Sociodemographic changes such as the outmigration of children and shrinking family and friendship network size were perceived to contribute to a situation where there was less intensive support for people as they age.

“Lack of family support is a barrier as children are moving away and relocating to different countries and cities and there is also loss of family members and friends.” (Direct intervention service provider)

Good community infrastructure was thought to aid in the prevention of loneliness and social isolation by creating opportunities for individuals to connect and build resilience by enabling networks of mutual support. This was thought to facilitate a sense of belonging among older people. Unfortunately, service providers also reported that good community networks were not always apparent, and older people were not always “visible” or overtly valued within their communities. They were not always included or facilitated to engage in community activities.

“There are so many different factors that result in an older person becoming lonely and socially isolated. One of the factors is the breakdown in community networks as a sense of community. People are becoming more withdrawn. . . We need to check up on neighbours and try to get to know individuals living in the same community.” (Direct intervention service provider)

Cited frequently by service providers was the perspective that tackling loneliness and social isolation requires integrated action from organisations across different sectors. A joined-up approach helps to build greater community capacity and infrastructure which would lead to better social outcomes for populations at risk. Local organisations, including health and care professionals, were considered to be well situated to work in partnership to identify and engage those people who are hard to reach and at risk of loneliness and social isolation.

“More referrals from health professionals such as doctors to community services such as this, rather than prescribing medication to patients to treat depression when actually they are just lonely and need good quality company.” (Direct intervention service provider)

3.2.4. Accessible, Affordable, and Safe Public Transport. Another frequently cited barrier to the prevention of loneliness was the inadequate community transport options available to older people. Community-based transport was considered to provide a more reliable and resilient way to address the growing number of transport needs among older people and facilitate social opportunities, allowing those most at risk of loneliness and social isolation to benefit from services within their community. Older individuals are more prone to age-related conditions that can affect their mobility and consequently hinder their ability to complete normal day-to-day activities such as driving. A good transportation link can help to create a sense of belonging and allow individuals to access services such as healthcare and other opportunities that promote social engagement.

“Service providers can make the services available to older people however these individuals are often unable to attend due to lack of transport and their poor health which reduces their mobility. Sometimes it’s a case of the public transport services not accommodating limited mobility, for example, no wheelchair ramp. Therefore these individuals are likely to become housebound.” (Direct intervention service provider)

4. Discussion

This study explored the perspectives of service providers about the barriers and facilitators of successful service provision and prevention of loneliness among older people. Specific characteristics of the service and its personnel were considered to be key determinants of success, including a person-centred approach; empowerment of service users and staff/volunteers; personal qualities of staff and volunteers; and funding for service provision. Other more systemic factors believed to interact with the provision of services in preventing or alleviating loneliness were as follows: the difficulties associated with hard to reach/identify lonely individuals; education and awareness; family and community structures; and accessible, affordable, and safe public transport. These themes mirror the 3 core foundation services proposed by the CTCL [15, 16] in addressing loneliness: reaching lonely individuals; understanding the nature of an individual’s loneliness and developing a personalised response; and supporting lonely individuals to access appropriate services.

Loneliness is often defined as a negative and subjective response to a perceived lack of desired social relations [24–26]. This definition helps to explain why loneliness interventions need to be individually tailored and person-centred because, for some people, a large network of contacts and activities might improve subjective well-being whilst, for others, one meaningful friendship might be sufficient. Some service users may strive to improve existing relationships whilst others may desire new ones. Some individuals may need preliminary support to overcome barriers to (re-) integration within their community where they can subsequently forge and nurture their own relationships. Other people may be able to manage feelings of loneliness without requiring any support at all. This is why, although often conflated, loneliness and social isolation are not highly correlated [3]. This heterogeneity in the experience of loneliness also helps to explain the difficulty in the design of a “one-size-fits-all” approach to interventions and has been suggested to account for some disappointing findings on impact [27]. A range of services is, therefore, justified including befriending services that focus on the provision of an individual friendship with a “matched” volunteer, to “activity groups” such as walking groups or Men’s Sheds that do not promote themselves as loneliness interventions at all.

Empowering service users and volunteers through their involvement in the design and delivery of services is recognized in previous research where it has been shown to

influence levels of engagement, acceptance, and accessibility of services, ultimately contributing to effectiveness [11]. Such participant-led services are highly valued by participants [28–30]. Autonomy can be realized in various aspects of service design, as well as how individuals choose to engage with a service, and how they engage with their wider community because of the intervention [31]. It is imperative, therefore, that we continue to build on the Patient and Public Involvement and Engagement (PPIE) agenda that has seen an elevation of the “service user,” in the UK, particularly in relation to research [32]. Although further cultural change is needed [33], our findings suggest that many community-based services are using these principles successfully in service design and delivery and recognize the advantages they instill for service users and personnel alike.

