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Evaluation of the Improving Social Connectedness of Older Australians project pilot: Informing future policy considerations

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Abstract

This report draws on findings and lessons learned through the Australian Government funded evaluation of the Improving Social Connectedness of Older Australians (ISCOA) pilot. It summarises what has worked in the context of the evaluation to help inform the Government's future models of care and interventions for lonely and socially isolated older Australians.

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Contents

Glossary of key terms and abbreviations

Term	Definition
Consumer	In accordance with the conditions of funding, this term is used to refer to older people aged 75 years and over and Aboriginal and Torres Strait Islander peoples aged 65 years and over that participated in the pilot
CHSP	Commonwealth Home Support Programme
Community Connector	Member of the general community who has undergone a short training program to engage in a conversation with potentially lonely and socially isolated older people for the purposes of assisting them with community information or referral to a health connector
Community Connector Touchpoints	Connection points where members of the general community can access the web-based directory of community activities and services for older people developed for the project pilot
GPNs	General Practice Nurses
GPs	General Practitioners
Health Connector	A new role established through the pilot where general practice nurses assess and respond to lonely and socially isolated older people referred to them in their health connector role
HealthPathways	An online health information portal for GPs, to be used at the point of care; it provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and/or services
ISCOA	Improving Social Connectedness of Older Australians
LGA	Local Government Area
Loneliness	A subjective experience that occurs when an individual feels they have inadequate social relationships and contact with people; it may be emotional loneliness, when people miss the companionship of one particular person, or social loneliness, when people perceive that they lack a wider social network (de Jong-Gierveld 1989, 1998)
Mental Health Outcome Measures	Assess whether a change has occurred for a consumer as a result of mental health care and a range of clinician-rated and consumer-rated measures are used (Australian Mental Health Outcomes and Classification Network 2021)
MyHealthConnector	A web-based directory of socially relevant local supports and services in the community
NBM PHN	Nepean Blue Mountains Primary Health Network
PS PHN	Perth South Primary Health Network
RAS	Regional Assessment Services
Social Connectedness	Comes from the sum of a person's individual relationships and a sense of belonging. It is crucial to overall health and wellbeing. An age-friendly community assists older adults to maintain social

Term	Definition
	connectedness while deepening existing relationships (Emlet & Moceri 2012)
Social Isolation	An objective state measured by the numbers and/or frequency of social contact (Victor et al. 2001)
Wellbeing	A multi-dimensional concept incorporating physical and emotional needs, connectedness to others, the ability to exert influence over one's environment and safety from harm (Australian Government Productivity Commission 2011)

Executive summary

- This report draws on findings and lessons learned through the Australian Government funded evaluation of the Improving Social Connectedness of Older Australians (ISCOA) pilot. It summarises what has worked in the context of the evaluation to help inform the Government's future models of care and interventions for lonely and socially isolated older Australians.

- The pilot commenced in January 2019 and concluded in June 2021. However during this period, project activities were suspended for approximately six months due to the impact of COVID-19. There were also several natural disasters that occurred during this time.

- Two Primary Health Networks (PHNs) effectively implemented the pilot. Perth South (PS) PHN commissioned an external community-managed organisation to deliver the pilot and Nepean Blue Mountains (NBM) PHN directly employed a project officer and commissioned particular project components.

- Each PHN implemented an individual-level strategy to directly assist lonely and socially isolated older people. This was supported by a complementary suite of asset-based community development strategies.

- Findings from this pilot are context dependent, however, useful insights have been learned. Program reach was smaller than anticipated (a total of 90 consumers received individual-level support across the two PHNs). All participants reported health-related limitations, especially pain and mobility deficits, with 39% (NBM PHN) and 61% (PS PHN) lonely at initial assessment. Evidence suggests that interventions that reduce loneliness could prevent or reduce depression in older adults (Lee et al. 2021).

- Expansion of the target population for future related initiatives to younger old people should be considered. It may be more useful to refer to a 'life stage or transition point' rather than a specific age group. For example, retirement is a life stage when older people may be looking to strengthen existing and create new social connections.

- Major barriers for older people in forming social connections arise from the restrictions of reduced physical mobility and chronic health issues, difficulties accessing appropriate transport, digital exclusion, reduced self-confidence and self-efficacy, financial concerns about the cost of activities, limited mental health literacy and the enduring stigma surrounding mental illness, loneliness and social isolation.

- Models of care and future interventions should view older people as important contributors to the social capital of our communities, engage them in co-design, use a strengths-based personalised response, and incorporate principles of reciprocity where older people are able to 'give something back'. The effectiveness of referral networks is dependent on the intervention or program integrating with existing local measures and service providers.

- The Australian Government supports existing service platforms relevant to older people: general practice which is assisted by PHNs, and the national network of My Aged Care Regional Assessment Services (RAS). This infrastructure provides potentially cost-effective mechanisms for the early identification and assessment of lonely and socially isolated older people and their referral to existing community assets and activities including low-intensity mental health supports.

- For this to be effective, many older people will require facilitated support to engage with these activities and services. Health connectors, community connectors and community-builder roles were trialled in this pilot and offer an inexpensive and flexible means to enhance the capacity of communities to respond to loneliness, social isolation and other critical issues such as the COVID-19 pandemic.

