



Only the Lonely:

a randomized controlled trial of a volunteer visiting programme for older people experiencing loneliness

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At a Window

Carl Sandburg, 1878 - 1967

Give me hunger,
O you gods that sit and give
The world its orders...
Give me your shabbiest,
weariest hunger!

But leave me a little love,
A voice to speak to me in the day end,
A hand to touch me in the dark room
Breaking the long loneliness.
In the dusk of day-shapes
Blurring the sunset,
One little wandering, western star
Thrust out from the changing shores
of shadow.

Let me go to the window,
Watch there the day-shapes of dusk
And wait and know the coming
Of a little love.

FOREWORD



As recent research has found, the majority of Irish older people are very happy. However for some loneliness is a big problem. Loneliness happens when there is a mismatch between a person's actual and desired quality (and quantity) of social contacts. We know that it is not necessarily the quantity of contacts but the quality that makes the difference - a single strong bond may be more important than several weak social relationships.

While loneliness is something that can occur at any stage in life, the number of people available for social contact can reduce in later life for a variety of reasons. The loss of a life partner or close friend can be a cause of great loneliness and can result in a person feeling unable or unwilling to try to socialise alone. Family members or younger neighbours may have moved away

or emigrated leaving older people with fewer people to call on when they need help or simply to talk to when feeling lonely. Ill health can affect people in many ways, maybe causing them to lose confidence in their ability to go out on their own or resulting in them being confined to the house if there is nobody nearby to help them get out.

Although they are the minority, we need to be aware that there are lonely people all over Ireland wishing they could reach out to others or have someone drop in unexpectedly for a chat. This report identifies one successful intervention for tackling loneliness. It offered benefits for the participants and for the volunteers who gave their time to help other people.

As Chair of Age Friendly Ireland I would encourage all of the many agencies, statutory and non-statutory alike, who are actively supporting the roll out of the Age Friendly Cities & Counties Programme across the country to consider this research. The successful intervention provides one low cost, practical way of dealing with the problem and is an intervention that could be readily adopted by a range of community groups and other organisations that operate across the country.

Brendan Henny

ACKNOWLEDGEMENTS

The research team would like to thank all the people who contributed to the study. We would particularly like to thank all the participants and volunteers, without whom the research would not have been possible. We very much appreciate the time and commitment they devoted to the study.

We would also like to acknowledge the contribution of the many individuals working in the community setting who assisted us in the recruitment and organization of the study.

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EXECUTIVE SUMMARY

Loneliness is a significant problem among older people living in Ireland. The negative effects of loneliness on physical and emotional health are well documented in the literature. This study was established in the context of a dearth of effective interventions to alleviate loneliness. A peer visiting intervention for community dwelling older adults experiencing loneliness was designed and subjected to the rigor of a Randomized Controlled Trial. It consisted of ten home visits to the intervention participants from a volunteer, themselves an older person. The volunteer built up a rapport with the participant and encouraged them to identify a social connection they wished to establish. Several participants made new social connections outside their home while most continued to receive visits from their volunteer following the end of the study period.

The main study finding was very positive. The primary outcome, loneliness, decreased in the intervention group at one month and three month follow up. Potential benefits for the volunteers were also identified, in particular a decrease in loneliness. Both participants and volunteers reported that they enjoyed the intervention.

The intervention is low cost and could be incorporated into existing support services or non-government organizations caring for community dwelling older adults. It is a potentially scalable model to deal with the major societal challenge of loneliness.



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“where there is an unpleasant or inadmissible lack of (quality of) certain relationships...the number of existing relationships is smaller than is considered desirable”



Introduction

INTRODUCTION

Social isolation and loneliness are common in older people and negatively impact on their day-to-day lives. Social isolation is an objective measure of lack of relationships with other people, whereas loneliness refers to the subjective and negative appraisal of the quality of these supports and relationships and has been defined as:

'... a situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (quality of) certain relationships. This includes situations, in which the number of existing relationships is smaller than is considered desirable or admissible, as well as situations where the intimacy one wishes for has not been realized.'

(De Jong Gierveld, 1987; 120)

Loneliness can be classified into two types: social or emotional. (Weiss, 1973) Social loneliness occurs due to a lack of social connection or integration. Emotional loneliness refers to a lack or loss of an attachment figure such as an intimate partner (O'Luanaigh and Lawlor 2008). Although social isolation and loneliness may coexist in individuals they are not necessarily connected (De Jong Gierveld et al 2006). For instance an individual may be lonely and not socially isolated, or socially isolated and not lonely.

Several studies have documented the extent of loneliness among community dwelling older people in Ireland. Golden et al (2009) reported a prevalence of

“The value of the peer relationship has previously been evaluated in a broad variety of health issues”

loneliness of 35% among 1299 people over the age of 65 years living in their own homes in Dublin. In a national telephone survey of 683 people over the age of 65 years Drennan et al (2008) identified low levels of social and family loneliness but relatively high levels of romantic loneliness.

It is well documented that loneliness and social isolation are detrimental to the health of older people and are associated with depression (Cacioppo et al 2006), hypertension (Hawkley et al 2006) disturbed sleep (Cacioppo et al 2002) and excess mortality (Holwerda et al 2012, and Shiovitz-Ezra et al 2010). In previous work conducted in Ireland both loneliness and isolation were independently associated with depression, with loneliness having a relatively greater impact and both together accounting for 70% of the prevalence of depression in the sample. (Golden et al 2009) Furthermore, engagement with the community and friends, rather than family, appears to be more important in terms of quality of life and mood.

Two systematic reviews of interventions targeting loneliness and social isolation in

Introduction

older people support the implementation educational and social group activities. (Cattan et al 2005 and Dickens et al 2011) Befriending and home visiting schemes have yet to be proven to be effective. (Cattan et al 2005) In particular interventions to reduce loneliness in older people based on a home visits from a peer require rigorous evaluation. In an intervention to reduce loneliness the peer relationship could facilitate the sharing of common interests, backgrounds and may foster reciprocity within the dyad. (Cattan et al 2003)

Peer support in the context of healthcare has been defined as the provision of support to a selected individual from a person with similar characteristics and life experiences. (Dennis 2003) The value of the peer relationship has previously been evaluated in a broad variety of health issues such as diabetes (Smith et al 2011), post natal depression (Dennis et al 2009), and teenage sex education (Stephenson et al 2004). There have been varying results from such peer support interventions. Peer support is often provided on a voluntary basis. (Smith et al 2011) There are documented positive effects of volunteering (Barrett et al 2011) and so potentially both the recipient and the provider may benefit from participating in an intervention of voluntary peer support.


The study presented below was established in the context of a lack of evidence surrounding home visiting schemes for

older people experiencing loneliness in which the visitors are peers of the participants. The study was set in both urban and rural areas of three counties in the east of the Republic of Ireland.

