Social Isolation, Loneliness & Older People:

Study of Neighbour Aid Home Visiting Service.

by

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I certify that it has not been submitted, in part or whole, for a higher degree in any other university and/or institution.

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Signed J Boardman Date 20/1/2000

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ABSTRACT

The purpose of this research study is to investigate social isolation and loneliness and its impact it has on a person's well being. Social isolation and loneliness occurs in people of all ages but with older generation more vulnerable to its development. The emphasis of this study is placed upon social isolation and loneliness among older people who are receiving a Home and Community Care funded service called Neighbour Aid Home Visiting in the Parramatta Local Government of NSW. This service provides volunteer workers to visit housebound and isolated clients and provide them with companionship and practical assistance to alleviate some of the social isolation and loneliness they encounter. The service not only provided individuals with social companionship, but also offered a range of other benefits. These other benefits were ongoing learning/sharing of wisdom, empowerment and helping the participants to deal with loss and grief issues. These outcomes assisted the individuals to improve their social skills and develop self-esteem and ultimately to improve their quality of life. The results show the service was instrumental in alleviating social isolation and feelings of loneliness among the sample group.

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BACKGROUND

Conducting this study has provided me with the opportunity to write about a service that assists people through out New South Wales. Neighbour Aid Home Visiting is a 'service with a difference' (Baines, 1995). It provides a wide range of help to people in the community who live in their own home and are isolated and housebound. The target group for this Home and Community Care funded Program, are people who are frail aged, younger people with disabilities and the carers of these people. The participants in this research study were at high risk of social isolation and loneliness, due to their health problems and disabilities. They were all receiving a volunteer through the Neighbour Aid Home Visiting Service providing companionship and other practical assistance. This study was conducted to assess how this service might alleviate social isolation and loneliness.

SOCIAL ISOLATION AND LONELINESS

> *"It is no new thing to be lonely. It comes to all of us sooner or later ... if we face it, if we remember that there are a million others like us, if we try to reach out to comfort them and not ourselves, we find in the end we are lonely no longer. We are in a new family, the family of man..."*
>
> Morris L. West (1959)

Loneliness is caused not by being alone but by being without close relationships. It is an unpleasant, at times acutely painful, feeling of isolation. Isolation or aloneness on the other hand, is a state of being that can be growth producing and desirable. 'Being alone' is not the same experience as feeling separated from others; it is not the empty feeling of being lonely. We all need 'time out' from others.

Social isolation refers to the objective state of having minimal contact with other people; while loneliness refers to the subjective state of negative feelings associated with perceived social isolation, a lower level of contact than that desired, or the absence of a specific desired companion (Wenger, Davies, Shantahmasebi and Scott, 1996). It suggests that isolation is related to: limited opportunity to establish social contacts; lack of established networks and reduced ability to communicate and a corresponding lack of awareness of available resources (Wenger et al. 1996).

What is the difference between social isolation and loneliness? There are different concepts of loneliness and words that can describe the feeling that loneliness invoke. Killeen (1998) argues that the difference between loneliness and social isolation can be confusing, he states "social isolation is almost a compromise concept between loneliness and aloneness, dependent on whether choice is involved. Loneliness indicates no choice, and aloneness indicates that there is an element of choice. Social isolation with choice is aloneness, while social isolation without choice is loneliness" (p. 764).

Social isolation and loneliness is becoming increasingly widespread throughout the community for groups of people of all ages. It has become evident that for older people in Australia who have become housebound and isolated due to frailty/disability/illness it can be intense (Killeen, 1998). To assist this group of people various government departments, community organisations and volunteer groups have set up programs to address the issue and decrease the level of social isolation and loneliness. Social isolation and loneliness suffered by individuals needs to be understood from the perceptive of the individual for interventions to be effective.

THEORIES OF LONELINESS

Killeen (1998) describes loneliness as a pervasive, depressing, debilitating condition that can affect all of one's life, it can make you feel as though you are the only person in the world; as if you do not want to live any more. The author further states it can make you feel totally isolated and useless; that your life is without purpose, all in all, it is a very destructive condition, and it can cause a vicious downward spiral, because the more lonely one becomes, the more one is isolated even further from 'normal' society, and without care, one can 'go under'.

To understand the destructive effects of the loneliness on individuals, theories of isolation and loneliness provide an understanding into the complexities of individuals. However Donaldson and Watson (1996) argue that "the development and acceptance of theories of loneliness has been hampered by the fact that they are often masked by other clinical syndromes, for example there is a link with loneliness and depression. Isolation and loneliness also has a large stigma attached to it and some would find it very hard to admit they were suffering from loneliness" (p. 954). However according to Peplau and Perlam (1982) at least eight theories of loneliness have been presented, but four distinct theories prevail within which some of the others are contained (cited in Donaldson et al., 1996). These four theories identify issues relating to isolation and loneliness. These prevailing theories are the Psychodynamic, the Existential, the Cognitive and the Interactionist; all of which are described below.

The Psychodynamic Theory

This theory rests on a Freudian psychotherapeutic approach to loneliness whereby

interpersonal, infant and childhood attachments and dilemmas are considered to provide a personality base which predicts future coping strategies (Donaldson et al., 1996). If a person had negative experiences with socialising in their life, the ability to cope later in life is effected and can lead to social isolation and loneliness. Later authors have agreed with this theory, and described "loneliness as a state of mind which is symptomatic of neurosis and which stems form an 'earlier life' which makes it difficult for a lonely person to form relationships" (Kaye et al., 1996 cited in Donaldson et al., 1996, p. 954). Woods, Potnoyn, Head and Jones (1992) state this Psychodynamic theory of loneliness has found some expression within nursing in the form of reminiscence therapy. This theory however does not take into account any of the factors of the social environment of an individual. Donaldson et al. (1996) states "the main deficiency of the Psychodynamic theory of loneliness is that it basically ignores the social world of people" (p. 556). Factors such as culture, education, language skills and health, all may be acting on an individual and potentially causing loneliness at certain times in an individual's life.

The Existential Theory

Donaldson et al. (1996) describes the Existential theory "as essentially, a 'Christian' perspective on loneliness which stems from work whereby man's 'alone-ness, the pain of being alone, 'solitude' could be considered as 'the glory of being alone' aloneness, pain of being alone, 'solitude' involves confrontation or encounter with oneself" (p. 966). This could be described as a positive aspect of loneliness, a time to reflect and grow. Moustakas (1972) and Tillich (1963) that loneliness can be transformed by those who interact with 'love' (cited in Donaldson et al., 1996). A caring and positive reaction to a person would then make a difference and alleviate the loneliness. The problem with this theory is that it excludes the experience of being alone which gives individuals time to contemplate, have peace, and rest

and does not differentiate with being alone and the negative aspects of social isolation and loneliness. Donaldson et al. (1996) argues that "a person's 'aloneness' using this theory's perspective may provide the opportunity for others to interact and this could be a positive aspect of loneliness" (p. 966).

The Cognitive Theory

This theory recognises the contribution of social factors in the development of loneliness and it explains how an individual responds to or feels about their loneliness (Peplau and Perlam, 1982, cited in Donaldson, 1996). According to this theory it is how people feel about their loneliness and how they respond to these feelings which determines how they experience social isolation and loneliness. Donaldson et al. (1996) argues that with this theory loneliness can be manipulated because people evaluate their social relations against some standards and can find themselves to be deficient because of poor evaluation of their own social skills. The authors state further that if this theory is accurate, it should be possible to increase the self-esteem of the individual relative to their own social skills, to show them that they have considerable resources at their disposal and hopefully, to help them overcome loneliness. This theory may help people to take control and responsibility for their isolation and loneliness but tends to ignore the value of social networks in alleviating loneliness.

The Interactionist Theory

This interactionist theory according to Weiss (cited in Donaldson et al., 1995) explains that there are two elements to loneliness, emotional loneliness due to 'the absence of an attachment figure' and social loneliness due to the 'absence of an acceptable social network'. Elements of the Cognitive and Psychodynamic theory are also identifiable with in the

interactionist framework (Wenger et al., 1993). This theory has been criticised by Wenger et al. (1993) who consider that the types of loneliness described by Weiss are not, necessarily negative. Weiss (1973, cited in Donaldson et al., 1995) states further that the absence of others is not a negative condition, solitude is not a condition of unmanageable loneliness and that social loneliness is a subjective state and not always a cause of loneliness. The problem with this theory is that this interpretation of loneliness is based on the individuals subjective evaluation of social isolation, and loneliness could be measured not by quality but by the quantity using the Interactionist perspective (Donaldson et al., 1996).

Summary of the Four Theories

These four theoretical perspectives on loneliness explain that loneliness can be experienced differently for individuals. Psychodynamic theory is loneliness experienced because of the losses in individuals early life stages. Existential theory explains loneliness in terms of a positive time of being alone, to grow and learn about oneself. Cognitive theory develops the line of loneliness depends on the reaction to isolation. Interactionist theory has two elements that lead to loneliness; the absence of emotional and social contacts. To assist in the study of individuals who are isolated or lonely a number of approaches would be useful. Approaches which recognise the causes of isolation and measure if this social isolation is leading to the negative aspects of loneliness and that also recognises the kind of social networks and benefits of these networks that individuals are involved in.

SOCIAL SUPPORT

Loneliness is subjective to individuals personal feelings at specific times and needs at any given time, but social support networks may alleviate loneliness and are essential in

preventing isolation. A study by Spitzer, Bar-Tal, and Golander (1995) examining social support showed that social support had a significant effect on stress and adaptation of individuals. Spitzer et al. (1995) states that "social interactions are considered to be the major source for resource acquisition and protection" (p. 857). A person who perceives himself or herself as loved and supported, is likely to conclude that they have the ability and skills that brought them this support (Spitzer et al., 1995). Resources promote control as in a sense of control that reduces stress and hence promotes adaptation, where as resources that reduce the sense of control contribute to and increase stress (Hobfoll and Freedy, 1990). As well as reducing stress and giving individuals a sense of control, social support provided by contacts can be described as exchanges of resources between individuals. These resources can be tangible as in financial aid, or intangible as in emotional help (Langford, Bowsher, Maloney and Lillis, 1997). This social support may assist people and shield them from the adverse effects of life stresses and therefore help to prevent physical and psychological health problems.

Berkman (1995) argues that in the prevention and treatment of health problems, disease and disability it is important to keep in mind that individuals do not live in a vacuum. They are and need to be enmeshed in social environments and in a series of social relationships. The lack of social support leading to social isolation and loneliness in individuals have been associated with poorer health status, decreased well-being, depression and an increased risk of institutionalisation. Studies have demonstrated the relationship between supportive social contacts and relationships and improved physical health (Byles, Harris, Nair, and Butler, 1996).