- Further research is needed to quantify potential benefits of related initiatives, learn more about effective implementation and assess policy options.

1   Introduction

1.1   Policy issue

Loneliness and social isolation present a serious public health issue for older people, with compelling evidence about the physical and mental health impact of these phenomena. The Australian population is ageing and living longer (Australian Bureau of Statistics 2019). The prevalence of loneliness and social isolation is rising, and risks for older people have been exacerbated by the COVID-19 pandemic (Ogrin et al. 2021; Smith & Lim 2020).

Being older is a strong predictor of loneliness; evidence from the United Kingdom (UK) indicates people aged over 80 are more than twice as likely to suffer severe loneliness when compared to younger age groups (Griffiths 2017). Loneliness is a fluid experience: it can come and go over a short time, or persist in the longer term becoming chronic (Goodman et al. 2015). There are serious health consequences for older people, particularly those experiencing chronic loneliness (Armitage & Nellums 2020; Brooke & Jackson 2020). These effects increase the risk of death more than other known public health problems such as smoking and obesity (Holt-Lunstad et al. 2015). The association between loneliness and social isolation and poor mental health is well established (Donovan & Blazer 2020). This is a reciprocal relationship as those with mental health issues are more likely to be lonely and socially isolated; in turn, those who are lonely and socially isolated are more likely to develop anxiety and depression (Schwartz & Litwin 2019). Loneliness and social isolation are amenable to intervention and there is growing evidence about effective interventions. Developed countries are investing in policy and strategies to address this issue.

Prior to the COVID-19 pandemic, approximately one in five older Australians were socially isolated (Beer et al. 2016), noting that estimates of the prevalence of social isolation and loneliness vary (Smith & Lim 2020). Low levels of digital inclusion experienced by older people (due to factors including affordability and digital confidence) create a barrier to social engagement, increasing the risks of social isolation and loneliness (Thomas et al. 2020). Changes in the proportion of people experiencing loneliness and social isolation have been observed at different points of the COVID-19 pandemic (Australian Institute of Health and Welfare 2021a). The disproportionate impact of social restrictions on older people raises concerns about reduced social connections for this population group, and the negative effect of such restrictions on mental wellbeing for older Australians has also been shown (Siette et al. 2021).

Policy makers, primary health practitioners and local government commissioners should consider social isolation and loneliness as important upstream factors impacting on morbidity and mortality due to their effects on cardiovascular and mental health. Prevention strategies should therefore be developed across the public and voluntary sectors, integrating an asset-based approach (Leigh-Hunt et al. 2017).

1.2   Purpose of this report

The evaluation of the ISCOA pilot has provided valuable insights about the delivery of a multi-component intervention to address loneliness and social isolation that was adapted for implementation in the Australian setting. The purpose of this report is to distil potential implications for policy arising from the evaluation findings that may assist in supporting lonely and socially isolated older people in the future. It focuses on findings and lessons that can help inform future models of care and interventions to support the mental health of older people.

This report draws from a comprehensive evaluation of the initiative that was conducted in two PHNs, NBM PHN and PS PHN from January 2019 to June 2021. The project pilot objectives were to:

▪   increase social connectedness;

▪   reduce social isolation and loneliness; and

- improve mental health outcomes of older Australians (Australian Government Department of Health 2018).[1]

The report briefly explains the project, the policy context, what worked and provides considerations to help inform future policy development.

1.3   Project overview

The ISCOA project was initially conceived as a two-year pilot adapting applicable models and frameworks to inform interventions to increase the social connectedness of older Australians. The target population was people aged 75 years and over and Aboriginal and Torres Strait Islander peoples aged 65 years and over, who were at risk of the mental and physical health impacts of social isolation and/or loneliness. Implementation commenced in two PHNs in July 2019. The progress of the pilot was significantly disrupted by the COVID-19 pandemic with project delivery suspended for approximately six months from April – September 2020. The project was originally scheduled to end in December 2020, however, an extension was granted until June 2021.

A multi-component model based on evidence from the established programs of Age UK and the Campaign to End Loneliness (2016) was implemented. It comprised two arms: an individual-level strategy and an asset-based community development strategy. Underpinning these strategies was coordinated action aimed at building and strengthening networks between primary health, aged and social care service providers.

The design of the intervention was influenced by several key assumptions. Many older Australians have a trusted relationship with their General Practitioner (GP) and General Practice Nurse (GPN). As older people become less mobile and develop chronic health issues, seeking support for their health care from their GP occurs more frequently (Royal Australian College of General Practitioners 2020). General practice currently provides health assessments to people aged 75 years and over and Aboriginal and Torres Strait Islander peoples aged 55 years and over. Ageing can create demand for home support and assistance with activities of daily living to enable frailer older people to remain living independently in their own home. Service needs are determined through My Aged Care RAS that provide a face-to-face assessment undertaken by a trained Home Support Assessor to identify an older person's aged care service needs. These needs are met by referral to services available through the Commonwealth Home Support Programme (CHSP). GPs, GPNs and Home Support Assessors undertake assessments of older people's health and/or social care needs as part of usual care and are well positioned to identify lonely and socially isolated older people.