It aimed to test the effectiveness of a brief peer visiting programme for community dwelling older adults who are lonely, and to explore the participants and volunteers' experience of the programme. To achieve this overarching aim the following individual studies were conducted by the research team:

1. A Randomized Controlled Trial (RCT) of a volunteer intervention for older people who experience loneliness
2. A descriptive study of the effect of participating in the study on volunteers
3. A qualitative study of the experience of the participants during the study
4. A qualitative study of the experience of the volunteers during the study

The methods and main results of the four studies are presented separately below. This is followed by a general discussion of the results Ethical approval for the studies was provided by the joint Adelaide, Meath incorporating the National Children's Hospital (AMNCH) and St James's Hospital Ethics Committee.



Study 1

1. RANDOMIZED CONTROLLED TRIAL (RCT)

This RCT aimed to implement a brief peer visiting programme for community dwelling older adults who experience loneliness and to test the effectiveness of the programme.

1.1. Methods

Recruitment of participants

One hundred people participated in the study. The inclusion criteria for participation were as follows:

- Be aged over 60 years
- Be community dwelling
- Have no significant memory problems
- To score 3 or more on the De Jong Gierveld Loneliness Scale OR answer 'Yes' to the question Item 5 on the CESD scale 'Would you say that much of the time during the past week you felt lonely?'
- Agree to have a volunteer visiting them in their own home if allocated to the intervention group

Study 1

Potential participants were identified by people working with older people in the community including general practitioners, public health nurses, parish staff, day centre staff, home helps and members of local active retirement groups. Individuals identified were asked if they were interested in participating in the study and if so information was sent to them. This was followed up by a phone call from a member of the research team.

If the individual was in agreement they were visited by a researcher who explained the study in more detail. On expressing a desire to participate they gave informed consent and were screened for loneliness. If they scored 3 or more on the De Jong Gierveld Loneliness Scale or answered 'Yes' to Item 5 on the CESD scale '**Would you say that much of the time during the past week you felt lonely?**' they were deemed to be experiencing loneliness and were eligible for inclusion in the study.

Sample size and randomization

The sample size calculation estimated that 50 participants were required for each group. Block randomization was conducted and a computer generated random sequence list was used to randomly allocate participants. Group allocation was concealed from both participants and the researchers until after baseline data collection was conducted.





Data collection

Data were collected from participants in their homes at baseline and at one and three months post intervention using a researcher-administered questionnaire.

Intervention group

The intervention contained four elements: the recruitment, training and retention of volunteers and home visits to the intervention participants from the volunteers. Each intervention participant was matched with a volunteer. Volunteers visited them for an hour once a week for ten weeks over approximately a three month period. Initially the aim of these visits was to develop a rapport with the participant. The volunteer then encouraged the participant to identify a social connection they would like to make and that would be sustainable beyond the timeframe of the study. If a participant had difficulty identifying a connection the volunteer helped the participant in the process as they had knowledge of local services and social activities. Potential barriers were identified and feasible ways to overcome the barriers were discussed with the participant.

The elements of the intervention are detailed in Figure 2.1.

Study 1

Figure 1.1. Details of the intervention

The intervention consisted of the following four components:

1. Recruitment of volunteers

Local volunteer services and active retirement groups were asked to identify individuals they deemed suitable for the role of volunteer. The inclusion criteria for volunteers was as follows:

- Aged over 55 years
- Cognitively intact/ no significant memory problems
- Had the capacity and commitment to undergo the training required
- Had a full understanding of confidentiality
- Agreed to undertake to liaise with the research team if problems arose during the course of their visits to participants
- Agree to the Garda (Police) clearance process prior to taking up the role of volunteer

A member of the research team met potential volunteers to discuss the study in more detail. Individuals interested in becoming a volunteer were asked to provide names of two referees who were then contacted by a member of the research team.

2. Volunteer training

All the volunteers attended 2 training sessions, which were conducted by the

research team. The content of these sessions was as follows:

- Introduction to the project
- Role of the volunteer (including boundaries of their role)
- Background to loneliness and social isolation
- Local services for older people
- Trouble shooting
- Communication skills
- Role play
- Confidentiality

3. Retention and support of volunteers

Retention of volunteers was crucial to the intervention. Volunteers were supported in their role through the following structures:

- Contact details and explicit support from the research team
- Feasible time commitment to the project
- Outline of responsibilities/ volunteer policy
- Adequate training (outlined above)
- Course handbook and information booklet on services and activities for older people in their locality
- Telephone call from a member of the research team following each visit
- A referral system was established so if a volunteer encountered a problem in the course of their visits they will

Study 1

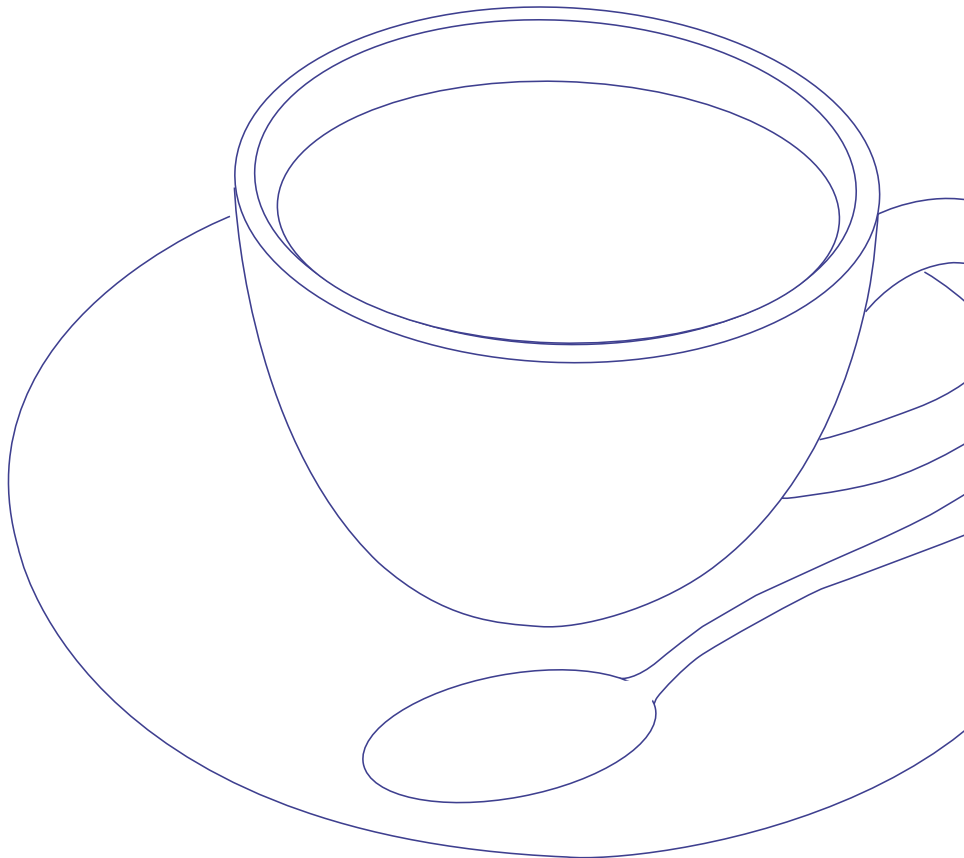
referred the problem to a member of the research team.