Langford et al. (1997) state there is a positive relationship between social support and health.

Examples of positive health states that social support can provide are personal competence, health maintenance behaviours, effective coping behaviours, perceived control, sense of stability, recognition of self-worth, positive affect, psychological well-being and decreased anxiety and depression (Langford et al., 1997). However there are difficulties in measuring social isolation and loneliness.

MEASUREMENT OF ISOLATION AND LONELINESS

Teshuva, Stanislavsky and Kendig (1994) state that "social networks and support are multi-dimensional concepts which involve frequency of contacts, perceived adequacy and type of support and other features that necessitate different approaches to measurement" (p. 78). Not only are different approaches needed but also due to social isolation and loneliness being subjective to an older person and their perception of social contact and networks, measurement of social isolation and loneliness is difficult. Loneliness can be confused with social isolation, which can be measured by the number of social contacts a person has. However, well-being may not be positively correlated with social contact: but might depend on the nature of the contacts made (Forbes, 1996). Having a visit from a particular person may be more important than the number of people who call each day. For some solitude is a way of life, which temperamentally suits them, or a time to reflect and grow. Therefore some people may feel very lonely even when they have many visitors and others may not feel lonely even if they have no visitors. Donaldson et al. (1996) also argues that there can be significant problems researching the phenomenon of loneliness in older people due to the fact that loneliness carries a stigma, which may bias investigation.

According to Teshuva et al. (1994) studies examining loneliness do not distinguish between the degree of social isolation and feelings of loneliness. The authors state that these two

aspects should be studied further as the measures could be quite different. A study of loneliness amongst Swedish people aged 15 to 80 years, Tornstam (1990) "identified three kinds of loneliness: intensity or quantity of loneliness (found to be higher among younger people), inner loneliness (slightly higher among older people) and positive loneliness" (cited in Teshuva et al., p. 78). Killeen (1998) describes some of the problems with measuring loneliness, he states

> *"Loneliness is still very taboo, and it is almost an embarrassment to admit that you are or ever have been lonely, as well people are also scared by it, because of how terrible it can make them feel. Most people would never admit to being lonely for if they have survived such an ordeal, then it is one that they would rather not talk about" (p. 764).*

Anybody and everybody is lonely at some time in their life, some people may be more prone to it at certain times in their lives than other people, for example people who are frail aged and housebound. Some people have ways of coping with this isolation and have networks that can assist in alleviating this loneliness. Others find if very difficult because of personality traits, where they have not been able or learnt to cope with difficult traumatic periods or events in their lives. Killeen (1998) states that every individual is unique, and has different life experiences and ways of dealing with them, some more successful than others. He further states that rather than researching which type of person or personality types are more vulnerable to loneliness, it would be more helpful if researchers could look for ways to alleviate this distressing disorder, so that the psychological pain is reduced. Killeen (1998) argues that loneliness is far more prevalent in today's society than it has been in previous generations. One of societies groups of people who are at risk of social isolation and loneliness are older people (Killeen, 1998).

OLDER PEOPLE AND SOCIAL SUPPORT

Donaldson et al. (1996) argue that "the problem of isolation and loneliness for the elderly is not a necessary accompaniment to ageing and ageing is not responsible for the development of loneliness" (p. 957). But there are relationships between ageing, social isolation and loneliness. Older adults are more likely to have lost relationships due to retirement, relocation and death, and are therefore at greater risk of becoming socially isolated and lonely with advancing age, than younger adults. Literature indicates that factors contributing to social isolation include instability of residence; infrequent contact with friends; children and siblings; lack of participation in social groups; and declines in sensory acuity and health (Dugan and Kivett, 1996). Collingridge (1997) argues that "the lack of contact with family and friends or even others in the neighbourhood and minimal or no contact with health and social services might result in exposure to risk of harm" (p.10). He further states that "research shows a strong correlation between depression and social isolation, the former being implicated in a number of suicides by older people" (p. 10).

In a study of older people in America in 1994 by Roberts, Kaplan, Shema and Strawbridge (1997) found that depression in older people is not due to the ageing process but risk factors that older people may be prone to, poor physical health, disability and social isolation lead to higher rates of depression. The authors further move that if these factors are modified and social support is improved through interventions, this will assist in reducing the prevalence and impact of depression. A study of older people by Prince, Harwood, Blizard, Thomas and Mann (1997) in the United Kingdom in a period from December 1993 to September 1994 found that frequent loneliness was one of the strongest cross-sectional associations with pervasive depression. It was very common among those living alone and among those lacking supportive neighbours or friends and family.

This study showed that older people with some network domains were more important than others; frequency of contact with and availability of friends and neighbours were related to loneliness, where as contact with relatives and childlessness was not. While older people gain support from spouses and relatives, they value friends for the companionship and emotional support, which they can provide. It is interaction with friends, rather than contact with relations, which best predicts well being (Prince et al. 1997).

A cohort study by Bassuk, Glass and Berkman (1999) conducted in the United States of America looked at 2,812 older people who lived in a home setting and who were 65 years of age and older. They were all interviewed in their homes over a 12 year period. The study looked at social engagement, which was defined in this study as "maintenance of many social connections and a high level of participation in social activities" (p. 167). Social engagement was examined using six indicators: presence of a spouse, monthly visual contact with at least three relatives or close friends, yearly non-visual contact (telephone calls or letters) with at least ten relatives or close friends. Also examined were frequent attendance (at least once per month) at religious services, membership in other groups, and regular participation in recreational social activities. This study found that people who had five or six social ties, compared to those who had no social ties were less likely to have an increased risk of cognitive decline. The authors concluded that social disengagement is a risk factor for cognitive impairment among older people.

A cross-sectional study by Krach, DeVaney, DeTurk and Zink (1996) conducted in the United States of America looked at participants over the age of 85 who again lived in a home setting. This study examined six domains of functioning; physical, mental, social, spiritual, economic and activities of daily living. The purpose of this study was to determine how biological,

psychological, social and economic factors and ability to carry out activities of daily living contributed to successful adaptation. The study found that social support provided the participants with a sense of security, and opportunity to share concerns, and increased feelings of worthiness and belonging. The participants of this study stressed to attain a state of high level of functioning, it was important to have empathy and affection for others through positive relationships. The study also identified the presence of themes in the participants' lives: 'living life to the fullest', 'taking an interest in others', and 'always respecting self and others'. The authors suggest that an internally rooted and theme-based sense of self and concern of the larger world stands up to the vicissitudes of very old age.

Other social support studies have shown that the support given provides mechanisms to reduce stress and promote adaptation. A study by Spitzer et al. (1995) looked at these issues and examined social support and how it effected stress and adaptation through the mediating effect of control. The participants were 12 male and 65 females, all were older people, mean age being 54.2 years. Each participant was interviewed in his or her home. They all suffered rheumatoid arthritis and were patients who were being treated in outpatient clinics of three large hospitals in Israel. The findings suggested that social support did have significant effect on stress and adaptation, though this effect was through the mediating effect of control and not as a buffer, as was first thought. However it was found that resources available to the participants alleviated stress, and social support often provided this mechanism for resource acquisition.

Hupcey (1998) argued that although hundreds of studies are done yearly which include social support as a variable, this research remains stagnant. The author further states that even though the characteristics of samples have continually changed, the results remain the same:

social support is important for positive health related outcomes. Studies that can identify ways to provide this meaningful social support are needed to produce these health outcomes. Older people also through lack of social networks can be vulnerable to many risks (Rogers 1997). Vulnerable populations are defined as being at risk of poor physical, psychological and/or social health (Roberts et al., 1997). A person's level of social support is one of the most potent indicators of his/her degree of vulnerability (Rogers 1997).

Older People in Australia

There is a growing ageing population in Australian and this trend is expected to continue for at least the next 20 years (Bishop 1999). It is estimated that in the next 20 years, the proportion of Australia's population aged 65 years and over will increase from 12 per cent to more than 16 percent, an increase from 2.2 million in 1996 to about 3.5 million by 2016. Bishop (1999) states this is the fastest growth rate of any age group. Further stating that by 2036, it is expected that 21.3 per cent of the population, (or 5.2 million Australians) will be over 65 years of age, and 6.2 per cent of the population (or 1.5 million Australians) will be over 80 years of age.

The majority of older people in Australia live independently and require no assistance with daily tasks. Only about one in 20 people (5%) aged over 65 years live in a nursing home or hostel for the aged (Bishop, 1999). People aged 60 years or more with a disability and living in the community are more likely to receive assistance from their spouse or partner than from formal community services. More than 75 per cent of older Australians own their own homes and plan to remain in the community, in which they have lived and worked (Bishop, 1999). However the age profile of the older population is changing. In the next 20 years, the number of people in Australia aged 80 years and over is expected to grow by 63 per cent from just

under 500,000 people in 1996 (a ratio of one older people in five people) to about 850,000 people by 2016 (one in four) (Bishop, 1999).

Coombs (1989) classification of older people can be identified into three groups. The 'young-old' aged between 65-74, often physically healthy, functionally independent and mentally alert. The 'old-old', 75-84 years, have chronic illnesses and physical disabilities and seek the greatest number of medical consultations, plus may have functional, behavioural, social and economic dependencies. The 'very elderly', 85 years plus, who suffer chronic diseases, continuing and progressive disability, socio-economic disadvantage, impairment of mental health, social isolation and dependency. Older people as they age and remain living in homes in the communities at times in their lives may need assistance through community services, assistance to stay independent and remain healthy. The Australian government has initiated a program to address the needs of older people who require assistance in their home, this program is called Home and Community Care.

HOME AND COMMUNITY CARE PROGRAM

The Home and Community Care Program was introduced in Australia in 1985 in response to a variety of reports which recommended a change in the balance from institutional care to community based services for older people. The program assists people who are frail aged, younger people with disabilities and their carers, who are living in the community and are at risk of premature or inappropriate long term residential care (Department of Human Services and Health, 1995). During the early implementation of the Home and Community Care Services, 'young-old' were given services but the 'old-old' and 'very elderly' are now the main users of the program, due to a number of changes which are outlined later.

The types of services eligible for direct funding under the Home and Community Care Program are:

- Home help or personal care (or both);
- Home maintenance or modification (or both);
- Food services;
- Community respite care;
- Transport;
- Allied health services (eg. paramedical services such as podiatry and physiotherapy);
- Community nursing (which may include personal care);
- Assessment or referral (or both);
- Education and training for service providers and users;
- Information and co-ordination;
- And other such services as agreed upon by the Commonwealth and State Ministers.

The Home and Community Care Program also provides services for special needs groups,

including people from Aboriginal or Torres Strait Island descent, people with dementia and people from non-English speaking backgrounds (Home and Community Care Program National Guidelines, 1989).