The personal qualities of volunteers and other personnel, including empathy and reciprocity, have been recognized as key mechanisms influencing intervention effectiveness [18]. Many services rely on unpaid volunteers to operate, and their value within the health and social care system remains undervalued and underresourced.

Other determinants identified by service managers reflect more of a systems approach to the prevention and alleviation of loneliness, specifically that the successful delivery of interventions is contingent on other qualities of the community “system” including the ability of communities to identify, via other points of contact, people who should be referred to services, as well as education and awareness among the public and healthcare professionals about the signs, symptoms, and potential solutions of loneliness, and accessible public transport. This interaction of community context and available services is illustrated in the most recent report from the UK Campaign to End Loneliness [15] which describes the different categories of action that are needed in communities to build an effective “ecosystem” to address loneliness. We know already that individuals who are lonely can be hard to reach [34], and without interagency working to identify the most vulnerable lonely people, services may only serve those individuals who are more mobile, aware, and able to support themselves [14]. Healthcare professionals can be encouraged to assess patients for loneliness using one of several short measurement scales [15], to recognize telling symptoms, and to refer people to social prescribing initiatives within the communities they serve [35, 36]. These agencies are already collaborating within the primary care sector across the UK to identify people at risk of loneliness and to make “prescriptions” for local, non-pharmacological nonclinical services tackling loneliness and social isolation. Unfortunately, as social prescribing services begin to establish networks of community collaborations and support within communities, for many, their reach is endangered by financial cuts to community-based services and decreased community resources [37]. In this study, lack of reliable funding was cited by most service providers as a barrier to the successful delivery of services that constrains the development of longer-term projects and thinking. This “systems thinking” is advocated in recent reports [15], and all the UK nations have strategies that prioritise interagency working and community-level responses to loneliness and

social isolation. It is important that these community development approaches, grounded in principles of empowerment, inclusion, self-determination, and collective action [38] are not put at risk because of financial austerity [31]. In particular, a systems approach must include the provision of suitable transport, critical to the reduction of social deprivation and geographical isolation [39, 40], and other structural enablers that work to enhance the strengths of preexisting communities [15].

Service providers also discussed the various types of awareness-raising and education necessary within communities and society at large to aid with the prevention and alleviation of loneliness. The term “loneliness” can carry a social stigma, and many older people consider it to be a private matter [41]. Hence, many services do not promote themselves explicitly as “loneliness interventions,” as these services are often considered undesirable and can act as a barrier to participation [41, 42]. Services can be framed using alternative language, as holistic services to promote healthy ageing. Nonetheless, like other societal taboos such as “death and dying,” loneliness needs to be reconceptualized as a normal part of the human experience to promote discussion and disclosure within families and communities.

4.1. Strengths and Limitations. This study sought to recruit representatives of a range of services influential for the alleviation and prevention of loneliness, whereas previous research has largely focused on the evaluation of direct interventions. Despite our efforts, direct interventions are still overrepresented in our findings. In part, this is because many structural enablers, foundations, and gateway services, whilst supporting the community ecosystem, are not identified as loneliness interventions. Nonetheless, it is noteworthy that service providers across these categories identified a homogenous pattern of barriers and facilitators to the prevention of loneliness and successful delivery of services, consistent with contemporary recommendations for the future of loneliness services in the UK [15].

5. Conclusions and Implications

Determinants of successful service provision to alleviate loneliness among older people include both characteristics of the services (person-centred services; empowerment of service users and staff/volunteers; personal qualities of staff and volunteers; and provision of funding) and characteristics of the wider community context where services operate (hard to identify and/or reach lonely people; education and awareness of services; family and community structures; and accessible, affordable, and safe public transport). Developments in this area should prioritise integrated, systemic solutions that harness capacity and partnership working within communities, grounded in the principles of empowerment, inclusion, self-determination, and collective action [38].

Services should continue to advocate a person-centred, tailored approach that empowers both service users and providers, and recognizes and values those personal qualities that

are integral to successful service delivery. We also need to redress the balance of academic enquiry that, in the past, has meant that community-based services were overlooked in comparison to statutory services, in the academic literature [16].

Data Availability

The data used to support the findings in this study are available upon request from the corresponding author.

Disclosure

This study is part of a PhD project that was undertaken by the first author, OAF, supervised by NMC and MD. The funder had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Conflicts of Interest

All authors declare that they have no conflicts of interest.

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