- Problems referred were discussed by the team and a decision was made as to how best to proceed with the referral.
- Social event for all volunteers at the end of the study

4. Home visits

Each intervention participant was matched with a volunteer. Volunteers visited them for an hour once a week for ten weeks over approx. a three month

period. Initially the aim of these visits was to develop a rapport with the participant. The volunteer then encouraged the participant to identify a social connection they would like to make and that would be sustainable beyond the timeframe of the study. If a participant had difficulty identifying a connection the volunteer helped the participant in the process as they had knowledge of local services and social activities. Potential barriers were identified and feasible ways to overcome the barriers discussed with the participant. All intervention participants were invited to a social event at the end of the study.



Study 1

“The volunteer then encouraged the participant to identify a social connection they would like to make and that would be sustainable beyond the timeframe of the study.”

Control group

Participants in the control group received their usual individualized care from community services. In addition, they received a home visit from a member of the research team to conduct data collection at the three data collection time points outlined below. At the final data collection time point, 3 months, each control participant was offered an information booklet on services and activities for older people in their locality and a discussion with the member of the research team regarding what activity might suit them. All control participants were invited to a social event following the completion of the study.

Main outcomes

The primary outcome was loneliness as measured by the De Jong Gierveld Loneliness Scale (11 item). The secondary outcomes included a range of psychosocial and biophysical outcomes as listed below:

Psychosocial outcomes

- The Center for Epidemiologic Studies Depression (CESD) Scale
- The Lubben Social Network Scale
- The Montreal Cognitive Assessment Scale (MOCA)
- Hospital Anxiety and Depression Scale (HADS)
- CASP 19 (Control, Autonomy, Self-Realisation and Pleasure scale)
- The Pittsburgh Sleep Quality Index (Item 6)
- OSLO social support scale

Biophysical outcomes

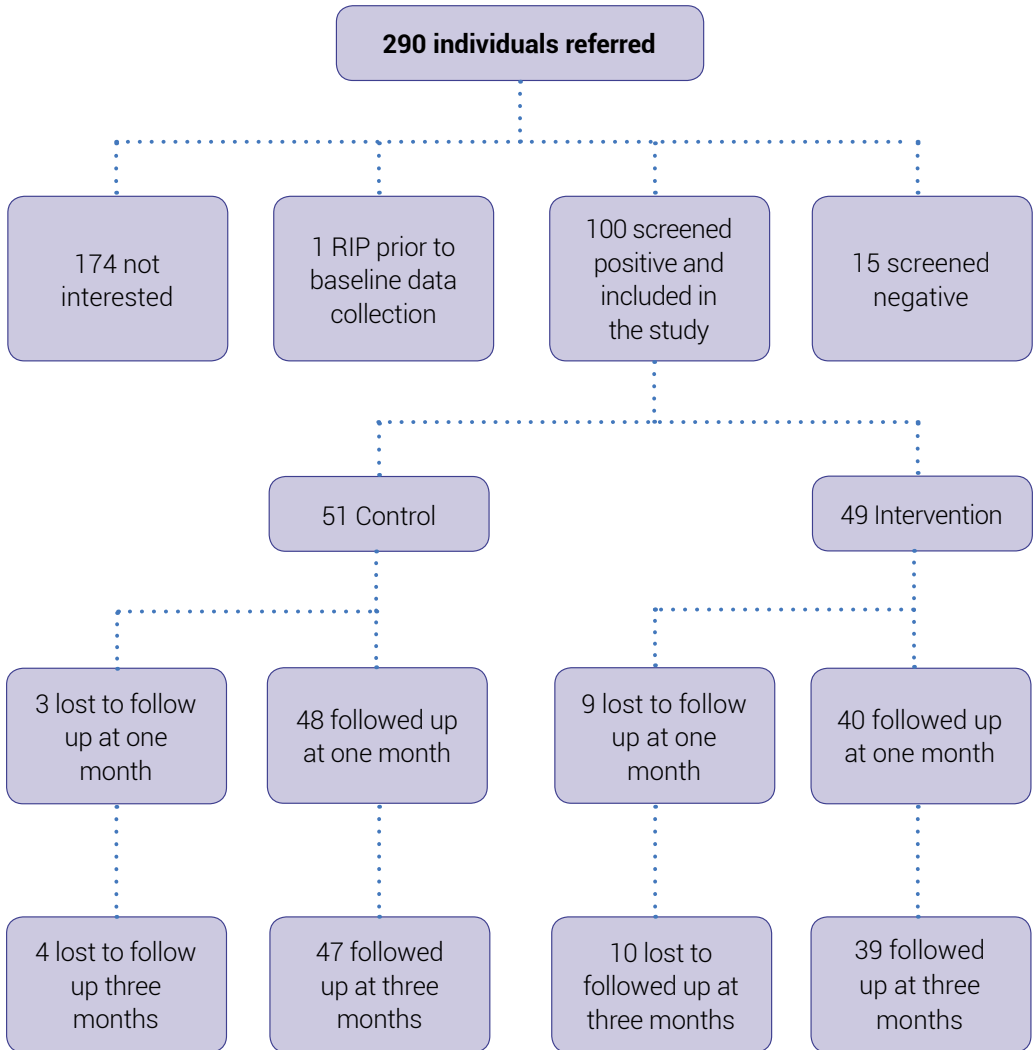
- Body Mass Index
- Grip strength
- Timed up and go

Data management and analysis

Each participant was allocated a unique identification number. The anonymous data were entered into Excel and then transferred into STATA for statistical analysis.

Study 1

Figure 1.2. Flow chart of participants



1.2. Results

Participants

Of the 100 originally-randomized participants, there were 88 participants (40 in the intervention group and 48 in the control group) available for follow-up at one month. Three controls had dropped out, and of the 9 intervention participants who had been lost to the study, four had dropped out, a further four had become too physically unwell to participate (three of whom were admitted to hospital) and one had died.

Between one- and three-month follow-ups a further three participants were lost from the intervention group: in the case of two of these, the volunteer stopped visiting as the person was either in bed or not at home on several occasions on which visits had been arranged. The third simply withdrew from the study. One further participant from the control group withdrew from the study between one and three months.