The objectives of the program are: to provide a comprehensive and integrated range of basic support services for the target population; to help these people to be more independent at home and in the community, thereby preventing inappropriate admission to long term residential care and enhancing their quality of life. This program also provides a greater range of services and more flexible service provision, to ensure that services respond to the needs of users (Ageing and Disability Department, 1996). The Home and Community Care Program also provides services to people for short periods, such as during a period of illness or rehabilitation, or recovery from surgery.

Home and Community Care Funding

The Commonwealth meets an average of 60% of total matched funding nationally and matches funds made available by each State and Territory on the basis of an agreed prevailing ratio. State and Territory expenditure can include funding provided by Local Government and community organisations (Department of Human Services and Health, 1995). The original goal of 20% annual growth for the Home and Community Care Program was going to determine the long-term viability of the services. However the diminishing annual growth from 20% down to the present 2% over the seven years, means that millions of dollars have been lost from the program in New South Wales and the effectiveness has been greatly reduced (Baines, 1995).

At the same time as growth funding is decreasing, client numbers are increasing, as are the

range of services needed to assist them. Moore (1995) states that "a recent Commonwealth-State review of Home and Community Care programs predicted a 2.7% growth in demand each year until 2020 and found that current programs met only half the demand for such services."

Effectiveness of Home and Community Care Program

The afore mentioned short fall in funding has impacted on the effectiveness of services provided under the Home and Community Care Program. The focus of service provision has had to adapt to the financial constraints. During the early implementation of the Home and Community Care Program 'young-old' were targeted to receive services as a preventive measure however the 'old-old' and 'very elderly' are now the main users of the program. A large number of people in the later stages of 'young-old' who live independently and who will stay healthy with minimum support in and outside the home, do not receive Home and Community Care Program services. This is due to the growing numbers of consumers with high needs who require Home and Community Care Services to live independently in their homes, the effectiveness of the program has been reduced. The program originally set up to provide basic support and for the prevention of health problems and premature institutionalisation, is now a program managing services to large numbers of consumers with high needs due to chronic conditions and multiple physical, emotional and social disabilities.

Many Home and Community Care Program services are experiencing a dilemma. While they are supplying services to clients with higher needs and greater dependency, they are at the same time uncomfortable with their inability to provide services to people of the original target group with a lower level of dependency. However the original target group are nevertheless in need of services to prevent further health problems occurring (Howe, Gray,

Gilchrist and Beyer, 1996). Sax (1993) argues that, due to the changes in the needs of consumers of community care, it is likely to result in sharper targeting of Home and Community Care services on high-need clients. The author further states a conclusion likely to disturb those who favour the expansion of community services that promote the health and welfare of ageing people and their families. Other strategies need to be put into place which prevent older people reaching crisis situations therefore decreasing the load on these Home and Community Care Programs.

NEIGHBOUR AID HOME VISITING SERVICE

One program to address the social isolation and loneliness of the Home and Community Care clients is the Home and Community Care funded Neighbour Aid Home Visiting Service. This service has developed creative and flexible community base support services primarily via the co-ordination of volunteers to ensure that the clients of the Home and Community Care Program target group can continue to live at home safely and enhance their well being. The Neighbour Aid Home Visiting Service is client centred, uses a holistic approach and builds relationships with clients. Neighbour Aid Home Visiting Service keeps people connected by providing social companionship and therefore preventing social isolation and loneliness. Neighbour Aid Home Visiting Projects have been able to provide a range of practical and social support services that assist the social and emotional needs of the target group. This service raises the self esteem and self confidence of the target group and contributes to the maintenance and enhancement of the well being, independence, security and quality of life of people who are frail aged, younger people with disabilities and their carers (Department of Community Services, 1993).

The Neighbour Aid Home Visiting program is unique to Australia and to the state of New

South Wales. It is not formally recognised as a service under the Home and Community Care Program but it is acknowledged as a viable, indeed exemplary, service delivery model. Neighbour Aid Home Visiting has developed creative and flexible community based support services, primarily via the co-ordination of volunteers to help the Home and Community Care target group. The Neighbour Aid Home Visiting Services are usually funded for Local Government Areas some areas due to large client numbers have more then one Neighbour Aid Home Visiting Service. Table 1 shows statistical information for one of three Neighbour Aid Home Visiting services that operate in the Parramatta Local Government Area. This service is funded for 40 clients to be linked at any one time, that is each client receiving visits from at least one volunteer.

Table 1: Statistics of Parramatta Neighbour Aid Home Visiting for Jan 98 to Dec 98

CLIENTS	
Total Clients assisted	105
Female	73
Male	32
VOLUNTEERS	
Total Volunteers registered	63
Female	47
Male	16
SERVICE	
Total hours of visits provided	1,799
Number of contact visits provided	1,212

The goal of the Neighbour Aid Home Visiting services is about improving the quality of life of the target group. The service is planned around the needs of the individual rather than an expectation that individuals will fit into established service types. The services are, for the most part, provided by volunteers from and within the community. Due to the one to one

nature (volunteer to client) Neighbour Aid Home Visiting services also develop and provide services that other Home and Community Care services cannot or will not provide such as specialty shopping, exercising a blind persons guide dog, washing pets, reading the newspaper for the visually impaired and taking the rubbish out. Neighbour Aid Home Visiting has the flexibility to respond to change more readily than other Home and Community Care services. Many Neighbour Aid Home Visiting Services developed initially to provide practical and social support services. There is a great variety between the programs of various Neighbour Aid Home Visiting Services, which consciously embraces the diverse needs of people.

Neighbour Aid Home Visiting is frequently an initial contact point rather than an end point of the referral process utilised by Home and Community Care services. It is popular and is frequently seen as a low key, non-threatening and less stereotyping service than more specialised services. Neighbour Aid Home Visiting embodies a holistic approach to the client. Its services build an important knowledge base and relationships with clients who when contacted are usually comparatively 'light' consumers of resources. The 'light' care co-ordination function of Neighbour Aid Home Visiting means that when these people require greater assistance, appropriate and timely referrals and interventions can be initiated. Neighbour Aid Home Visiting is a highly cost effective way of delivering this 'light' care.

Neighbour Aid Home Visiting Services also provide a generalist perspective on clients as people in a community, rather than a collection of tasks in a need group. Neighbour Aid Home Visiting Service does not wish to compromise this perspective simply to improve its ability to fit with a specialist based delivery system. It revolves around the needs of clients, not regions, populations, service providers or service delivery. As Chris Baines reported in

her 1995 study 'Neighbour Aid – Invisible or Invincible' the Neighbour Aid Home Visiting Service's perceived invisibility is one of its greatest strengths as well as being one of its greatest weaknesses. Neighbour Aid Home Visiting is submerged in its community. Neighbour Aid Home Visiting is to do with the community's right to volunteer, to be involved in the design and delivery of their 'own' service. Neighbour Aid Home Visiting helps to provide the conditions for this community development. Neighbour Aid Home Visiting keeps people connected (NSW Neighbour Aid Association, 1998-99).

Volunteering with Neighbour Aid Home Visiting

The volunteers of the Neighbour Aid Home Visiting Service come from a wide range of backgrounds, ages and cultures, and they register and work for a variety of reasons. Some of these reasons are to gain knowledge of the Home and Community Care Program for future employment, meeting new people due to also feeling socially isolated and lonely. To be with people with simular interests, to practice speaking English, to fulfil requirements for certain courses or basically to be a good person and help others in the community.

To join the Parramatta/Dundas Neighbour Aid Service a person must attend an induction training program or have skills/knowledge of the target client group. The induction training covers the topics needed to provide the services to the clients and fulfils the service duty of care to volunteers and clients, these include:

- Volunteering
- Home and Community Care Program services and its clients
- Attitudes and Values
- Communication Skills
- Ageing Process

- Dealing with Clients
- Rights and Responsibilities of Volunteering
- Code of Conduct

After the induction training and the volunteer references are checked, a suitable client is organised for the volunteer to meet. Due to the Neighbour Aid Home Visiting Service introducing people on a one to one bases, greater attention is paid to the specific needs of the client and skills and attributes of the volunteer. The link is decided on a number of issues including; culture, needs, skills, allergies, language and communication, gender, location, time and day preferred by both the volunteer and client. The co-ordinator takes the volunteer to meet a suitable client in the client's home and discusses the proposed service; how it works, and the 'dos and don'ts'. When both the client and volunteer feel comfortable with the service, a day and time are organised and the volunteer continues to visit regularly until there is a change of circumstances either for the volunteer or client. There is ongoing support for the volunteers through the co-ordinators telephone and personal contact with regular support meetings and ongoing training to keep up to date with client and volunteer issues. The volunteers also receive a monthly reimbursement for out of pocket expenses such as petrol and public transport costs.

Volunteer Work

Being a volunteer in a community service also assists individuals who may feel they are socially isolated and lonely. In a study of four Iranian older women, Boardman (1998) found a major difference in the interviewed participants. The participants who did not feel isolated had occupations before retiring and coming to Australia, both were teachers and continued to use these skills today in volunteer community work. Voluntary activity, apart from providing

an important and irreplaceable part of community service, is itself a way of maintaining social contacts and enabling older people to remain active, healthy and involved (Encel, Kaye and Zdenkowski, 1994). For these participants, the volunteer teaching work also enabled them to use their qualifications and skills to provide assistance to others in their Iranian community (Boardman 1998).

Hembury (1998) states that human resources are the most valuable asset in any business in the community sector. This notion is of particular relevance given the nature of work in the not-for-profit organisations and the very heavy reliance on human resources, most of whom are volunteers. Volunteers are the mainstay of many thousands of community organisations across Australia and the world. The value of voluntary work is immense to people, it gives work experience to people whose confidence and self-esteem has been affected by such things as unemployment (Hembury, 1998). It also gives a sense of achievement, of renewed purpose and personal growth that follows from the participation and connection with communities through organised voluntary work.

SOCIAL CAPITAL

Communities have many support networks to alleviate the social isolation and loneliness of members of the their community and in particular older people. Networks in communities and systems to provide help and assistance to each other in communities has been named as social capital. "The core concepts of social capital, according to it principal theorists, Putman and Coleman, consists of civic engagement and levels of mutual trust among community members" (Kawachi, Kennedy, Lochner and Prothrow-Smith, 1997, p. 1494). This social capital has been recognised to improve the health of individuals and the communities they live in. "The aspect of social capital that makes it a classic public good is its property of

nonexcludability; that is, its benefits are available to all living within a particular community, and access to it cannot be restricted" (Kawachi et al. 1997). According to Putnam (1993) the notion of 'social capital' refers to norms of reciprocity and networks of civic engagement that become embedded and enacted through moral resources such as trust and co-operation across the whole social system and not only by individuals (cited in Cowley and Billings, 1999). Mustard (1996) links this idea with 'health capital' by identifying forces that influence health across populations, such as socio-economic factors; childhood, competence and coping skills; and health service policies (cited in Cowley et al. 1999).

