Social isolation and loneliness among older people in Europe

Evidence, policies and interventions

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1 Introduction

Older people in Europe generally live longer and are healthier and more active compared to previous generations, but they tend to live more often alone and experience feelings of loneliness and isolation. A significant prevalence of loneliness among the older population has been reported in numerous national and European comparative studies. Explanations for this are linked to old age factors including declining health and mobility limitations, to life-cycle changes, such as retirement or becoming a carer, and to age-related losses, e.g. the death of spouse or friends. Older people also tend to spend more time at home or in their immediate neighbourhood making neighbourhood contacts, community activities and the living environment particularly important for enhancing their social participation and integration into society.

As Europe's population is getting older, with a projected increase in the old age dependency ratio from the current 30% to 50% by 2070 (EC, 2018), the prevalence of loneliness is expected to increase in the future. In international and national policies, there is a growing recognition of the salience of tackling loneliness and social isolation. A number of European countries have recently adopted national strategies and launched public campaigns that address this topic. In the Spanish National Strategy (*Estrategia Nacional de Personas Mayores para un Envejecimiento Activo y para su Buen Trato 2018–2021*), preventing and reducing loneliness and social isolation is identified as a key focus area for promoting and enhancing social inclusion of older people proposing concrete policy measures in this regard.

Although loneliness has received increased attention in the public discourse and social media, more effort is needed to better understand this phenomenon and to develop and implement policies and interventions to combat its potential detrimental effects on the well-being and quality of life of older people. As a starting point, it is important to differentiate between different definitions, that are often used interchangeably when referring to loneliness. Loneliness, social isolation and being alone are distinct concepts. Loneliness should also not be mixed with depression. While there exist various definitions, loneliness is generally understood to be a negative, unpleasant feeling and experience that occurs when there is a discrepancy between a person's actual and desired social relationships. It is also very subjective. Social isolation, by contrast, concerns an objective experience of reduced social interactions and social ties (Dykstra, 2009).

The COVID-19 pandemic and related lockdown periods significantly contributed to increased loneliness and social isolation. COVID-19 severity fatality rates increase

considerably with age, which increases the necessity of older people to be isolated. The social isolation of older people in times of pandemic is impacted by lower digital literacy which limits the possibility of online social interaction. The prevalence of loneliness significantly increased in the first months following the pandemic. In 2016, about 12% of EU citizens reported feeling lonely; a figure that rose to 25% in the first months of the pandemic (April to July 2020) (Baarck et al., 2021).

This report focuses on both loneliness and social isolation. Section 2 discusses findings from relevant literature regarding the main factors associated with loneliness and social isolation and sub-groups of the older population who are at a greater risk. Section 3 presents results on the prevalence and different aspects of loneliness and social isolation from a European comparative analysis. Section 4 provides an overview of existing policies and examples for a broad variety of targeted interventions from across Europe. The concluding section presents a summary of the findings emerging from the report and offers policy recommendations.