Demographics

The intervention and control groups were similar in age, sex, marital status and education. Three quarters of participants in both groups were female. The mean age was similar in both groups (81.5 years in the control group and 80 in the intervention group). The majority of participants were widowed. Forty seven percent of participants in the control group had less than 16 years education compared to 61% in the intervention group, though this difference was not shown to be statistically significant. (Table 5.1)



Study 1

Table 1.1 Characteristics of the 88 participants followed to one month

	Control	Intervention	Sig
Number	48	40	
Sex			
Women	37 (77%)	30 (75%)	0.819*
Men	11 (23%)	10 (25%)	
Age (median, IQR)	81.5 (13.5)	80 (9)	0.906**
Marital status			
Single	21%	18%	0.611*
Married/cohabits	13%	8%	
Separated/Divorced	4%	3%	
Widowed	63%	73%	
Education level			
Less than 16 years	47%	61%	0.155*
16 year or more	53%	39%	

*Chi-squared and **Mann-Whitney Wilcoxon tests

Outcomes at one month follow-up

Total scores on the primary outcome measure, the De Jong Gierveld scale, were significantly lower in the intervention group ($p=0.027$, adjusted for baseline values). While there was no difference between the groups on the social loneliness subscale, the scores on the emotional loneliness subscale were significantly lower in the intervention group ($p=0.016$). Although the Lubben social network scale scores also differed between the groups with higher scores in the intervention group, this fell short of statistical significance when adjusted for baseline scores ($p=0.055$).

While there was no significant difference between the groups on the total CESD scale score, those in the intervention group had significantly lower scores on the scale depression item (item 7).

They also had lower scores on the loneliness item (item 5) but this fell short of statistical significance when adjusted for baseline scores. (Table 5.2)

Study 1

Table 1.2 Primary and secondary outcomes in the trial groups at one month

	Mean scores		Difference (95% CI) [¶]	Sig*
	Control N=48	Intervention N=40		
De Jong Gierveld scale				
Total score	6.7	5.3	1.1 (0.10 to 2.1)	0.027
Social loneliness	2.4	1.8	0.4 (-0.1 to 1.0)	0.113
Emotional loneliness	4.4	3.6	0.8 (0.2 to 1.4)	0.016
Lubben Total score	21.5	23.3	2.2 (-0.05 to 4.5)	0.055
CESD Total score	3.6	2.8	0.51 (-0.45 to 1.47)	0.314 [†]
CESD 5 - Felt Lonely	66.7%	42.5%	OR: 0.44 (0.17 to 1.1)	0.085 [‡]
CESD 7 - Felt sad	60.4%	25.0%	OR: 0.22 (0.08 to 0.61)	0.004 [‡]

* All comparisons are adjusted for baseline scores on the appropriate measure. Significance levels based on regression ([†]Poisson regression or [‡]logistic regression) with robust standard errors.

[¶] Differences adjusted for baseline levels, differences in proportions expressed as adjusted odds ratios.

Outcomes at three month follow-up

At three months, there were 47 control and 39 intervention participants. Total scores on the primary outcome measure, the De Jong Gierveld scale, were significantly lower in the intervention group ($p=0.003$, adjusted for baseline values). This reflected differences between the groups on both the social loneliness subscale ($p=0.022$) and the emotional loneliness subscale ($p=0.015$).

Once again, the Lubben social network scale scores did not differ significantly between the groups ($p=0.065$) with higher scores in the intervention group.

While there was no significant difference between the groups on the total CESD scale score at three months, those in the intervention group had significantly lower scores on the scale depression item (item 7) and scores that fell short of statistical significance on the loneliness item (item 5). (Table 5.3)

Study 1

Table 1.3 Primary and secondary outcomes in the trial groups at three months

	Mean scores			Sig*
	Control N=47	Intervention N=39	Difference (95% CI)¶	
De Jong Gierveld scale				
Total score	7.0	5.3	1.4 (0.5 to 2.3)	0.003
Social loneliness	2.7	1.8	0.6 (0.1 to 1.2)	0.022
Emotional loneliness	4.3	3.4	0.8 (0.2 to 1.4)	0.015
Lubben Total score	22.2	23.8	2.1 (-0.1 to 4.2)	0.065
CESD Total score	3.8	2.7	0.6 (-0.2 to 1.4)	0.229†
CESD 5 - Felt Lonely	61.7%	33.3%	OR 0.39(0.14 to 1.06)	0.066‡
CESD 7 - Felt sad	57.4%	28.2%	OR 0.30(0.11 to 0.80)	0.016‡

* All comparisons are adjusted for baseline scores on the appropriate measure. Significance levels based on regression (†Poisson regression or ‡logistic regression) with robust standard errors.

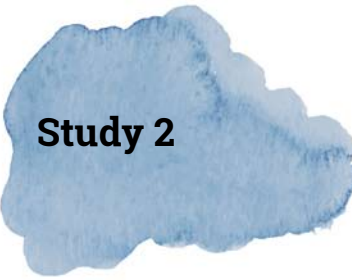
¶ Differences adjusted for baseline levels, differences in proportions expressed as adjusted odds ratios.

Of the intervention participants that were followed up at three months 30 had sustained a new social connection since the commencement of the study. Twenty five of the participants continued to receive visits from a volunteer, mostly the original volunteer they were allocated to at the beginning of the study. Seven participants were referred to a local befriending organisation in some cases were allocated another visitor. Two participants joined their local active retirement club, two joined their local group for older people and one joined a gardening club.

This descriptive study aimed to describe the volunteers as a group and explore the potential impact of their role as a volunteer on their wellbeing. A number of measures including loneliness, depression, anxiety, social network and cognition were assessed using standardized self-reported ratings before and after the study period to determine whether there were any changes in these measures over the course of the study period.

Study 1





Study 2

2. DESCRIPTIVE STUDY OF THE VOLUNTEERS

2.1. Methods

Participants

All the volunteers who delivered the intervention were invited to participate in this study. In order to be selected as a volunteer each individual had to meet the following inclusion criteria:

- Be aged over 55 years
- Have no significant memory problems
- Have capacity and commitment to undergo the training required
- Have full understanding of confidentiality
- Agree to undertake to liaise with the research team if problems arose during the course of their visits to participants
- Agree to the Garda (Police) clearance process prior to taking up the role of volunteer
- Provide the names of two referees who were then contacted by a member of the research team

Data collection

Data were collected from volunteers in their homes or at a venue of their choice prior to and following the intervention using a researcher-administered questionnaire. The questionnaire included demographic details and the following psychosocial outcomes:

- The De Jong Gierveld Loneliness Scale (11 item)
- The Center for Epidemiologic Studies Depression (CESD) Scale
- The Lubben Social Network Scale
- The Montreal Cognitive Assessment Scale (MoCA)
- Hospital Anxiety and Depression Scale (HADS)
- CASP 19 (Control, Autonomy, Self-Realisation and Pleasure scale)
- The Pittsburgh Sleep Quality Index (Item 6)
- OSLO social support scale

Data management and analysis

Each volunteer was allocated a unique identification number. The anonymous data were entered into Excel and transferred to STATA for statistical analysis.

Study 2

2.2. Results


Forty six volunteers were recruited for the study. One volunteer was not matched with a participant due to numbers of participants randomised to intervention group, one dropped out of the study and one was not available for follow up.

Table 3.1 presents the scores of the volunteers at baseline and follow-up. The

volunteers' total score on the Dr Jong Gierveld scale decreased significantly from baseline to follow-up ($p=0.046$, Wilcoxon matched-pairs signed-ranks test), however, neither subscale for emotional or social loneliness showed a statistically significant change. There was no significant change in the volunteers' Lubben network score, or in their scores on the CESD, although the latter were very low at baseline.