During the 19th century, advances in the health of the population mostly came from improvements in nutrition and environments in which people lived and worked. In the 20th century poor sanitation and malnutrition were solved in developed countries, but the circumstances in which people live and work are still crucial determinants of disease rates. Therefore, lifestyle provides a potential place for effective interventions to improve the public's health. Rose (1992) states "the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social" (cited in Marmot, 1998, p. 58). Therefore identifying and utilising these social factors can be a way to improve individuals health within communities.

Kawachi et al. (1997) suggests that socially isolated individuals could potentially benefit from living in a neighbourhood rich in social capital. An example of this is elderly people living by themself who have neighbours who meet regularly at neighbourhood centres, transport this and other older residents to voting booths on election days, make sure the housebound person's garbage is put out on garbage nights and so on. For the older person living alone and isolated due to health problems or disability, with few social networks would be classified as

socially isolated. Although with access to the stock of social capital in the community, in the form of passive surveillance and general regard for their welfare this isolation is alleviated. The neighbours or services like Neighbour Aid Home Visiting can assist older people to be able to live independently and remain living in their home. As in other words Kawachi et al. (1997) state "measurement of social capital at the ecologic level captures something distinct, over and above measurement of individual social connections" (p. 1494).

Cox (1995) states that social capital refers to the processes between people which establish networks, norms, social trust and facilitate co-ordination and co-operation for mutual benefit. The author further states that working together voluntarily in egalitarian organisations increases social capital. Learning some of the rough and tumble of group processes also has the advantages of connecting us with others. Accumulated social trust allows groups and organisations, and even nations, to develop the tolerance sometimes needed to deal with conflicts and differing interests.

Kawachi et al. (1997) examined levels of trust and density of membership in groups in America. He found that high levels of trust and high density of group membership were associated with reduced mortality rates. Several epidemiological studies have shown that social and emotional support can protect against premature mortality, prevent illness, and aid recovery (Berkman. and Syme, 1979). This could assist by reducing emotional distress. Various different types of studies have suggested that social capital is important for improved health. That is a feature of social organisation such as civic participation and social trust facilitates co-operation for mutual benefit (Wilkinson, 1996, cited in Stewart-Brown, 1998). Stewart-Brown (1998) states "that there is an increasing body of epidemiological, social science, and experimental research that is beginning to suggest that only promoting physical

wellbeing to the exclusion of mental and social well being may be doomed to failure" (p. 1608).

Cox (1997) describes the value of social capital as

> *"... pre-eminent and the most valued form of any capital as it provides the basis on which we build a truly civil society. Without our social bases we cannot be fully human. Social capital is as vital as language for human society".*

The author further states that social capital is produced through social processes: it production and reproduction depend on opportunities to socialise, particularly to socialise with those who one would not necessarily meet in one's immediate and intimate environment. Social capital measures the quality of our interactions and links with people outside our family and intimate circles.

RESEARCH STUDY

The aim of this research study is to ascertain the work of the Neighbour Aid Home Visiting Service in the Parramatta Local Government Area (LGA) and see how it has left its impact on the level of social isolation and loneliness among older people. The study in particular aims to answer the following questions:

1. Do older people in the Home and Community Care target group feel socially isolated and lonely?
2. For those who feel socially isolated and lonely, how do they cope with their social isolation and loneliness?
3. Has the Home and Community Care Program funding Neighbour Aid Home Visiting Service been instrumental in reducing the level of social isolation and loneliness?
4. How do the participants perceive the role and function of the Neighbour Aid Home Visiting Service in reducing the level of social isolation and loneliness?

METHODOLOGY

This is a qualitative research study to capture and understand the participants' own meanings, definitions and descriptions of assistance being obtained. Using a qualitative perspective addresses the meaning of the issues from the person's personal point of view, within the context of his or her family setting and social circumstances (Polgar and Thomes, 1995). Participants were chosen by convenient sample through workers from the Neighbour Aid Home Visiting Service Western Regional group. Participants in the study were 65 years or over, male and female, clients of the Neighbour Aid Home Visiting Service for a minimum of six months and receiving a volunteer visitor, who visits them for a minimum time of four

hours per month. The qualitative study is made up of a set of general questions and a semi-structured interview.

How were participants selected?

The Neighbour Home Visiting Service of the West Metropolitan regional group meets once per month for peer support and to share information. At this meeting the researcher discussed the research study and asked if any of the co-ordinators would consider finding clients to participate in the study. Four agreed to assist, the researcher asked each co-ordinator to find two clients each, who fit the criteria. Each were asked to explain to the participants that the researcher wanted to interview older people for about one hour who lived at home, to find out what is was like and if services helped to improve their situation. Neighbour Aid Home Visiting Service was not mentioned has the researcher didn't want to bias the participant's views or cause any distress as each participant was receiving a volunteer from this service. Also for this reason the researcher asked the co-ordinators not to mention the title of the research topic 'Social Isolation, Loneliness and Older People' as the researcher feared this might have lead to influencing the information discussed later in the interviews.

Questionnaire

A questionnaire (see appendix A) was designed to gather demographic information and information about services that the participants received. The questionnaire included: age, sex, marital status, if migrated to Australia and how long have they lived in Australia, did they live alone/with partner/children/grandchildren/other family member/friend, if they were primary Carer and who they cared for and what was their occupation before retiring. Other questions were the number of contacts per week, number of phone calls received and made in

a week/day, number of home visitors from Home and Community Care Program provided at home and other types of assisting services. The interviewer went through the questionnaire with each participant before the interview started.

Interviews

The researcher/interviewer contacted the willing participants individually and explained the purpose of the study. Participants were informed of their rights in the interview, the confidentiality of the study and the benefit of the outcome. The participants were interviewed in their own homes, and each informal interview lasted approximately one to two hours.

The questionnaire was filled in first and then the informal semi-structured interview began. The semi-structured interview included some of the listed questions below:

1. Do you feel social isolated?
2. Do you ever feel lonely?
3. If yes, how do you cope with this social isolation/loneliness?
4. If no, what do you do to prevent social isolation and loneliness?
5. How has the volunteer visiting program helped to prevent isolation/loneliness?

However the interviews were flexible and often most of the questions were not asked directly or if asked not always answered. The participants talked about their life and the researcher/interviewer steered the discussion to the research study topic.

Participants

The six participants of the study all lived in their own home. Only one participant lived with

another person, her daughter, who also needed services to assist her due to a chronic health condition. They cared and supported one another. All the participants were housebound due to a number of health and medical conditions, including severe arthritis, blindness, poor mobility, incontinence and frailty due to old age. They spent long hours at home, and received a variety of Home and Community Care services, Community Care services and other organisations and private services (see Table 4 and 5).

PILOT STUDY

This research study was initially piloted to test the interview questions and to test if there were any issues or concerns that needed to be addressed. One person was interviewed for one hour in her home. This participant was found through a Neighbour Aid Home Visiting Service provider and asked to participate in an interview to understand what it was like to live alone and what services assisted. There was no demographic data questionnaire given.

The participant was a female aged 75, widowed and lived in a one bedroom Department of Housing unit. She had lived there alone for the last 12 years. Her mobility was limited due to a failed knee replacement and severe leg ulcers. She received Home and Community Care services to maintain her independence and remain living on her own. The services included Home Care for daily help with showering, housekeeping and shopping fortnightly. Hot meals were delivered by Meals on Wheels volunteers five days a week. Community Home Nurses visited two times per week to tend to her leg ulcers and a Neighbour Aid Home Visiting volunteer visited weekly for social companionship and some practical assistance.

The participant's daughter provided the majority of practical assistance such as advocacy, speciality shopping and large home maintenance tasks. Her daughter also helped her maintain

meaningful social contacts with long time friends by transporting close friends to the participant's home. Other family networks such as grandchildren and great grandchildren provided the much-loved outings and trips outside the home, which the participant was unable to attend without help. The interview lasted one and half-hours, it was tape-recorded, transcribed and then analysed.

During the interview the participant often avoided the subject of loneliness, she would change the subject quickly when this question was asked, an example "do you feel a bit lonely now your good friend has moved away?" The participant stated "well, no, some days, most days I have to get up early because Home Care are coming". Another time when asked again she stated that "no, but I had a good friend who use to visit everyday and has now moved away".

The participant was isolated because of the disability and beside family, also relied on neighbours for practical help in her unit such as watering the garden and picking up letters or items from the shops. This also provided social contact. The twenty unit Department of Housing complex contained a community room, which in the past was used by the residents for social contact, leisure activities and functions. This room is no longer used as the neighbour who moved away organised these groups and it was stated that there is no one else able or willing to do this. The participant missed these activities and social contact with neighbours was achieved by meeting neighbours for a chat on a trip to the letterbox.

The interviewer identified a number of issues. These were social isolation and loneliness was alleviated by family support, support services, meaningful social contacts and networks. The participant conveyed that this support helps a housebound individual to be more optimistic and find alternatives to deal with the loss of past outside contacts. However to maintain

meaningful social contacts and networks, this participant needed practical assistance such as transport or organised visitors through family or services. Meaningful support for this participant was defined as being able to share interests and being valued for wisdom through life experience. Also to have the opportunity to be able to support family and friends in small ways, such as giving advice and sharing knowledge and experiences.

The Neighbour Aid Volunteer worker, organised for social companionship, visited weekly but provided much more than social contact to relieve loneliness. The participant herself as well as receiving assistance from the volunteer helped the volunteer in many ways. These were improving the volunteer's English skills (the volunteer was from a Non English Speaking Background), sharing wisdom through advice about the volunteer's family and also giving information on Australian society and culture. The participant stated "the volunteer said you always tell me to do the right thing". The participant also had a great sense of accomplishment at helping the volunteer stating "she speaks quite good English now, I am sort of proud of myself".

Although the participant suffered loss of mobility, independence and social support she seemed optimistic and was coping well with being housebound. Family support, supportive services such as Neighbour Aid Home Visiting and the meaningful social contact appeared to be the factors that helped the participant cope and alleviate loneliness. Future interviews would identify people in simular situations, with and without these support networks to assess if other factors and issues affect the well being of housebound and socially isolated individuals.

Three propositions were written from the analysis of the interview:

1. People with strong family support are less socially isolated and lonely and are more positive about being housebound.
2. To maintain meaningful social contacts and networks housebound people need practical assistance such as transport or organised visitors through family or services.
3. Meaningful support contact is being valued for wisdom and life experience and being able to reciprocate by giving support to friends as well as accepting support.