This pilot trialled these two access routes, that is, general practice and RAS as referral sources. Older people identified at risk of loneliness and social isolation met with a health connector based in general practice (NBM PHN) or community-based link worker/project coordinator (PS PHN) who also worked closely with a RAS provider. A conversational interview was provided by the health connector or project coordinator to more comprehensively assess the older person's social connections. A personalised plan was collaboratively developed with the older person with varying levels of support provided to participate in activities to strengthen social connections.

The community-based strategy used the principles of asset-based community development to enhance community connections and assets and engage services and agencies to work together to address social isolation and loneliness. In practice, this included community co-design workshops, community engagement in project governance, development of an online directory of community services, and several other community development activities to build upon community assets and increase community awareness of both the impact of social isolation and loneliness for older people and the project.

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[1] Australian Government Department of Health 2018, Evaluation of the Improving Social Connectedness of Older Australians project pilot - Schedule 5A Form of Request for Quotation - Health/18-19/04684, Australian Government Department of Health, Canberra, Australia.

2 High-level comparison of key evaluation findings

Implementation was led by PS PHN in the Mandurah Local Government Area (LGA) (in Western Australia) and the NBM PHN in the Hawkesbury LGA (in New South Wales). Each locality provided a significantly different context for implementation, which should be recognised when reviewing key evaluation findings.

2.1 Consumer outcomes and experience

The pilot's reach was significantly disrupted by the COVID-19 pandemic and the five natural disasters declared within NBM PHN. While the number of older people participating in the intervention was small, for most the impact of the project was positive and significant. Consumers valued being treated with empathy and respect, a personalised response, and facilitated support to engage in activities.

Table 1   Summary of key consumer outcomes and experience

Outcome	Mandurah	Hawkesbury
# participants	44 participated, 36 completed	46 participated, 40 completed
Participant characteristics	Mean age 81.5 years, 73% female, 59% lived alone, 57% widowed	Mean age 82 years, 84% female, 51% lived alone, 65% widowed
Participation	27 referred but declined to participate, 3 did not attend activities, 17 received assistance with transport	52 referred (from 3 practices) but did not participate, 22 did not attend activities, 9 required assistance with transport
Baseline health status	All had limitations, especially pain, mobility and anxiety / depression, 61% were lonely	All had limitations, especially pain, mobility and anxiety / depression, 39% were lonely
Health outcomes	From baseline to follow-up there were statistically significant improvements in self-rated health (mean 66 increased to 81), loneliness (61% decreased to 23%) and psychological distress improved	From baseline to follow-up there were no statistically significant improvements in health-related quality of life (HRQOL), self-rated health or loneliness
Consumer experience	16 respondents – 94% felt less lonely and more socially connected, 88% reported improved wellbeing, all had a positive experience, were satisfied, would recommend the project and thought it should continue for others; interviews (n = 7) strongly supported these findings	16 respondents – 81% felt less lonely and more socially connected, 75% reported improved wellbeing, at least 94% were more willing to join activities or groups, had a positive experience, were satisfied, would recommend the project and thought it should continue for others

2.2 Provider, community and system outcomes

Engagement with general practice needs to be driven by those with primary health care expertise, which in this intervention were the PHNs. Key community stakeholders overall had a positive perception of the project and felt the activities implemented were appropriate in addressing the pilot objectives. Relationships were developed (or strengthened) between project teams and a range of community organisations and groups.

Collaboration with local councils in each implementation site was particularly important as local government is well positioned to support sustainability of project components.

Table 2   Summary of key provider, community and system outcomes

Outcome	Mandurah	Hawkesbury
GP engagement	5 practices identified for engagement	7 practices commissioned, 11 health connectors (GPNs) completed training
Referrals	Referral pathways developed (including incorporation in HealthPathways)	Referral pathways developed (including incorporation in HealthPathways)
Co-design	Community reference group convened for 12 months, Collaborative Approaches Workshop facilitated (30+ community stakeholders)	3 co-design community workshops (100+ participants), advisory committee and working groups sustained throughout project
Community engagement	Asset-based community development through community-builder, range of community events held (e.g. Celebrate Seniors Expo), several new groups and activities initiated in response to community identified service gaps	Asset-based community development through project officer with 74 community connectors trained, 9 community connector touchpoints established, range of community events held (e.g. Seniors Week 2021)
Asset mapping / directory	Comprehensive asset mapping, used internally, Genie online platform trial continuing	Comprehensive asset mapping, online MyHealthConnector directory developed (570+ groups / organisations, 4,500 users over 12 months)
Stakeholder experience	5 survey respondents indicated positive perception of project; stakeholder interviewees (n=20) indicated overall support for the initiative	11 survey respondents – 94% agreed with all statements, indicating an overwhelmingly positive perception of project; stakeholder interviewees (n=27) indicated overall support for the initiative

This was an ambitious and complex multi-component intervention implemented efficiently during the most testing of times, a global pandemic. Overall, the evaluation concluded with a high degree of confidence that each component of the pilot, as implemented at the two implementation sites, made an important contribution to achieving the objectives of the project.

2.3   Key lessons from the evaluation

The key lessons that policy makers can take from the evaluation follow.

2.3.1   Context

- COVID-19 was a significant disrupter – but also focused attention on the issue of social isolation and older people.

Evaluation of the Improving Social Connectedness of Older Australians project pilot: Informing future policy considerations

5

- At the time of writing this report there is a receptive context for change, in part due to greater community empathy for lonely and socially isolated older people that has arisen during the pandemic. It is an opportune time to build on the work of the project pilot.