Table 3.1 Mean scores of the volunteers at baseline and follow-up.

	Mean scores		
	Baseline	Follow-up	Sig*
De Jong Gierveld scale			
Total score	2.1	1.6	0.046
Social loneliness	0.6	0.4	0.058
Emotional loneliness	1.7	1.2	0.072
Lubben Total score	33.3	31.8	0.510
CESD Total score	0.9	1.0	0.230
CESD 5 - Felt Lonely	15.2%	7.0%	0.250†
CESD 7 - Felt sad	8.7%	11.6%	1.000†



Study 3

3. THE QUALITATIVE STUDY OF PARTICIPANTS

A qualitative study of participant in the intervention group was conducted to explore the participants' experience of the intervention. The analysis was conducted by Ms. Emma Holfeld (2013) for the award of Masters in Social Science (Social Work), some of which is presented below.

3.1. Methods

All the intervention participants were invited to attend a focus group prior to and during or following the intervention. The topic guides for the focus groups presented in Appendix 1 were adhered to as far as possible. At the end of each focus group the participants were given a summary of the conversation that they validated and agreed was an accurate representation of the thoughts and views they expressed.

The data from the focus groups were transcribed verbatim for the purposes of data analysis. The data were analysed using framework analysis and the constant comparison method. The data was examined in depth for emerging trends. After several iterations of data analysis the emerging themes and issues were identified.

3.2. Results

Thirty three participants attended one or two of the focus groups. For the purpose of this report the following themes that emerged will be discussed: loneliness and barriers to maintaining social connections and the participants' experience of the intervention:

Loneliness and barriers to maintaining social connections

Participants expressed their thoughts on loneliness and the barriers they face in maintaining social connections and activities as they age.

The most common issue raised was being no longer physically able to do things due to deterioration in physical health. One participant who lives alone and is wheelchair bound spoke of his sense of

loneliness and increased dependency:

'When I am in bed this terrible weakness comes over me, that's my heart and I am so weak and tired and I'm afraid to get out of bed because my balance has just gone. If I cried out for help or a cup of tea or something like that but I have to do without the cup of tea as there's nobody there' (Participant 1, Male)

Another participant reported how a lack of energy affected her ability to engage in social activities:

'I haven't the energy for a lot of things I like to do' (Participant 11, Female)

“I haven't the energy for a lot of things I like to do”

“You don’t fit into society as well as you did when you were young”

Lack of transport was an issue raised by many participants with some reporting that they had to give up driving due to deteriorating health:

‘You’re lost without the car’
(Participant 8, Female)

Lack of transport in rural areas was a particular concern. Where public transport schemes were in operation participants complained that of the poor quality of this service. One participant mentioned difficulties embarking and disembarking the bus and how drivers can be dismissive of older people:

‘The driver will actually pull off before you even have your shopping bag on the bus’
(Participant 10, Female)

Participants highlighted a loss in sense of community in contemporary society and reported that neighbours have changed over time:

‘Society has changed, life is far more hectic and we are unable to keep up, there’s a lot of pressure now’
(Participant 6, Female)

Study 3

The neighbours are there but they are no longer neighbours anymore'

(Participant 5, Female)

Ultimately some participants felt as older people they were marginalized by society:

'You don't fit into society as well as you did when you were young'

(Participant 7, Male)

More participants living in urban areas than in rural areas complained of a lack of a community spirit. Participants from urban areas had positive views of rural living compared to living in a town or city:

'Growing up in the country you are never short for company, it is different living in the town. Now you could be short of company because everyone is minding their own business...you could be passed away for weeks/ months and nobody calls'

(Participant 3, Male)

'There is still a sense of neighbourly community in the country but not in the city. Loneliness is a factor of the city, in the city you don't even say hello to anyone on the street'

(Participant 9, Male)



Study 3

Bereavement was also identified as barrier to engaging in social activities:

'My husband and myself used to go into the pub or hotel together all the time and now I couldn't go on my own.'

(Participant 14, Female)

'Having a bereavement in your family, people tend to shun you and walk in the opposite direction, they don't know how to approach you. You feel like you've done something wrong.'

(Participant 13, Female)

The experience of the intervention

Overall participants had very positive feedback regarding the intervention. Aspects that they particularly enjoyed included the anticipation of the volunteer's weekly visit and the companionship of the volunteer:

'To hear the car stopping outside and you know it's for you. Or somebody saying they are going to come and you'd be waiting out in the living room for them to arrive.'

(Participant 15, Male)

'It changed my life in every way. Was something to look forward to every week which I hadn't had before. Another day I'd be sitting in my own looking at the four walls. When the volunteer came I'd be busy, I'd have to get ready for her.'

(Participant 16, Female)

'If it weren't for him I wouldn't see anyone.'

(Participant 18, Male)

'We connected from day one, I felt I had known her a long time and was really able to open up to her.'

(Participant 21, Female)

Over three quarters of participants reported that the intervention brought about positive changes to their lives. In many cases participants reported to have established a friendship with their volunteer and planned to keep in touch following the completion of the study:

'We're friends for life, you couldn't get any better than that'

(Participant 3, Male)

'We can ring each other and go to one another as we please, if it weren't for this project I would never have known her before.'

(Participant 13, Female)

Study 3

Volunteers shared information with participants regarding social activities in local community and encouraged them to increase their level of social activity. Some participants reported that the volunteer encouraged them to get out of the house and meet them for a walk, a cup of tea or lunch:

'He comes every Wednesday and we went out for lunch yesterday. I hadn't done that in ten years, I enjoyed it.'

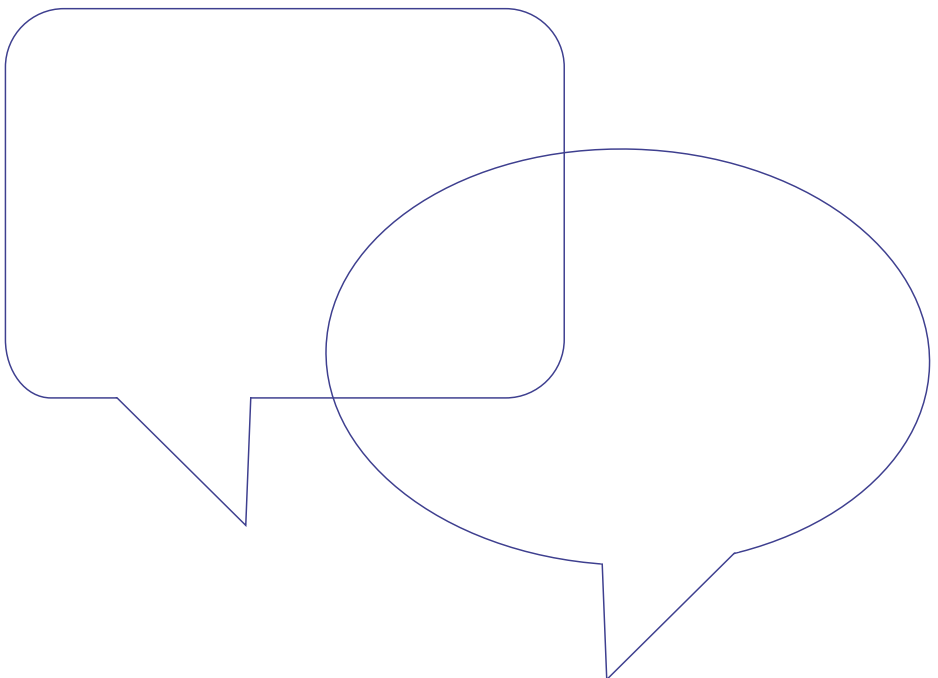
(Participant 18, Male)