The later research study explored these three propositions. How did others cope with isolation and loneliness without family support and networks? Did housebound and isolated people without family support and networks have simular positive attitudes to their situation. If their attitudes were positive what assisted this? Did the participants of the research study rely on practical assistance and organised visitors to maintain meaningful support? Did meaningful support mean being valued for their knowledge and being able to reciprocate and provide support to others?

RESULTS OF QUESITONAIRE

The demographic data in the table 2 shows that the participants' age ranged from 79 to 94 years of age. There were four females and two males in the research study. Only one participant had never married, the other five people were all widowed. Only one of the participants lived with another person, her daughter who had a chronic condition. They supported one another. All others participants lived alone. Three of the participants were born in Australia, three had migrated to Australia, two from the United Kingdom, one living in Australia for 53 years the other for 31 years. The other participant, who migrated was originally from Burma but grew up in India, she had been in Australia for 14 years.

All participants stated they had a number of jobs and professions in their course of working life. Table 2 shows their last job before retiring. These past occupations were in areas of office work, cooking in a restaurant, working in a retirement village, labourer, retail shop assistance, primary school teaching, running a privately owned business and working as a type setter for a newspaper.

The question in the questionnaire about phone calls and visits referred to the week before the interview. All participants, except one, telephoned family and friends, from 1-4 times per week. One of the participants did not have a phone in his home, but he said he is able to use his neighbours phone to ring friends. He had no family and these friends also left messages for him. That week he did not make or receive any phone calls.

Family and friends made telephone calls to three of the participants on average one to three times in the last week. One participant had seven to nine calls and another estimated ten or more in the last week. Family visits for four of the participants ranged from one to three in the last week, two of the participants did not receive any visits from family. Participants went out of their home to visit or see family and friends occasionally, these ranged from one to three times in the last week for three of the participants and three participants did not go out at all.

At the end of the questionnaire the participants were asked if they felt socially isolated. Three out of the six stated yes, one did on occasions and the other two felt socially isolated only at night. When asked if they felt lonely, only one participant admitted he did feel very lonely, two participants stated at night sometimes and the other stated yes, again in the evenings. The other three stated no. However, later during the informal interviews only one participant

stated no she did not feel lonely or socially isolated because she always had company due to her daughter living with her. The others all agreed that they had times that social isolation and loneliness affected them.

Table 3 shows the time each participant has been receiving the Neighbour Aid Home Visiting service. The volunteers visited on average two hours per week and provide a range of assistance. The main assistance all the participants received was companionship or friendly social contact. Three received assistance with shopping, three assistance with transport to the shops or for appointments, one participant as well as receiving transport, was accompanied by the volunteer to medical appointments. Four of the participants were helped with odd jobs such as picking up the newspapers or changing a blown light bulb. Four of the participants regularly went with the volunteer on outings, these outings ranged from a day trip to the mountains, a couple of hours at the local club or shopping centre and outings to the volunteer's home on special occasions such as Christmas.

Table 4 records the services provided by Home and Community Care funded programs. Three received assistance from Home Care for housekeeping and shopping, one participant utilised the Community Transport Service and one received food from the Meals on Wheels service. Table 5 recorded private or other government services being utilised to assist the elderly with living at home. These ranged from shopping by a friend who was paid a small amount, weekly outings at the local Returned Ex-serviceman's Limited Club (RSL) day activity group, transport was organised by the club for the participant. Two of the participants paid private gardeners and two participants used a Vital Call, a medi-alarm service. One had a home hairdresser, three received the free Redcross telephone service called Telecross and one participant used the Taxi Subsidy vouchers, these enabled the participant to have half

price off a taxi fare.

Table 2: Results of the questionnaire

Participant	*1*	*2*	*3*	*4*	*5*	*6*
Felt isolated	No	On occasions	At night sometimes	In the evenings	Yes	No
Felt lonely	No	No	At night sometimes	In the evenings	Yes	No
Age	91	94	91	79	86	81
Gender	Female	Female	Female	Female	Male	Male
Marital status	Widow	Widow	Widow	Widow	Single	Widower
Live with	Daughter	Alone	Alone	Alone	Alone	Alone
Carer	No	No	No	No	No	No
Migrant	Yes	No	Yes	Yes	No	No
Country of birth	England	Australia	England	India	Australia	Australia
Lived in Australia	53yrs	From birth	31yrs	14yrs	From birth	From Birth
Past occupation	Typist	Shop Assistant	Cook	Primary school teacher	Labour and owned a business	Newspaper Printer
Phone calls per week to friends and family	1-3	3-4	1-3	2 per day	No phone	1-3
Phone calls received from family and friends	1-3	10 +	1-3	1-3	No phone	7-9
Visitors last week	1-3	1-3	1-3	1-3	1-3	1-3
Visits from family and friends	1-3	0	0	1-3	1-3	1-3
Visits to family and friends	0	1-3	0	1-3	0	1-3

Table 3: Assistance Neighbour Aid Volunteers provided to participants

Participant	*1*	*2*	*3*	*4*	*5*	*6*
Time receiving Neighbour Aid visitor	2 years	3 years	9 years	4 years	2 years	1 year
Neighbour Aid volunteer visits on average	2 hrs per week	2hrs per week	1.5 hrs per week	2 hrs per week	2.5 hrs per ftnly	2hrs per week
Assisting given						
Companionship	✓	✓	✓	✓	✓	✓
Shopping			✓	✓	✓	
Transport			✓	✓	✓	
Accompany to medical appointments				✓		
Odd jobs	✓	✓	✓			✓
Outings		✓	✓	✓	✓	

Table 4: Home and Community Care services received by participants

Participant	*1*	*2*	*3*	*4*	*5*	*6*
Home Care	✓			✓		✓
Community Transport			✓			
Meals on Wheels					✓	

Table 5: Community Care services provided by other organisations

Participant	*1*	*2*	*3*	*4*	*5*	*6*
Shopping	✓					
RSL Day Centre		✓				
Lawn moving	✓					✓
Library housebound readers	✓		✓			
Vital Call		✓		✓		
Home hairdresser			✓			
Telecross	✓	✓	✓	✓		
Taxi subsidy		✓				

RESULTS OF THE INTERVIEWS

Were the participants socially isolated and lonely?

At the end of the questionnaire the participants were asked if they felt socially isolated or lonely. Three out of the six participants stated yes, one stated they did on occasions and the other two felt socially isolated only at night. However during the interview the participants found it difficult to discuss their own situation about their social isolation and loneliness, but often talked about it by way of discussing other people they knew, friends or family that they perceived as lonely. Some of the common themes that were openly discussed amongst the participants was that is was very difficult to go out alone and visits from friends and family to their home were infrequent.

Leaving the home and going on outings for the participants was a very difficult and frightening experience due to their frailty, disabilities or medical conditions. One participant who was very frail and lived in a third floor apartment which didn't have an elevator, described the reason why she felt afraid to go out alone

> *"I am frightened to go out, what if I have a fall, no one would know who I am and you have to be careful of vandals, I am very slow and would not be able to run away"*

This female participant who was born in India discussed how she very much wanted to go out and share her experiences and skills of teaching with the younger generation. A study of older people by Krach et al. (1996) found that their participants seemed to have an urgent need to tell their stories and they had a need to review, reflect upon and sum up their lives. To do this the participant in this study had applied for volunteer work at the local children's hospital she explained her situation

" I would love to talk to people and get out, but I must have some one to help me physically. To go anywhere I need help with transport, I don't have a car and I can't walk to the train station any more, I would love to do something, I would like to tell my history and experiences to younger people, but can't".

However she occasionally went out with some good friends who took her to the local church on Sundays. But if it was raining or if the participant was not well or the friends themselves were unwell, she missed out on this much loved social and spiritual outing. The study Krach et al. (1996) found that prayer was mentioned as a source of support in difficult times and in relation to dealing with chronic illness and pain. This participant often relied on the Neighbour Aid Home Visiting Volunteer to assist with transport to medical appointments and occasional outings.

Another of the female participants who was sight impaired and frail, was also taken on trips out and physically assisted by the Neighbour Aid Home Visiting Volunteer. These outings took place on weekends as the volunteer worked full time during the week. For medical appointments during the week this participant relied on taxis and utilised the Taxi Subsidy Scheme vouchers, but was now finding it difficult to go out alone. She describes the difficulties as:

"I can't expect people to drop every thing for me to go to specialists or for hearing aid appointments, but now I am finding it very difficult to go out alone. It is due to my eyesight deteriorating and I need help to manage gutters etc".

Medical conditions were the cause of the social isolation for some of the participants. One of the female participants who had an incontinence problem said that it was impossible to go out because the worry of having an accident made the incontinence worst. Another participant because of a heart problem had also become limited with social contact. He now had a

restricted licence due to health problems and can only drive to the local shops and the local club. He is unable to visit family and friends that live further than five kilometres from his home. All the participants except one of the males relied on other people for outings and transport to medical appointments.

Visits from family and friends to the participant's homes were infrequent for many reasons, some because of the distance that they lived from the participants' homes. The time available for visiting from family and friends was an issue, lack of visits was often due to them working full time and the busy lifestyle they lead. Another issue raised was that the age of the participant's friends. They could not visit because they themselves had mobility or transport problems. One female participant's reason was that her daily routines were out of sync with the rest of the world so she had very few visitors. Her comment was

> *"Visitors want to come at 8pm which is normal for most people to visit, all our arrangements are 'cockeyed' to the rest of the world, my daughter and I eat dinner at 4pm and then we go to bed early. So we can't have people over".*

One of the male participants who was unable to drive the distance to his daughters home stated:

> *"My daughter use to come on the weekends but now she is busy with work and I can't drive there, it is too far, I get too tired walking to the train station and travelling on the train. But my daughter rings me every night no matter where she is, all my other family, daughter, grandchildren, brother in law, live at the north shore, it is too far for me to go".*

The participants' neighbours provided some practical support but little social support. It was mentioned the practical support was infrequent and only when problems in the house or

neighbourhood needed attention. A common pattern discussed was that most of their neighbours, who they had built up relationships over many years had all died or moved away. The neighbours now, were often not seen for weeks, but if help was needed, could be called to assist. One participant stated:

> *"The neighbours beside me never ask favours, but if anything happens and I need help I could ask them, they are very friendly"*

Another participant stated:

> *"My recent neighbours are not seen much, one side are full time workers and away a lot but if anything goes wrong he is happy to help if asked, he fixed the shower screen the other day and puts the garbage bin out weekly, which is a great help"*

The last question of the questionnaire asked about the participant's feelings on loneliness. Two participants stated they felt lonely at night sometimes, and the other stated she did also feel lonely in the evenings. The other three stated that, no they were not lonely. However, later during the informal interviews only one participant stated no she did not feel lonely or isolated because she always had company due to her daughter living with here. The others all discussed the loneliness they felt at different times during the day, and they agreed that they had at many times felt socially isolated and lonely and this affected them.