- The health connector initiative has shown that integration of interventions implemented into the workflow of the general practice and MBS billing arrangements is necessary and achievable.

2.3.2 Identifying and engaging older people

- General practice and My Aged Care RAS are able to identify lonely and socially isolated people, however, personnel within these services require additional training, support and resources to be effective in this role and to optimise their capacity to appropriately identify, refer and/or respond.

- Older people have differing levels of self-confidence and self-efficacy. Guided self-help (i.e. facilitated support) is essential for a significant proportion of older people, particularly those aged 75 years and over.

- Personalised conversations enable a tailored response to meet individual needs, abilities and interests.

- Aboriginal and Torres Strait Islander peoples require a culturally appropriate intervention that emphasises strengthening kinship.

- For older people there is stigma associated with admitting to loneliness and social isolation and mental illness and limited awareness of the contemporary range of mental health supports. The use of positive language such as 'strengthening social connections' rather than referring to reducing loneliness and social isolation is preferred by older people and considered less stigmatising.

- In regional and rural areas, emergency service providers such as police and rural fire services can be of great assistance in identifying socially isolated older people because of their role in disaster response.

2.3.3 Design

- Use of evidence, clear objectives and an understanding of the theory of change underpinning interventions is crucial so that the proposed strategies are appropriate in addressing loneliness and social isolation. Rapid cycle planning that is iterative may aid in responding to unexpected events.

- There is no one-size-fits-all solution – initiatives need to be tailored not only to individuals but also to communities to effectively use and leverage off existing resources.

- As loneliness and social isolation are complex issues, flexible, multi-component initiatives are required. Place-based approaches appear to be well suited to an integrated health, aged and social care response.

- Initiatives should include 'younger' older people (e.g. ≥ 55 or ≥ 65) to extend their reach and potential benefit. Targeting certain life stages or transitions (e.g. retirement) may be a more useful approach than focusing on specific age groups.

- For some older people, particularly those with mobility and chronic health issues, they may need to be at a stage in life when they have the energy and capacity to try new activities.

- Early involvement of consumers and community stakeholders through co-design is important as initiatives are more likely to be sustained when high levels of community ownership are evident.

- Promoting multi-component interventions that address the social determinants of health as a complement to existing health care is likely to assist with GP engagement.

2.3.4 Implementation

- Effectively addressing loneliness and social isolation of older people requires an intersectoral approach that draws upon health, aged and social care service providers.

- Collaborative partnerships are vital, and local government is a critical partner because of its role in the provision of basic community infrastructure and services used by older people.

- General practice is an important setting to support the mental health of older people, PHNs are experienced in working with general practice and can leverage off established relationships.

- Focus should be on general practices that are 'receptive' to the intervention and engagement is likely to be enhanced through modest remuneration, support with training in areas such as motivational interviewing, and assistance with integrating the intervention strategies into usual workflow.

- Service providers that routinely work with older people, such as providers of My Aged Care RAS, are likely to have a workforce that is experienced in engaging with older people and establishing rapport.

- The mapping of community assets is fundamental to increasing the awareness of health and social care service providers of the rich range of existing community groups and services already available within the local community.

- Clear and wide-ranging referral pathways are necessary so that older people, other community members and service providers understand how best to refer and support lonely and socially isolated older people.

- PHNs require flexibility in the implementation of loneliness and social isolation interventions for older people so that differences in community infrastructure can be accommodated. This may be facilitated by permitting blended approaches that allow in-house project coordination supported by commissioning of external expertise as necessary. Hybrid models should include recognition of the true costs borne by PHNs.

- Interagency relationships take time to develop and are based on trust, mutual respect and reciprocal support. These existing community networks can make an important contribution to interventions designed for older people, but some basic funding may be needed to facilitate this engagement.

2.3.5 Evaluation

- Where possible, it is more efficient to use existing routinely collected data for monitoring and evaluation to minimise the burden upon project participants. This requires data-sharing agreements with general practice and may necessitate some compromise as to the available data items.

- Data linkage, while challenging, provides opportunities to obtain highly valuable information about medium to longer-term health outcomes of older program participants.

- As many older people may not have the capacity to participate in online data collection activities, innovative qualitative and quantitative approaches to gathering information about their experience and perspectives is essential to ensure they can contribute to evaluation findings.

- If available, appropriate validated scales should be used to measure outcomes that align with the primary aim of the intervention.

3 National policy environment

3.1 Policy context

This project pilot was funded through the 'Better Ageing' initiative of the 2018-19 More Choices for a Longer Life Budget Package (Australian Government Department of Health 2018a).

The pilot took place in a policy context in which a range of broader mental health supports are available to older Australians. This includes funding since 2018-19 to PHNs to commission psychological treatment services targeting the mental health needs of older people living in residential aged care facilities through the 'Improved Access to Psychological Services in Residential Aged Care Facilities' initiative. In addition, in response to the impacts of the COVID-19 pandemic, in 2020-21 the Australian Government funded PHNs to commission mental health nurses and equivalent workforces to provide additional support to older Australians experiencing loneliness and/or isolation and who have or are at risk of mental health conditions until 31 December 2021. Furthermore, from 10 December 2020 to 31 December 2022 individual Medicare subsidised psychological support under the *Better Access to Psychiatrists, Psychologists and GPs through the MBS* initiative has been expanded to aged care residents (Australian Government Department of Health 2018c).