Several participants joined a local active retirement club as a result of motivation and encouragement from their volunteer

and now attend on a weekly basis. On participant who joined such a group expressed how difficult she found socializing prior to the intervention:

'I've been trying to go to them [active retirement groups] myself but I just bottled it every time I got there, I wouldn't have the confidence to go in....I watched them go in and everything. I found it hard to mingle with new people you know.'

(Participant 22, Female)





Study 4

4. QUALITATIVE STUDY OF VOLUNTEERS

A qualitative descriptive study of volunteers was conducted to explore their experience of the intervention.

4.1. Methods

All the volunteers were invited to attend a focus group following the intervention. The topic guides for the focus groups presented in Appendix 1 were adhered to as far as possible. At the end of each focus group the volunteers were given a summary of the conversation that they validated and agreed was an accurate representation of the thoughts and views they expressed. The data from the focus groups were transcribed verbatim for the purposes of data analysis. The data were analysed using content analysis. After several iterations of data analysis the emerging themes and issues were identified.

4.2. Results

Thirty four attended one of four focus groups. The following themes emerged from the data: the benefits and challenges of visiting participants; encouraging and supporting participants to initiate a social connection; continued visiting; barriers to developing social connections and support for volunteers. These are explored in more detail below.

At first she wouldn't say much but then she'd start to tell you little things, only between herself and myself. It was lovely.

When September came she decided that she was joining the active retirement in [local town] so she didn't really need me coming down anymore.

One time she mentioned wanting to join an active retirement group and she just sat in her car outside and she didn't have the courage to go in.

I'm still friends with her now...A truly lovely person.

The benefits and challenges of visiting participants

Many of the volunteers expressed how they benefitted from delivering the intervention. In particular a number of them expressed a great sense of enjoyment from visiting their participant.

I enjoyed every minute of it and I became great friends with her and the whole family

(Volunteer 24, Female)

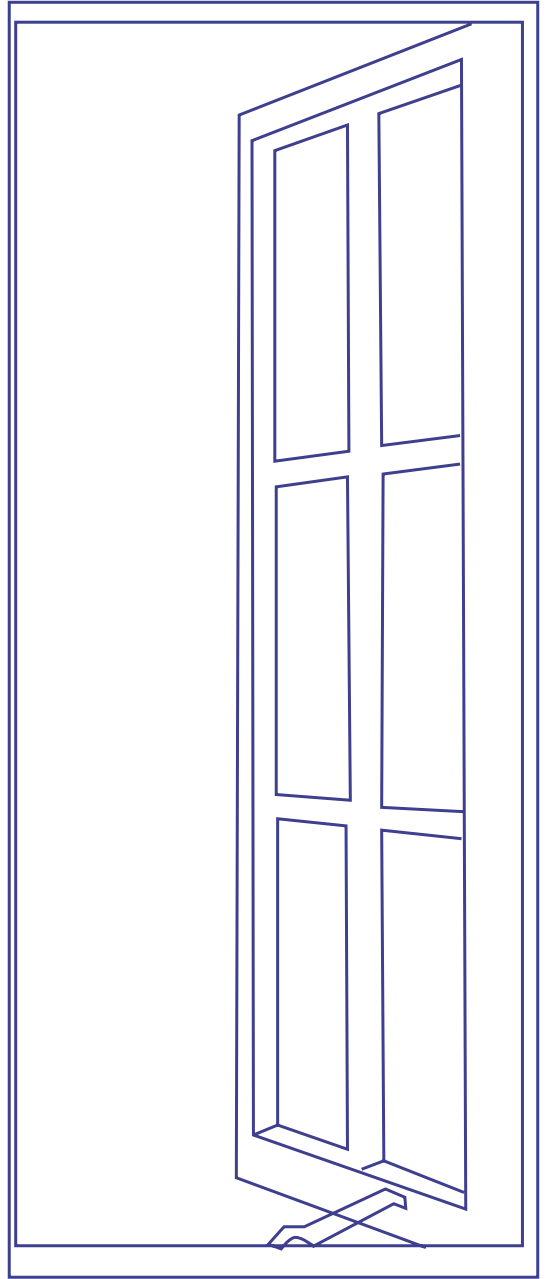
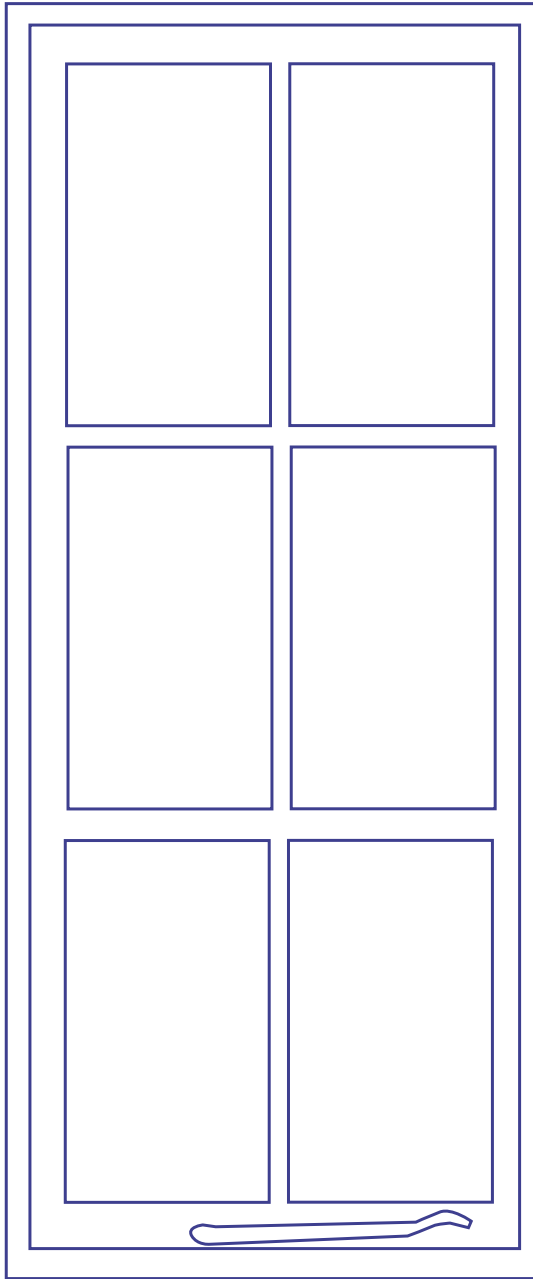
We really hit it off from the beginning. I really enjoyed it.