One male participant when asked about loneliness admitted he did feel very lonely. He said:

> *"Oh very much so, some days I don't have or see any one to speak too, Saturday and Sunday there is no one around, I have become so use to it now, I read and contemplate. You get use to something that is unnatural and get hardened to it, you have to put up with it"*

One female participant describes her loneliness in the evenings and how she dealt with it. She stated:

> *"I am very lonely in the evenings, I have to talk to myself and say family and friends can't come to visit me at night because everyone has to be with their families. They are busy cooking their dinners and taking care of their children. I pray a lot and this helps me with this loneliness"*

One of the male participants who stated he was not lonely was the only one with a house pet. He was very fond of his cat, which he had had for four years. Part of his day was spent with his pet and the chores needed in keeping a cat. He described how important having this animal in his home was. His comment was:

> *"Cat is a old friend of mine, my daughter brought it for me because she had read that old people who get a bit incapacitated look forward to animals... He comes into bed every morning to see if I am alive, he jumps up on the bed and walks on my stomach, he peeps over the bed clothes to see if I am alive and then I pet him. He then goes down to the bottom of the bed for a snooze. He only comes in at dawn, he is a good friend and good company."*

It appears that the pet assisted in alleviating the loneliness by having a 'living thing' in his home. As a result when he woke up in the morning and was greeted each day by the presence of the cat. Brodie and Biley (1999) in a study of older people and pet therapy, found that people who interact with pet animals benefit from improved physical, psychological and social health experiences. The author further states that "decreased loneliness, improved morale and increased social interaction appear to result from interaction with animals" (p 333). One other participant also gained some companionship from the presence of an animal, her neighbour's dog. She describes the dogs visits:

"The next door neighbours little dog comes to visit me every day, I give him a bone which I buy at the local shops and he sits on my knee. I also look after him when they go shopping and he seems to know the meaning of everything I say. He is lovely, I miss him right now, and he is away on holidays with his owners".

How did the participants cope with the social isolation and loneliness?

All the participants were housebound due to a variety of health problems and disabilities. To occupy their time and alleviate the social isolation and loneliness there were a number of similar interests that were used to pass the long hours spent alone. All the participants stated that a range of housekeeping activities occupied their time. They followed routines for household chores. Household chores such as dusting, cooking and general tiding up, took up a lot of their day. One female participant also enjoyed planning and cooking biscuits for visitors. The long time needed to complete these chores was due to their health problems or disabilities. It was a big physical effort and the household chores were extremely time consuming to complete. One of the male participants with a heart condition said:

"It takes me thirty minutes to change my sheets on my bed because I get so tired, I need frequent rests and have to sit on the bed to get my breath".

One of the female participants enjoyed gardening and had a number of pot plants to tend. She had water bottles conveniently placed near the front door so there was only a few steps to water her plants daily. The water bottles were then individually refilled for the next day this chore could be done slowly during the day, depending on her energy levels. The participant stated:

" I water my plants everyday and then I can chat to neighbours in the complex at the same time. My little garden in little pots provide variety, I can arrange them the way I want them, when I feel like a change I can rearrange them".

Three of the participants watched television shows to pass the time during the day, shows such as sport, news and current affairs. One male enjoyed cable television for the sports and the horse racing broadcasts. The other three participants did not watch television at all because of poor hearing and eyesight. Two of the female participants listen to talk back radio during the day and at night in bed.

Making craft items was mentioned by two of the women participants, one female crocheted rugs to give to local services to raffle and the proceeds went to assist these services. This participant stated:

"I made cushions and rugs that are raffled to raise money for services like the volunteer visiting service in the local area. It feels very good to help, they raised $60 with the last one raffle".

She also made crocheted gifts for family and friends. The other two female participants stated that in the past they also enjoyed and spent a lot of time making items for family and friends, but due to failing eye sight and difficultly using their hands due to arthritis, were now unable to continue with the crafts.

Reading was high on the list of activities. The Housebound Library service delivered large print books to two of the participants. One of these participants stated she read 15 books every two weeks. Historical novels about life in the participant's younger years were her favourite. The two male participants had the local paper delivered and spent most mornings

reading the articles. One of these participants stated he enjoyed reading and always had. The other male participant who read the daily paper for four hours everyday stated:

> *"I have an extremely lonely life, I have always been a loner, and I do a lot of reading of newspaper to occupy my time. I also cut out newspaper articles to show and discuss with visitors".*

This participant also wrote letters to celebrities such as an American movie star or important world leaders of other countries to comment on relevant world issues he had read in the newspaper. He gained a lot of satisfaction displaying written responses to his letters. Many of these letters and cards were displayed on his walls of his home.

A female participant also liked the daily Herald newspaper for the crosswords and spent her day in between other activities working on them. However her eyesight is deteriorating and this activity was becoming difficult. She was unsure how long she could continue to do this activity. One of the male participants also enjoyed crosswords as he stated "they help to keep my mind alert and I spend a lot of time completing them". The same participant also spent a lot of time reading the form guides for the horse races. He shared this activity with his neighbour and close friend for many years two or three times a week to discuss the bets they placed and the winnings made.

Telephone conversations to family and friends also assisted to alleviate the social isolation and loneliness. Received calls to the participants' home were more frequent than out going calls. One participant stated she had more than ten per week from a range of people, all concerned about her. Another participant who is unable to visit his family stated the

telephone keeps them in touch, his daughter rings him every night.

One female participant relied on the telephone to keep in contact with her family in the United Kingdom. She migrated to Australia by herself 31 years ago and states:

> *"I don't miss my family, I just have to pick the phone up to talk to them. I have three telephone calls per week from my daughter in the United Kingdom and sometimes my son rings and sometimes my daughter's friend rings, it is just like they are here with me".*

Another female participant had made a very close friend through a telephone service called Telecross, this service is run by the Redcross and telephones isolated and housebound people daily to make sure they are alive and well. The volunteers who ring are given different clients each month and call at set times in the morning. The volunteer who was assigned this participant was from the same district in India where the participant herself had come from. This volunteer for Telecross now rings regularly in her own time and occasionally visits in person.

Only one participant did not have a phone because it was too expensive for him. However he stated he wished he could afford on, so he could have conversations with a particular friend he had become acquainted with. However his neighbour allowed him to occasionally use his phone and the participant also received messages from this neighbour, messages from a friend or service providers.

FINDINGS

How did the Neighbour Aid Home Visiting Service help to prevent social isolation/loneliness?

The participants of this research study received a variety of companionship and practical assistance through the Neighbour Aid Home Visiting Service as seen in Table 3. The types of practical assistance the Neighbour Aid Home Visiting volunteer provided varied depending on the individual needs. These needs range from being non-urgent too urgent. One participant described how much the volunteer helped when an urgent problem occur, she states:

> *"The volunteer has helped in many ways one example is she picked up and took my false teeth to be fixed at the dentist and then picked them up and brought them back on the same day. She is a very kind lady, very nice visitor. Will do anything this gives me a sense of security"*

Each participant had built bonds with their Neighbour Aid Home Visiting volunteer through this practical assistance, one participant stated:

> *"My Neighbour Aid volunteer rings me or I ring her and I tell her if I need anything and she brings it for me, she has been visiting for four years now...we talk about weather, any problems, children and my children, sometimes we go out which I like."*

Another female participant described how her Neighbour Aid Home Visitor helps to alleviate her isolation

> *"My visitors come every Saturday, they have been doing that for four to five years now. They take me out occasionally to the local club, and I have been to their home, she also telephones weekly we are now very good friends".*

One of the male participants stated he was grateful to the Neighbour Aid Home Visitor. The visits started as practical assistance with odd jobs and shopping trips but now had become much more. He stated:

> *"The Neighbour Aid Home visitor is a lovely girl, I feel she is like a daughter I never had, she is a full time worker and visits me fortnightly for two and half hours and takes me shopping, she has been visiting for several years.*

At the closing of the interview the participants were asked "what would you suggest for other people in your situation if they felt socially isolated and lonely?" The comments were all about inviting people into their homes. They stressed there were added benefits of having home visitors. Some of these benefits were learning from one another through discussing life experiences, teaching each other new skills and feeling that someone enjoyed your company.

One of the male participants, who very much enjoyed his Neighbour Aid Home Visitor, suggested it depended on types of personality traits, he argued:

> *"Depends on the person themselves, an inward person who doesn't want to tell people about themself shouldn't invite people over, but if your a type of person that I consider myself as, that likes to learn from other people. Even though I am as old as I am now, I still like to learn from people who like to talk, but if you don't like people coming into your house and telling your secrets then you will have a hard time getting on with them".*

One of the female participants stated:

> *"If people feel isolated or lonely, you need to pass the time of day and meet people. For me in my situation I go outside and talk to my neighbours".*

Another female participant stated:

"Entertain in your house if you can't get out, invite people for a coffee or tea and talk to them, talk is cheap and servility costs nothing and its good for you, I don't mind who comes here and I enjoy company".

All the participants enjoyed their volunteers and looked forward to the regular visits. These visits not only provided practical assistance that maintained their independence and assisted them to stay in their homes, but also provide the much-needed social contact that alleviated their social isolation and loneliness. Through this social contact other important issues were dealt with. Issues such as the loss of power through being housebound and through problems relating to the ageing process, many on-going loss and grief issues and lack of stimulation because of long hours alone.

DISCUSSION

There were a number of themes repeated in the analyses of the interviews. One strong theme emerged through the participants' discussions of activities was, that almost all of the participants who a positive attitude to life and the circumstances that they now facing. All appeared to have ways to overcome the negative side of loneliness. This is a example of the cognitive theory that "it is the way in which people respond to their loneliness that is the determining factor in their experience of loneliness" (Donaldson et al. 1996, p. 954). Donaldson et al. (1996) also argues loneliness is considered to be a state that can be manipulated. Moore and Shultz (1989) argue that accepting responsibility for loneliness correlated positively with life satisfaction; perceived personal control over loneliness was associated with decreased loneliness and with positive health attitudes.

In response to the questions during the interviews there were a number of other common

themes that emerged about the benefits that a regular organised visitor provides. In all the six cases the Neighbour Aid Home Visiting volunteers had become good friends and built up bonds with the clients they visited. The Neighbour Aid Home Visiting Services assisted the participants to alleviate their social isolation and loneliness because the contact was meaningful social support. This Interactionist theory explained that there are two elements of loneliness for people, 'emotional loneliness' due to the absence of an attachment figure and 'social loneliness' or absence of acceptable social network. Spitzer et al. (1995) argued that a person who feels loved and supported is likely to have more coping strategies to cope with any adversities.