Reports from a number of major inquiries addressing older Australians' mental health were also released during the pilot's implementation period. The Productivity Commission's Inquiry into Mental Health was handed to the Australian Government on 30 June 2020 (Australian Government Productivity Commission n.d.) and identified a range of issues relevant to the mental health of older people including the increased risk of mental ill-health arising from loneliness and social isolation and the importance of access to appropriate mental health supports (Australian Government Productivity Commission 2020). The final report of the Royal Commission into Aged Care Quality and Safety (Royal Commission) was tabled in the Australian Parliament on 1 March 2021 (Royal Commission into Aged Care Quality and Safety 2021). Particularly relevant recommendations include Recommendation 33 – Implementing a social supports category in the aged care program, Recommendation 59 – Increased access to Older Persons Mental Health Services, and Recommendation 61 – Short-term changes to the MBS to improve access to medical and allied health services. On 11 May 2021, the Australian Government published its response to the Royal Commission's report, accepting or accepting in-principle all recommendations. The Hon Greg Hunt MP, Minister for Health and Aged Care, also advised in a media release that the 2021-22 Budget measures announced in response to the Royal Commission signal a once in a generation reform, including a $17.7 billion investment in an aged care reform package.

3.2 Levels of mental health care

PHNs work with their communities to improve access to primary and specialist mental health care. Fundamental to the joint regional planning and commissioning of mental health services is a stepped care approach. This means that a person presenting to the health system is matched to the least intensive level of care that most suits their current treatment need, considering the balance between intended benefits and potential risks (Australian Government Department of Health 2020b, p. 10). A schematic representation of levels of care is included in Figure 1 (Australian Government Department of Health 2019, p. 8). Planning mental health services, according to this stepped care approach, relies on "stratification of the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions" (Australian Government Department of Health 2019, p. 8).

Figure 1   Schematic representation of levels of mental health care

3.3   Mental health impacts of the COVID-19 pandemic

The potential impact of the COVID-19 pandemic on the mental health of all Australians, including older people, was recognised with the endorsement by National Cabinet of the National Mental Health and Wellbeing Pandemic Response Plan in May 2020 (Australian Institute of Health and Welfare 2021b). This plan identified the particular vulnerability of older people to the coronavirus and the disproportionate impact on older people of physical distancing measures with loss of support leading to increased social isolation. Many older people had no access to online services and a fear of leaving their home to access services face-to-face (Australian Government Department of Health 2021b). These factors were anticipated to impact upon the wellbeing and mental health of older people (United Nations 2020). Other impacts reported include those arising from "reduced access to essential medicines and supplies occurring because of global disruption to supply chains and reduced access to usual healthcare" (Richardson et al. 2020, p. 2).

4 Shaping models of care for older Australians in the future

4.1 Snapshot of current evidence

Many of the findings reported through the pilot evaluation are supported by literature. A brief summary of this evidence is provided below.

4.1.1 Service models, interventions and strategies

- Loneliness and social isolation is a personal experience and consequently individualised person-centred responses are essential – one size will not fit all (Fakoya et al. 2020).

- Initiatives described in the literature largely include one-to-one interventions, group activities or community engagement approaches (Skingley 2013).

- Interventions aiming to tackle loneliness and social isolation typically address three main areas: enabling individuals to maintain existing relationships, facilitating the creation of new connections, and using psychological therapies to help the individual reassess the way they think about their relationships (Jopling 2015).

- Multi-component strategies are less researched but show promise based on implementation experience with other complex health and social issues (Ogrin et al. 2021).

- Place-based approaches appropriately implemented provide an effective mechanism for engaging the local community and strengthening collaborative efforts to strengthen social connections (Crew 2020).

- Addressing loneliness, social isolation and social connectedness of older people requires intersectoral action between health, aged and social care sectors (Ogrin et al. 2021).

- There is good evidence about the effectiveness of self-help treatments for depression and anxiety, particularly with therapist support (Boulton et al. 2021).

- Telehealth interventions have been shown to improve psychological outcomes for older adults, including decreasing anxiety and depressive symptoms (Kruse et al. 2020).

- Low intensity interventions have been found to produce positive outcomes when patients are highly motivated, a coach or therapist guides the use of the materials, and several low intensity interventions are used simultaneously (Joice et al. 2010).

- Strategies to connect with older Australians require establishment of two-way forms of engaging, rather than only offering help or creating one-way forms of engagement (Maisey 2020).

4.1.2 Barriers to engaging older people

- Older people who are socially isolated are by definition hard to reach. Understanding the characteristics of people who are most at risk can help with targeting these groups. For example, living alone, health problems and disability (including cognitive impairment), sensory impairment such as hearing loss, and major life events such as loss of a spouse have all been identified as risk factors for loneliness and social isolation (Findlay 2003; Grenade & Boldy 2008).

- Different ways of identifying, assessing and responding to loneliness and social isolation are needed for particular sub-groups of older people including those with:

    - significant chronic health issues

    - mobility impairment

    - cognitive impairment

    - serious mental health issues

- diverse cultural needs (Jopling 2015).