(Volunteer 18, Female)

I looked forward to the chats like, because we became such good friends.

(Volunteer 12, Female)





Qualitative Study of Volunteers

At first she wouldn't say much but then she'd start to tell you little things, only between herself and myself. It was lovely.

(Volunteer 14, Female)

I did [enjoy the visits], yes, I did. It was quite, he was good to listen to and so well read and so well-travelled. Far above my head intellectually.

(Volunteer 3, Female)

Others reported some challenges with the visits including communications difficulties:

He is very conservative about certain things..... I found all along I had to be on my guard a lot as to what I said to him... He's the type of man that isn't too familiar with meeting people and he has this barrier, he'll only go so far with you but no further.

(Volunteer 19, Male)

Encouraging and supporting participants to initiate a social connection

The focus of the intervention was to encourage and support participants to initiate a new social connection or re kindle a previous connection. This was achieved in some cases:

I got within him altogether because he was very outgoing and he joined the leisure centre, or not the leisure centre, he played bingo and cards and things....he joined a group.

(Volunteer 5, Male)

When September came she decided that she was joining the active retirement in [local town] so she didn't really need me coming down anymore.

(Volunteer 21, Female)

Qualitative Study of Volunteers

In one case the volunteer helped her participant to overcome a particular fear of joining an active retirement:

One time she mentioned wanting to join an active retirement group and she just sat in her car outside and she didn't have the courage to go in. But since our visits I've got her involved in the [local active retirement group] and she did come a number of times.... So it wasn't all negative she did join and she felt really good about it.
(Volunteer 26, Female)

Some of the volunteers encouraged their participant to re kindle an old social connection and facilitated a meeting between two old friends:

It involved meeting a neighbour. The neighbour ended up being an old friend of my participant so I re-introduced them to one another and ended up ferrying them across to see one another. They are still in touch now.
(Volunteer 16, Female)

Although some participants did make a new social connection they were not always sustained:

He's the type of man in my opinion that no one will ever be able to change. I did get him out to active retirement for 3 weeks which was a big step. He came to play whist with the ladies. The reports from the ladies were he didn't speak, he just stuck to his cards and that was that. Very much a loner of an individual. He stopped after three weeks.
(Volunteer 19, Male)

She was already at the door waiting for me with the hair done etc. and I introduced her to everybody in the hall and it was a great enjoyable day but nothing came of it. I had thought if she met the gang from the [active retirement] that she may join eventually and it would be a great outlet for her but nothing came of it. She wasn't ready to take on something on a weekly basis.
(Volunteer 18, Female)

Continued visiting

Although some participants did not initiate a social connection outside of their home many remained in contact with their volunteer, which in itself could be considered a new social connection:

She enjoyed the visits and I really enjoyed going to her too you know. So much so that I continue now through [the local volunteer visiting scheme]

(Volunteer 2, Female)

I'm still friends with her now...A truly lovely person.

(Volunteer 24, Female)

Once we got the first day out of it we just gelled and got on great and we still keep in touch. But a very nice person I found it all a great experience. I really learned something from him.

(Volunteer 10, Male)

But my participant was a very quiet person, very much into herself. As time went on we actually became good friends. She's away now at the moment but we always keep in contact by phone. I really enjoyed it.

(Volunteer 13, Female)



Barriers to developing social connections

The volunteers spoke of the barriers to developing social connections. Some volunteers felt that their participants were resistant to change and that this negatively impacted on making new connections:

I tried to get her involved in things like going back to the library to do the knitting circle and other things that she used to do, but she said no I have had all that, done all that. So basically I couldn't get her back to anything.

(Volunteer 4, Female)

One volunteer reported how his participant was restricted socially due to his responsibilities of caring for his wife:

Well because of his wife being sick, he couldn't actually leave the house. He was essentially tied to the ground. My visits were something that he would look forward to. He lives on a farm so sometimes he gets out to do a bit of farm work with his son, milking cows etc. I plan to keep in touch with him.

(Volunteer 22, Male)

She's a person that used to really enjoy going out dancing etc. but due to a stroke everything stopped, she lost all her confidence and stopped going to anything.

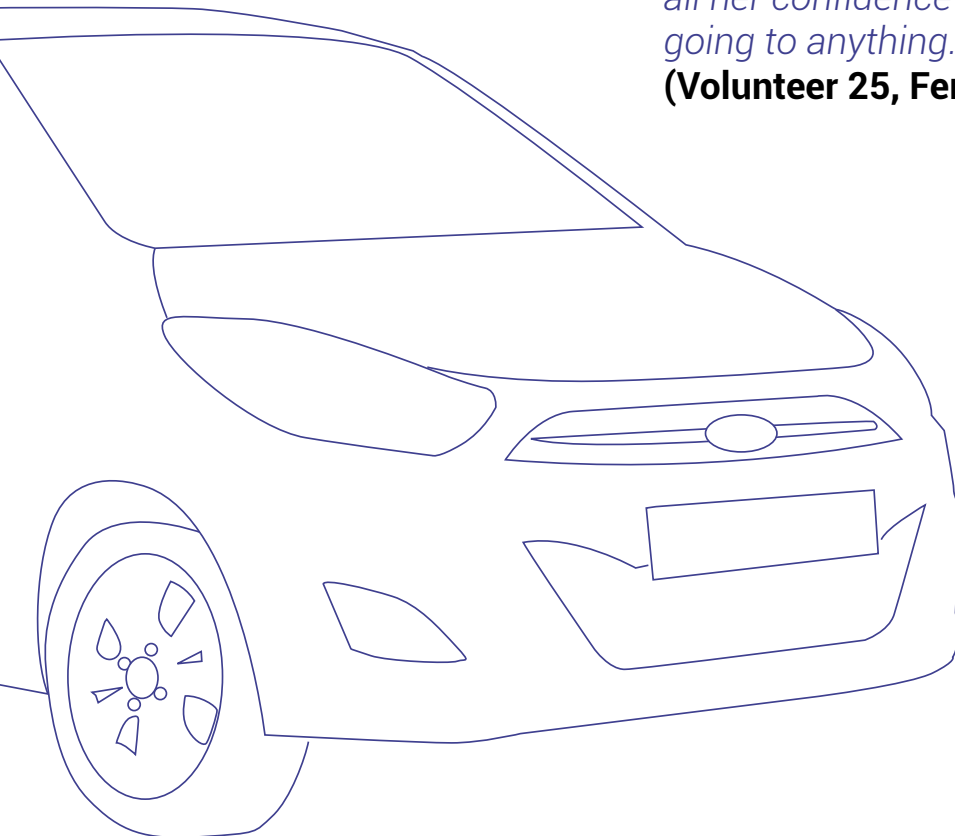
They have a huge big flat screen television and their radio but they are lonely. They don't have people coming to visit them, it's not that they don't want visitors but they live in a rural area, and you know the way society has gotten now, people don't call in for visits anymore.