The Neighbour Aid Home Visiting Service provided this emotional bond because of the care given to the clients the volunteers visited, which had grown through the many, in some cases years of contact. For example one of the male participants felt his volunteer was like the daughter he never had. The acceptable social network was also achieved for the participants because of shared simular experiences they were able to discuss, such as personal history and experiences during World War II. These contacts also provided other health benefits through this meaningful social support. A sense of control was one of the evident benefits.

One of the male participants displayed the Existential theory that is 'being alone can be a time to grow and contemplate'. He stated he was very lonely and spoke about how he lived with this loneliness. He said:

> *"... I have become so use to it now, I read and contemplate. You get use to something that is unnatural and get hardened to it, you have to put up with it"*

To assist in this type of loneliness Donaldson et al. (1996) state being able to interact with

'love' can assist to alleviate the negative side of loneliness. This participant stated a number of times during the interview that his volunteer was just like a daughter and they were very close and suggested that this regular contact with the Neighbour Aid Home Visiting volunteer has lead to this loneliness having less impact on his quality of life.

Empowerment

How did the Neighbour Aid Home Visiting Service assist with the loss of power and encourage a sense of control? As well as providing basic support services, the Home and Community Care Program encourages individuals, and older people in particular, to make decisions regarding their own individual needs. It is a partnership, which respects and values self and others and aims to develop a positive belief in self and the future (Rodwell, 1996). By encouraging individuals to make these decisions, they are empowered to be independent and autonomous. Empowerment is a helping process whereby groups or individuals are enabled to change a situation and given the skills, resources, opportunities and authority to do so.

A study by Krach et al. (1996) suggests that being able to control or effect one's own life is the key to healthy functioning. One recurring theme of the participants was that the Neighbour Aid Home Visiting volunteer provided the mechanisms to empower the clients they visit. This empowerment appeared to be through the volunteers being there every week for years and in some of the cases to support the clients through traumatic periods in their lives. One participant, a 91-year-old who previously lived in a Retirement Village first, became a Neighbour Aid Home Visiting client because of the need for transportation to visit her husband while he was seriously ill in the hospital. A Neighbour Aid Home Visiting volunteer was arranged to drive and accompany her daily until her husband passed away.

Soon after the death of her husband, this participant moved into a hostel section of the retirement village. During this time she gained a lot of satisfaction and self worth from helping out in the hostel, such as making tea for the other residents and helping to set the tables in the dining room. She described the time at the hostel, she states as:

> *"It was lovely at first I helped in the hostel with the food preparation, making toast and tea, afternoon tea I set the tables, I was a handy person and then they started to take the jobs off me. I was too active not to do things they treated me like I had dementia"*

These jobs for reasons unexplained by the participant were taken away from her. She began to start to feel useless and would have wasted away doing nothing all day if she had not moved away.

The participant decided she would like to live independently away from the hostel and sought help through the Neighbour Aid Home Visiting Service. Through this service providing advocacy and support, she now lives in a Department of Housings two-bedroom unit in an eighteen-unit seniors complex. The participant is independent and maintains the unit herself, needing only Community Transport for trips to medical appointments and fortnightly shopping. The Neighbour Aid Home Visiting volunteer is still involved and visits weekly to provide companionship and weekly outings to the shops. They were first introduced nine years ago and have now become very good friends. The participant described how the volunteer assisted to make her feel important:

> *"I am in my own unit now it is lovely, the volunteer helped me move and helped me clean it ... choices are important to me ... the volunteer helps to reach things when I go shopping that I can't reach myself. I appreciate things like that ... helping you to help yourself, not relying on people to do things for me, but encourage you to do these*

things for yourself. Some people think you need help all the time but that is not what I want."

Mason, Backer and Georges (1991) suggests that empowerment means enabling people to recognise their strengths, abilities and personal power and includes power sharing, respect for self and others as part of the process. The Neighbour Aid Home Visiting Service enables this empowerment by giving the individual access to and choice of a range of assistance that suit their needs over time, so the older person can remain in their home. The home has special meaning for older people, as it often has a lifetime of personal memories, sometimes if not in the building in the possession that it holds. The home often can be part of the community they know, with networks and social contacts and with a layout adapted over time to suit the occupants lifestyle and needs.

Another participant who also is 91 years and lives with her chronically ill daughter stated that:

"The Neighbour Aid gives me security and I know very well I can call on certain people for certain help, and my aim is to stay in my own home as long as I can without being a nuisance to any one and that helps. I don't like to ask favours, but if anything happens and I needed help I could ask them, they are very friendly"

This participant suffers from a number of health problems and relies on Neighbour Aid Home Visiting to pick up items from for the local shop. This participant finds it very difficult to go out of the home and the peace of mind she feels due to someone visiting and providing a flexible service helps to improve the social isolation. The participant stated:

"The Neighbour Aid visitor began because I broke my wrist and my daughter needed some respite from the ongoing demands of full time caring, someone to sit with me two times per week, now they visit once per week. I no longer need respite but they

continue to visit because we are good friends".

Byles et al. (1996) states the most common preventable conditions for older people are:

- Falls, causing trauma, disability, mortality and high health care costs;
- Inappropriate medication use, causing confusion, depression and adverse reactions;
- Nutritional deficiencies, leading to weight loss and high mortality and morbidity;
- Social isolation leading to depression, loss of mobility and increased risk of institutionalisation.

Preventing these common conditions and providing services that cause even small improvements in the well-being of an older person can enhance their life expectancy and gains in function and quality of life, which reduces the burden on the community and health care system.

Being in control and having choices empowers older people. Older people suffer from a number of common preventable health conditions. To help prevent these common conditions, choices through the Neighbour Aid Home Visiting Service are available to enable older people to lead independent lives in their homes, and communities for as long as possible. Thus care must be flexible and designed to alleviate disabilities, relieve pain and maintain lucidity, comfort and dignity so that older people can adjust to their circumstances (Sax, 1993). Neighbour Aid Home Visiting Service provide this flexibility, to meet the existing needs and the changing needs of the clients as described in the two participants stories above. Neighbour Aid Home Visiting Service also appeared to reduced stress by providing this sense of control through the social support by the exchanging of resources.

Loss and Grief

Another recurring theme evident from the interviews was the number of personal losses that the participants had suffered in their lives particularly in the later years. These personal losses lead to different degrees of grief. Some of the losses included friends and other neighbours in their neighbourhood moving or passing away. Other losses where loss of spouse, family members being too far to visit and the on-going loss of health due to the ageing process. Teshuva et al. (1994) found in a study that inner loneliness was higher among older people and this was often because of loss of family and friends.

The experience of grief from loss of meaningful support in the participants' lives affected the participants in a variety of ways. One participant described dreams which she called nightmares about all her friends from years ago, friends that are now deceased. She concluded:

> *"I have dreams about friends from years ago, these friends are all gone* (deceased) *the dreams are really nightmares. I have had lots of bad news lately, there have been four deaths in the family, I am now frightened to answer phone in case there is more bad news".*

One participant's wife died two years ago and he has a heart condition that prevents him from visiting anyone that lives more than five kilometres away from him. He expressed his condition like:

> *"I have a restricted licence due to health problems and I drive to the local shop and the local club only, as far as I go now. My daughter use to come on the weekends but now she is busy with work and I can't drive there it is too far, I get too tired walking to the train station and travelling on the train, so I don't see her or my*

grandchildren".

He relies on the volunteer to visit and to alleviate the loss of his partner and family members by discussing and comparing family stories and events. He said:

> *"We talk about her family and I realised I was interested and she knew that, I tell her about my family, we talk about things in common and I enjoy her company, kind and nice person"*

One male participant has no family as they had all died, and he describes the volunteer as part of his family:

> *"The Neighbour Aid Home visitor is a lovely girl, I feel she is like a daughter ... visits me fortnightly for two and a half hours and takes me shopping ... I have been to her place on Christmas Day with her family".*

Another participant, a female ninety-one years, shared stories and reminisced about her life in England with the volunteer who also was from England. This volunteer visited her for two hours once per week. They discussed England as it was years ago and times during the war. How they coped with the bombings and what it was like for families. This participant read a lot of historical novels on the subject and would discuss these stories with the volunteer. The participant who described herself as a loner believed:

> *"The volunteer helps in lots of ways, she is a very kind lady, very nice visitor ... we share stories and conversations on England, the times during the war, and bombings, the funny things that happened with family and the special moments, she* (volunteer) *was there in England, we were different ages at that time but have a lot in common".*

Prince et al. (1997) states that dislocation, the loss of intimate relationships, rather than isolation characterises loneliness. In a study of Iranian older people, Boardman (1998) found

that the participants also mentioned that loss of their homeland, family and friends was a reason for being lonely. Dugan et al. (1994) further agues that emotional isolation through loss and grief can be alleviated with programs or services that focus on the attachment loss, addressing the grief issue and exploring other replacement attachment figures.

Learning From One Another

This research study and subsequent interviews shows that the Neighbour Aid Home Visiting Services provides learning opportunities for the participants. The volunteers gaining knowledge from the clients they visited and the clients enjoying learning about the volunteers life. One of the male participants who has been with the Neighbour Aid Home Visiting service for one year stated, at first he was unsure about receiving a volunteer visitor, but decided to try it. His wife died two years before, his health had deteriorated which affected his mobility and ability to go out and he liked to talk to people. He had daily telephone contact with his daughter and visited his neighbour across the road twice per week but still had long hours alone to fill in at home. He stated at the beginning of the interview he was not lonely, but really enjoyed the volunteer's company, and time they spent together and would miss her when she went on a six weeks holiday next month. He described the conversations as:

> *"We talk about everything, different countries like Hong Kong where she comes from, she gives me an insight into life over there and I tell her about the way we use to live as kids and what it was like in the army etc, we learn from one another. As old as I am now, I still like to learn from people who like to talk".*

He also stated he liked people from other cultures. The volunteer's culture he particularly admired:

"I like the Chinese people they are a great race, they have been on the earth so long, they are knowledgeable people, they have been through a lot and work hard. They do well when they come here because they work long hours, they are good for this country".

Another participant is writing her memories about a trek when she was 22 years of age and 600 people were in a convoy escaping from Burma to India. This group were assisted and guarded by English soldiers. A friend suggested she write this story, as it would be real history from personal experience. The participant shares this story with the volunteer and is able to relive the events in her mind:

"I enjoy someone coming every week it is very nice gives a good break helps me remember the past, and I am writing my memories for a friend. The moment they are here it is such a pleasure but I am sad when they go".