▪ Older people are reluctant to identify as being lonely or socially isolated often because of the stigma associated with this unless they believe they have the need and capacity to strengthen their social connections (Cattan et al. 2003; Cattan et al. 2005).

▪ Older people who are experiencing chronic loneliness may need specialist mental health support (Age UK 2018).

▪ People aged 65 years and over remain Australia's least digitally included age group with an Australian Digital Inclusion Index (ADII) of 49.7 compared with the national average of 63.0. The ADII measures three key dimensions of digital inclusion: access, affordability, and digital ability (Thomas et al. 2020).

4.2   Framing loneliness and social isolation interventions

Within Australia, there is socio-demographic and health data which in conjunction with internationally robust research evidence confirms that loneliness and social isolation in older people is a significant health issue that governments must address. How this issue and policy responses to it are 'framed' have important implications and will influence possible solutions. For example, at a broader societal level loneliness and social isolation may be seen as a public health issue and responded to with primary, secondary and tertiary health promotion strategies. However, if it is framed as a mental health issue affecting individuals then this may drive a therapeutic approach through the use of a stepped care mental health model which may or may not involve other community and social care services.

PS PHN framed the pilot as a mental health promotion and prevention initiative, because the focus of the initiative was the 'social connectedness of older Australians' which is not a mental disorder, and in and of itself may not necessarily lead to one (although it can contribute). The initiative was perceived as more of a social support program that wasn't necessarily mental health treatment specific. Challenges arose in the context of broader PHN guidance documentation relating to low intensity services. Funding guidelines were perceived to suggest a treatment orientation and for treatment to occur there needs to be a diagnosable condition or an assessment that the individual is at risk of one (Australian Government Department of Health 2019).

Several stakeholders framed the project as a social prescribing initiative, citing that the health and community connectors in NBM PHN and project coordinators in PS PHN were effectively acting as 'link workers' through linking older people to non-medical services and activities. PHN teams were reluctant to describe the individual-level intervention strategy in this way as they correctly recognised that there is currently no policy guidance for PHNs in relation to social prescribing and no Australian Government policy position on the use of MBS items for social prescribing. The interest in social prescribing has been growing, with the Royal Australian College of General Practitioners and Consumers Health Forum of Australia co-hosting a Social Prescribing roundtable in November 2019. Their report of this event highlighted the trend in several countries of implementing policies to integrate health and social care and noted:

We foresee a future where social prescribing supports better connections between our systems of care and better connections between people in our communities. (Royal Australian College of General Practitioners and Consumers Health Forum of Australia 2020, p. 8)

Several recommendations for policy makers were included, such as the need for:

…an analysis of which professions are best placed to fulfil the link worker role in Australia, adjusting for different levels of complexity. (Royal Australian College of General Practitioners and Consumers Health Forum of Australia 2020, p. 8)

The UK National Health Service views social prescribing as a key component of universal personalised care and, through their Long Term Plan, NHS England has committed to building a social prescribing workforce (National Health Service 2019, n.d.). The plan states:

Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. (National Health Service 2019, p. 25)

Within Australia (Ending Loneliness Together 2020), New Zealand (Let's End Loneliness 2021; Loneliness NZ 2021), Canada (Hamilton Seniors Isolation Impact Plan 2016; HelpAge Canada 2021) and the UK (Campaign to End Loneliness 2021), there is increasing interest at government and community levels in the impact of loneliness and social isolation. This has been exacerbated by the COVID-19 pandemic and is now firmly on the policy agenda of many nations (The Commonwealth Fund 2021). The UK was one of the first governments to appoint a Minister for Loneliness (GOV.UK 2018), with Japan recently establishing a Minister for Loneliness and Isolation (Kawaguchi 2021).

4.3   Addressing loneliness and social isolation through existing infrastructure
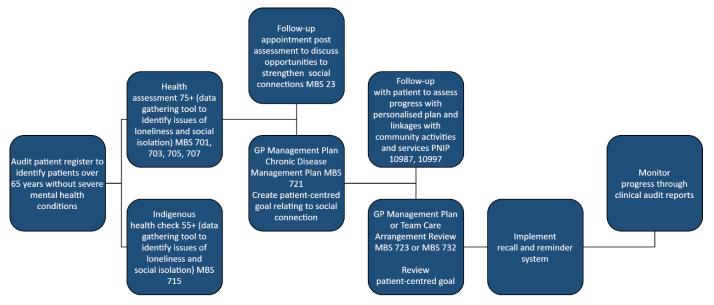
The pilot demonstrated that commissioning into general practice might be a helpful policy approach into the future. The Australian Government has access to two important networks that can help with systematically identifying, assessing and supporting lonely and socially isolated older people: the integrated infrastructure of PHNs and general practices, and the RAS that provide entry to the My Aged Care service gateway (Australian Government Department of Health 2021c).

The first step in intervening to reduce the mental and physical health impacts of loneliness and social isolation is to identify older people at risk. GPs and My Aged Care RAS are well positioned to identify at risk older people through existing assessment processes, for example the health assessment for people aged 75 years and older and the CHSP service assessment process. The assessment process for CHSP services already allows for identification of social support needs, however, variability in access to services may often mean that there is no appropriate means to assist lonely older people. Regional assessors could refer these at risk older people to either appropriately resourced general practices who, through a health connector role, could holistically assess physical and mental health needs or directly refer patients requiring facilitated support to a community connector or link worker that supports several general practices. These community connectors can then support older people to become more socially connected, utilising existing community assets. There are several MBS items that may be able to support the health connector role within general practice (refer to Figure 2).