Qualitative Study of Volunteers

Other issues identified as barriers to social engagement included lack of transport, declining physical health and bereavement:

The difficulty with my lady was that she doesn't drive and lives in the middle of nowhere. She was always depending on neighbours for lifts into town.
(Volunteer 15, Female)

She's a person that used to really enjoy going out dancing etc. but due to a stroke everything stopped, she lost all her confidence and stopped going to anything.
(Volunteer 25, Female)



Qualitative Study of Volunteers

He was lonely too however, he misses his wife terribly who died a few years ago. He told me that that's the one thing he misses in life. There's some things you just can't replace for people no matter how hard you try. The way he was talking you could see he missed his wife. I'd say they were a very happy couple.
(Volunteer 10, Male)

Two volunteers raised the issue of societal changes and how they impacted on the social lives of their participants:

They have a huge big flat screen television and their radio but they are lonely. They don't have people coming to visit them, it's not that they don't want visitors but they live in a rural area, and you know the way society has gotten now, people don't call in for visits anymore. They looked forward to my visits though.
(Volunteer 17, Male)

And it didn't dawn on me for a while but what they [family members] do is come in, potter about, put the dinner in the oven, do their little bits and bobs but nobody actually sits down to talk to them and to listen to them.
(Volunteer 16, Female)

Training and support for volunteers

The volunteers were asked about their experience of their training. They were very positive about it and no suggestions regarding changing the content were raised.

I enjoyed the training and the support from [the researcher]. I found it excellent.
(Volunteer 15, Female)

Two volunteers felt the role was intuitive and one felt that he did not require training:

We didn't really need any training, it came naturally.
(Volunteer 22, Male)

I enjoyed the training and the support from [the researcher]. I found it excellent.

You never felt you were on your own, there was always back up support there if you needed it.

I found [the researcher] very supportive, from going with me in the beginning and then especially as things evolved for me she was very supportive.

Qualitative Study of Volunteers

I think it was a lot of common sense...to listen to the person and to be a good listener.

(Volunteer, Male 34)

The volunteers were very positive about the support they received from the research team during the intervention:

You never felt you were on your own, there was always back up support there if you needed it.

(Volunteer 20, Male)

You knew there was somebody there who would take it on board for you if you had a problem.

(Volunteer 18, Female)

I found [the researcher] very supportive, from going with me in the beginning and then especially as things evolved for me she was very supportive.

(Volunteer 11, Female)

Participants in one focus group discussed the benefit of the support phone call from a member of the research team after each visit:

*That fact that [the researcher] called you after each visit was very good....I needed that... and she called really that day so it [the visit] was fresh in your mind. **(Volunteer 32, Female)***



5. DISCUSSION

For community dwelling older people a brief intervention of home visiting from a peer was shown to be a feasible method of reducing loneliness. To our knowledge this is the first time that the benefit of such an intervention has been reported in a randomized controlled trial. Both total loneliness and emotional loneliness mean scores were lower in the intervention group at one month and three months. The mean score for social loneliness was lower in the intervention group at three months.

Emotional loneliness has been found to be difficult to alleviate so this finding is a very important addition to the existing literature. There was no change in the remaining study outcomes.

It was apparent from the qualitative studies that both the participants and volunteers very much enjoyed the visits and benefitted from the interaction. Similar results are presented by Butler (2006) in a mixed methods descriptive study of the Senior Companion Program. The study identified benefits for both volunteers and participants, all of whom were over 60 years of age. The findings of both studies are supported by Cattan et al's (2005) argument that older people emphasize the need for reciprocity in social support and this may be more likely to occur in a peer relationship where people are from the same generation.

Discussion

A focus of the volunteer visits was to encourage the participant to make a new social connection. The findings from the qualitative study of the volunteers revealed that this aspect of the intervention was challenging. Several participants joined a local club however the most common social connection established was the friendship with their volunteer.

Forty two per cent of older people in Ireland engage in voluntary work: 15 % once a week, 11% once a month and 16% at least once a year. (Barrett 2011) The benefits of volunteering are well documented in the literature. Barrett et al (2011) in The Irish Longitudinal Study of Ageing (TILDA) reported that quality of life people in over the age of 50 years improved with frequency of engagement in voluntary work. Potential benefits of engaging in volunteering were apparent in our study of the volunteers. [The mean score for loneliness lower among volunteers following the intervention.](#) Although this result is interesting, it is important to note that the mean score for

loneliness in this group was already low at baseline and so the reduction may not be clinically significant. Also the study was observational in design and it is not possible to ascertain if the reduction in loneliness was as a result of volunteering in the study.

There are some limitations to the study, for example due to the nature of the intervention it was not possible to blind the participants from their allocation. However [the results are promising and present a feasible and acceptable intervention for reducing loneliness in older people.](#) It engages volunteers as a valuable natural resource of the community and is delivered by the community for the community. The intervention is low cost and so could be easily adopted in current economically challenging times by existing support services or non-government organizations caring for community dwelling older adults.

Discussion



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7. APPENDIX 1 - TOPIC GUIDES FOR FOCUS GROUPS

1. Topic guide for focus groups with participants in the intervention group prior to or during the intervention

Introductory questions

- Often our social lives change as we go through life and in our old age. Do you agree with this?
- Why do you think so?

Transition questions

- Is there much going on for older people in you locality?
- What social activities do you know of?

Key questions

- Would you like to get out and about more?
- What kind of social activities would appeal to you?
- What stops you from getting involved in social activities?
- What activities do you engage in at home/ how do you manage your time?

Final question

- Would anyone like to add to what has been said?

2. Topic guide for focus groups with participants in the intervention group following the intervention

FOCUS GROUP 2

Introductory questions

- Have you enjoyed being a part of the project?
- Can you identify what you enjoyed most about the taking part?

Key questions

- How did the volunteer help you think about social connections?
- What did you find particularly useful?
- Did you make any changes as a result of being involved in the project?
- Please explain more about these changes.
- What could we do to improve the project if we were to continue it on?

Final question

- Would anyone like to add to what has been said?

3. Topic guide for focus groups with volunteers

Introductory questions

- Did you enjoy being a volunteer?
- What did you enjoy most about being a volunteer?
- What did you find difficult about being a volunteer?

Training and support

- Did you feel adequately trained and supported for your role as a volunteer?
- Can you explain what was particularly useful?
- Can you identify anything that should be added to the volunteer training and support structure?

Social connections

- Did you find it difficult to encourage the person you visited to make a new social connection?
- If yes, can you explain the difficulties you encountered?
- Do you have any ideas as to how these difficulties could be overcome?
- Did the person you visited make a new social connection during the time you were visiting them?
- If yes, what connection did they make?
- If they did not make a new social connection can you identify reasons why?

Ending

- Would anyone like to add to what has been said?