Langford et al. (1997) argued that social support and healthy behaviours bring about positive health states. Effective coping through a perceived sense of control, sense of stability by ongoing visiting, recognition of self-worth leads to psychological well-being and decreased anxiety and depression. This participant also displays an example of the Cognitive theory that develops the line that loneliness depends on the reaction to isolation. This participant, although socially isolated, found a productive way to alleviate her loneliness and used her time to detail her historical events in her life.

There were opportunities through other services for the participants to attend group activities at Home and Community Care Seniors Day Care Centres in the areas where they lived, but none took up these opportunities. It may have been due to physical or health problems but it could be argued that the Neighbour Aid Home Visiting Service volunteers filled their social

needs. Quality social support in these cases was having a particular person to visit and was more important than quantity of social support. This follows a finding by Forbes (1996) who argues that well being is not positively correlated with social contact but depends on the nature of the contacts.

The participants were articulate during the interviews and expressed their feelings well. All had methods and strategies to cope/deal with physical problems and isolation around the home. Haan (1999) argues our need for social contact and involvement is built into our biology, social withdrawal as consequence of disease or loss of a person's network of friends, family, and social circles may be a pathologic state and not a common one. The meaningful social support provided stimulation for these participants. Haan (1999) argues that some studies measuring cognitive decline in old age have underestimated the effect of social engagement on cognitive decline. The author suggests "the implications for programmatic intervention are clear, if elderly persons are actively provided with opportunities for engagement, their cognitive abilities will remain more intact"(p. 220).

CONCLUSION

In planning for the International Year of Older Persons for 1999, the Federal Government consulted a wide cross section of the community to identify key areas of interest and concern to older Australians. One of the key areas was building respect – recognising and valuing the contributions that older Australians make to our society, including their skills, wisdom and work (Bishop, 1999). Older people are diverse groups with a lot to offer the community. They are survivors of war and the depression, overcoming many losses including family members, friends, homes and even pets. They have been givers to the communities they lived in, assisting to make communities a better place for the younger generations. Establishing an

improved society, enriching our communities through the chosen professions, volunteer work, building families and supporting others and important causes. They have a wealth of experience and knowledge to share with others willing to listen. Being housebound and socially isolated does not change these characteristics. However social isolation and loneliness does lead to this wisdom and knowledge being lost.

Social isolation and loneliness may be a state of mind, or arise from a very real situation brought about by a range of different circumstances (Encel, et al. 1996). Social isolation and loneliness is subjective to an individuals feelings or desire for a specific type of contact and companionship. This paper has argued that the Home and Community Care Program in general Neighbour Aid Home Visiting Service in particular assists to alleviate social isolation and loneliness for older people. The service assists by providing companionship that suits the needs of individuals at a given time of their lives. Not only assisting to alleviate the social isolation and loneliness but also providing practical assistance to maintain an older housebound person's independence thus giving the older person a sense that they are important and deserve to be listened too.

Stewart-Brown (1998) argues solutions to apparently intractable public health problems like inequalities in health and unhealthy lifestyles may therefore lie in research into emotional wellbeing. A broad range of studies are needed to test the hypotheses that emotional distress creates susceptibility to physical illness and a further range is to research interventions which can prevent emotional distress and promote mental and social health. The author further states "for this to happen doctors, and others who determine the allocation of funds to services will need to believe that emotional and social wellbeing are at least as important for health as physical wellbeing and invest both development and research funds accordingly" (p.1609).

For emotional and physical wellbeing the Neighbour Aid Home Visiting Service arranges friendly volunteer visitors to Home and Community Care clients who are housebound and feeling isolated and lonely to provide companionship and practical assistance. This research study identifies a range of ways this volunteer program alleviated social isolation and loneliness. The findings suggest that for the housebound participants the Neighbour Aid Home Visiting Service is one of a range of Home and Community Care Programs which is an effective health strategy to maintain the independence of people who are older and frail and/or disabled. The Neighbour Aid Home Visiting Service also provided emotional and psychological support by way of assisting the participants to discuss important life events, go through grief from losses and belong to a community again by having a person within their community visiting regularly. To assist in maintaining independence and well being, Killeen (1998) argues that empathy is needed for lonely individuals and often it is not necessary to say anything, just being there for a person will alleviate or make the loneliness less painful.

Older people who are social isolated and lonely are a small but vulnerable group. Maintaining their integration in the community presents a challenge now and will continue to do so in the years to come as numbers grow (Moyer, Coristine, Jamault, Roberge and O'Hagan, 1999). It is important that older people recognise the importance of maintaining strong support networks and have the skills to form social relationships after retiring in order to ensure adequate support and access to community resources. It is equally important that communities take responsibility for the continuing well being of their members. Recognising, utilising and promoting the social capital within these communities.

Decline in the older person is complex and mulitfactorial, and medical treatment of complicated cases is, at best, ameliorative, under such circumstances, the simple act of caring

may be enough to slow the long slide of deterioration (Haan 1999). Neighbour Aid Home Visiting Service is a service that can provide this act of caring. Moyer et al. (1999) argues that prevention requires identification of those at risk for becoming socially isolated. Major life change 'events' such as bereavement, discharge from hospital, and entry into apartments or public housing provide an access point. Simple screening criteria could be employed by persons in key positions (for example: doctors; funeral workers; discharge planners; building caretakers/supervisors), who could then provide links to support groups and other community resources for assistance with improving social networks (Moyer et al. 1999).

According to Rokach (cited in Killeen 1998, p.765)

> *"...Although the human race is made up of different people, and despite the diversity of age, sex, culture, language and religious beliefs, there are fundamental similarities. One of these similarities is our yearning for love, acceptance and understanding, and conversely our hedonistic nature and aversion to such painful experiences as loneliness".*

These findings have important implications for policy specialists, health care planners and health care providers. Further study into programs and services such as the Neighbour Aid Home Visiting Service are needed in order to supply information to the funding bodies of the ongoing need of this and other similar services to assist older people to remain functional, physically and emotionally in the communities they live.

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APENDIXES

A. Questionnaire

B. Home and Community Care Services in the Parramatta L.G.A.

APPENDIX A:

Questionnaire

Below is a list of questions please answer them by ticking the box that is most suitable or writing the answers on the line provided.

1. Are you? Male ☐ Female ☐

2. How old are you? 60 to 65 ☐ 66 to 70 ☐ 71 to 75 ☐
   76 to 79 ☐ 80 to 85 ☐ 86 to 90 ☐ 91 to 99 ☐

3. What is your marital status?
   Single ☐ Married ☐ Divorced ☐ Widowed ☐

4. Do you live? (You may tick more than one box).
   Alone ☐ Spouse ☐ Children ☐
   grandchildren ☐ other ☐ please specific_____

5. Are you a Carer? Yes ☐ Who do you care for? _____
   No ☐

6. Are you a migrant to Australia? Yes ☐ No ☐
   If yes please state country of birth_____

7. How long have you lived in Australia? _____

8. What was your occupation before retiring? _____

9. Please tick the Home and Community Care services you receive?

Home Care ☐ Meals on Wheels ☐ Home Nurses ☐

Neighbour Aid Home Visiting ☐ Other _____

10. How often does the Neighbour Aid Home Worker visit you? _____

11. On average how long dose the Neighbour Aid Worker stay? _____

12. What help does the Neighbour Aid Worker provide?

Companionship ☐ Shopping ☐ Sorting letters/bill ☐

Transport ☐ Outings ☐ Other ☐ please specify _____

13. Please state any other help you receive to help you live in your home?

_____

_____

14. How many phone calls do you make have per week to family and friends?

0 ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 9 ☐

other ☐ please specific _____

15. How many phone calls in the past week have you had from family and friends?

0 ☐ 1 to 3 ☐ 4 to 6 ☐

7 to 9 ☐ other ☐ please specific _____

16. How many home visitors did you have last week?

0☐ 1 to 3☐ 4 to 6☐ 7 to 9☐ 10 or more☐

17. How many times per week do your family or friends visit you at home?

0☐ 1 to 3☐ 4 to 6☐ 7 to 9☐ 10 or more☐

18. How many times last week did you spend your time with friends or family away from home?

0☐ 1 to 3☐ 4 to 6☐ 7 to 9☐ 10 or more☐

19. Do you feel socially isolated? Yes☐ No☐

20. Do you feel lonely? Yes☐ No☐

Thank you for participating in this questionnaire and interview.

APPENDIX B:

Home and Community Care (HACC) Services in the Parramatta Local Government Area

Australian Chinese Community Association Aged Day Care Service for Chinese people who are frail aged or have a disability - **9637 9913**

Carers Project
Provides support, information, education and referrals - **9806 5125**

Community Nursing Teams
Parramatta Community Nurses - **9843 3182**
Merrylands Community Nurses - **9682 3133**

Community Worker - Aged/Disabled
Social planning and development of Home and Community Care services in Parramatta L.G.A. - **9806 5110**

Food Services
Meal on Wheels Service (hot, chilled and frozen meal delivery) - **9635 5293**

Home and Community Care Multicultural Access Program and Home and Community Care Services Agency - 9687 1456

Home Care Service of NSW
Personal care, respite care and housekeeping. Parramatta Branch - **Inquiries: 9685 1333 Referrals: 9685 1388**

Home Maintenance Scheme
Repairs and minor/medium modification - **9749 1044**

Home Modification Service (Department of Housing)
Home Maintenance, major modifications - **9821 6095**

Interaction Disability Services (Community Options Program) Obtaining services for adults with intellectual disabilities, and their carers, to enable them to remain living in the family home - **9686 1022 / 9686 2033**

Midwest Community Options
A case coordination and brokerage service for people whose ongoing needs cannot be met by existing community services - **9806 0099**

Midwest Dementia Support
A service which monitors people who have dementia and provides respite for carers – **9806 0099**

Neighbour Aid Services
Home visits by trained volunteers to provide companionship and practical assistance.
Dundas - 9806 5122 **Granville - 9806 5123** **Wentworthville - 9631 6575**

Parramatta Community Transport
Transport services for HACC clients. Wheel chair modified minibus available for groups - **9630 0160**

Peer Support
Provides recreational and social activities to adults' 18-55 years, with disabilities, as a respite service. Volunteers assist the participants on outings - **9806 5124**

Podiatry (Foot Care) Services
Parramatta Community Health Services - **9843 3222**
Dundas Community Health Centre - **9638 6511**

Robertson Day Care
Provides day care for frail aged people and people with dementia. Short-10am to 2pm, long-8.30am to 4.30pm - **9871 7736**

Wesley Mission
Assistance with Care and Housing for the Aged Program - **9874 8100**

Westlink - Anglicare
Family based respite care for children with disabilities, aged 0-18 years. Western Sydney area - **9832 2300**

Willyama Cottage
A special needs respite/day centre service for people with severe physical disability or dementia, and their carers – **9688 3110**