A network of community connectors could support a range of primary care initiatives, as currently occurs in the UK and was demonstrated particularly in response to the COVID-19 pandemic (Giebel et al. 2020). In addition, there are existing Departmental initiatives (e.g. Aged Care Navigator initiative) and government programs (e.g. Village Hubs) that could be leveraged to support older people, particularly for those who face additional barriers or are vulnerable and require face-to-face engagement, with repeated interactions over time (Australian Healthcare Associates 2020). Considering workload demands and time constraints experienced by mental health nurses (Foster et al. 2021), upskilling a network of GPNs and community-based workers to help support older people at risk of or experiencing social isolation or loneliness is a viable alternative. Such an approach has the potential to provide a personalised response close to home that includes options for facilitated support and guided self-help. Social prescribing has been identified as an effective mechanism for addressing the social determinants of health and may provide a useful demand management strategy to assist general practice to cope with the demands of an ageing population (Cordis Bright 2019).

Figure 2   Using existing MBS items to support the health connector role

For GPs and other service providers, including information about appropriate referral pathways to better manage loneliness and social isolation and appropriate interventions through an online health information platform like HealthPathways or a community information repository is an important way to assist them to work together with patients, at the point of care. Education and training of administrative and general practice staff about common risk factors may also help in identifying older patients in need of assistance. For many older people as they age, there is an increased reliance on their GP as a trusted source of advice (NBM PHN 2020; University of Southampton n.d.). The sensitive issue of loneliness and social isolation is clearly more likely to be discussed when rapport and trust has been established.

4.4   Future interventions

Future interventions should recognise the contribution that older people bring to the social capital of their communities. They have much to offer to the design and delivery of interventions that are developed to support their mental wellbeing. Using a strengths-based approach supports this view and aligns with current national mental health policy. Older people are not a homogeneous group and different strategies to reduce loneliness and social isolation and improve social connections will be needed that are appropriate for the target population and focus of the intervention. For example, less mobile older people with multiple chronic conditions who are unable to easily leave their home may require a significantly different approach to building social connections than older persons with a history of mental illness and maladaptive social cognition (Cacioppo et al. 2015). Loneliness and social isolation may be perceived quite differently in population sub-groups such as Aboriginal and Torres Strait Islander peoples, those from culturally and linguistically diverse groups and people from LGBTQI+ communities. Their perspectives may be shaped by historical experiences of alienation and/or discrimination and consequently interventions that are appropriate given this lived experience may need to be developed.

Throughout the evaluation, the major barriers to improving social connections for older people were frequently attributed to difficulties accessing appropriate transport, reduced mobility and impacts from chronic health conditions, limited digital skills and resources and issues that can be broadly described as mental health literacy. Future projects need to include the capacity to support older people unable to participate in interventions because of these barriers. Despite innovative programs being available to enhance the digital literacy of seniors, there will remain significant numbers of older people who will need ongoing help to adapt to new forms of service delivery that require an online presence or use of mechanisms such as telehealth. Older adults' relatively poor mental health literacy (Chesser et al. 2016; Piper et al. 2018) should
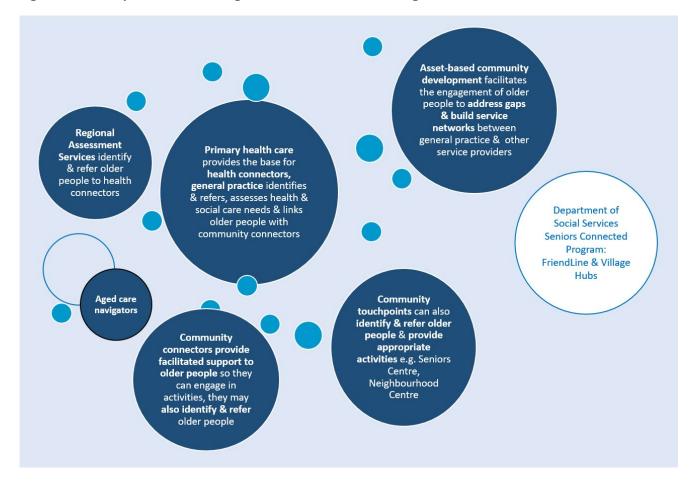
also be considered in the development of models of care, particularly in terms of their awareness of the impacts of loneliness and social isolation.

A whole of community effort is likely to be most effective and community connectors could support other primary health and social care workers, such as health connectors, in providing evidence-based programs for particular groups of older people. Through a place-based approach, the existing assets of the local community can be used for older people wishing to form new social connections. General practices with health connectors could be supported by a cluster of community connectors who provide facilitated support to older people, so they are able to attend activities. They may also link older people with mobility issues to activities that can be provided in their own home for example, telephone befriending services.

The components of an integrated model of care to strengthen social connections of older Australians is presented in Figure 3.

Figure 3   Components of an integrated model of care to strengthen older Australian's social connections

4.5   Engaging older people in evaluation

The engagement of evaluators at the project initiation stage facilitates a collaborative and evidence-based approach to the development, implementation and evaluation of interventions. This was a strength of the pilot. Involving older people in evaluation during the social disruptions that arose was extremely difficult as they quite rightly recognised their vulnerability to COVID-19.

Evaluation plans had to be continuously reassessed as the context for implementation shifted in response to the COVID-19 pandemic and other environmental disruptions. For example, the planned time series analysis of the participating practices to monitor changes in the provision of health assessments, mental health treatment plans etc., for older people was confounded by the COVID-19 pandemic as 'usual practice' and implementation in the targeted practices was severely disrupted by lockdowns and the introduction of

alternative consultation processes such as telehealth. Consequently, the time series was unable to be used as originally intended.

Project teams on occasion reported that the evaluation data they were asked to collect from older people was a disincentive to participation for older people. There is always a balancing act between achieving relevant evaluation data collection and reducing data collection burden, particularly in pilot evaluations. This led to renewed efforts by the evaluators to streamline data collection and minimise the inconvenience for both project teams and participants. Discussions are needed early in program planning to ascertain the availability and appropriateness of existing administrative datasets to support evaluation efforts.

A gap in data collection was unfortunately the voice of the consumer. A series of qualitative data collection activities were planned that brought older people together in groups to explore their experience. When restrictions on public gatherings prevented this, surveys were introduced with 16 responses secured from each implementation site, noting that this represented approximately 40% of consumers who completed the intervention. A large proportion of older people are reluctant to complete web-based surveys or use videoconferencing platforms. Despite repeated requests for interviews, at one site no consumer was prepared to participate in an interview. In the other implementation site, seven consumers participated in a telephone interview, and this provided rich and valuable project insights about consumer experience. To supplement data collected from consumers, project teams were asked to provide consumer or patient stories to illustrate their perception of the impact of the project for older participants.

In pilot studies where the design of the intervention and process of implementation are both being tested, economic analyses such as cost-effectiveness analysis may not be appropriate. An alternative method is a cost consequence analysis (CCA) which may be useful in pilot studies, or as a pre-cursor to a future cost-effectiveness analysis. A CCA was completed which showed relatively moderate investment resulted in a considerable range of outputs and short-term impacts and outcomes at each site, however, if more extensive trialling of an enhanced intervention was to occur, it would be appropriate to conduct a more comprehensive economic evaluation (Centre for Epidemiology and Evidence 2017).

5 Conclusion and recommendations

The ISCOA project pilot was implemented to build knowledge and capacity about how to address loneliness and social isolation among older Australians in the context of two PHNs. It is possible to integrate the most effective strategies from the two implementation sites to inform the design of an improved intervention. Consideration needs to be given to how this is 'framed' or described to ensure the intervention aligns with PHN priorities and funding guidelines in both mental health and aged care service delivery. Further research and evaluation is needed to determine the effectiveness of different interventions and approaches (Fakoya et al. 2020; Ogrin et al. 2021). This intervention could be tested through an experimental study with wider implementation and a robust cost-effectiveness analysis to quantify the anticipated savings to government.

The intersectoral nature of loneliness and social isolation necessitates collaboration and coordination between various departments of national, state and territory and local government – "social isolation requires a multi-faceted policy response" (Pate 2014). The connection between physical and mental health and loneliness and social isolation suggests the Australian Government Department of Health has a key role in addressing this issue. There are increasing calls from advocacy groups such as Ending Loneliness Together, in partnership with R U OK?, and professional associations such as the Australian Psychological Society, for the Australian Government to respond to the issue by "equipping, implementing and mobilising all sectors to deploy Australia's first National Loneliness and Social Isolation Response Strategy" (2021). In the ISCOA evaluation, those who delivered the individual-level strategy, the GPNs who worked as health connectors and regional assessors that acted as project coordinators, were strongly of the view that addressing loneliness and social isolation in older people is a fundamental part of providing person-centred health and social care.

The following recommendations arising from the evaluation findings are provided.

Recommendation 1: Review PHN guidance documents relating to low intensity services to ensure inclusion of mental health promotion and prevention strategies to reduce loneliness and social isolation amongst older people.

Recommendation 2: Design future interventions to include a focus on relevant life-stages or transition points so that access is available to a wider-range of older people, including people aged 65 years and over and older Aboriginal and Torres Strait Islander peoples aged 55 years and over.

Recommendation 3: Ensure barriers to older people's participation in loneliness and social isolation interventions are addressed through providing facilitated support to participate, access to transport and digital technologies, and ensuring interventions are culturally safe and appropriate.

Recommendation 4: Encourage intersectoral responses and networked service models to address older people's mental health needs, including loneliness and social isolation, that engage health, aged and social care service providers and relevant community-based organisations.

Recommendation 5: Allow flexibility in how PHNs implement loneliness and social isolation interventions so that commissioning can be blended with in-house project delivery if appropriate, recognising the true costs borne by PHNs when using a hybrid implementation model.

Recommendation 6: Support a larger trial of a place-based multi-component intervention that utilises existing infrastructure and engages the broader community in addressing loneliness and social isolation in older people.

Recommendation 7: Consider the opportunities to apply the learnings from the pilot nationally amongst Australia's 31 PHNs.

Recommendation 8: Consider a more comprehensive national policy response to the issue of loneliness and social isolation for older Australians.

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