2 Literature review

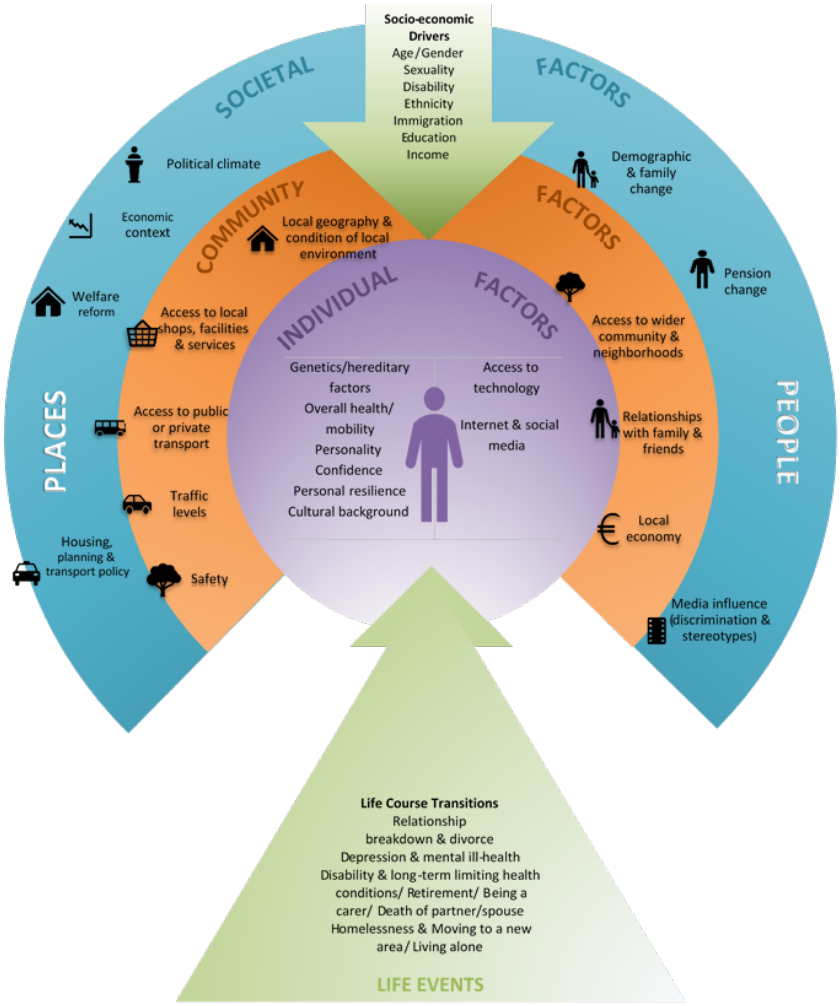
2.1 Factors associated with social isolation

Various factors place individuals at greater risks of social isolation in later life, which can be linked to individual circumstances and characteristics, health status or major life transitions and events (Morgan, 2017). Social isolation and loneliness are complex issues which affect people differently. The factors also differ through the life course and might be linked to a specific event or a permanent condition. Research shows that patterns of social engagement that might influence loneliness in old age were established at least 20 years earlier and having a spouse or a partner is a significant factor to avoid loneliness (Dahlberg et al., 2018). The literature makes a clear distinction between the long-standing low level of social engagement and loneliness as a result of recent events (Dahlberg et al., 2018). Traumatic events like abuse, imprisonment, addiction or being homeless can lead to isolation and loneliness.

While social isolation and loneliness caused by a recent event could be, to some extent, addressed through sector specific interventions, the long-standing isolation is a circumstance requiring complex intervention that would influence demographic, economic and cultural aspects in a country (Durcan & Bell, 2015). Social isolation and loneliness intensify with the changes brought by the modern way of life. Various factors such as demography, migration, urbanization, change in values and family structure (wiliness to marry, willingness to have children), and changes in the informal care support influence the individual state of isolation.

A common distinction between risk factors is made between the individual, community and the societal levels (Buffel et al., 2018; Durcan & Bell, 2015). Additionally, social demographic drivers and life events are part of the context that define social isolation and loneliness. Figure 1 presents an overview of factors linked to social isolation and loneliness at a later stage in life.

Figure 1: Factors contributing to social isolation and loneliness in later life



Source: Adapted from Clarke & McDougall (2014).

Individual factors

Personal relationships and connections define isolation and the feeling of loneliness. One person could be lonely due to a change in circumstances while another person in similar circumstances might not feel in the same way (Morgan, 2017). Age is a factor most directly linked with isolation and loneliness. Most of the analyses mark those at the oldest age spectrum, aged 75 and 80 years over, to be at a greater risk of isolation and loneliness (Bolton, 2012). A meta-analysis on influencers on loneliness in older adults shows that there is a U-shaped relationship between age and loneliness with loneliness being higher until the age of 60, lower in the 60-80 age group and rising again after 80 (Pinquart & Sörensen, 2001).

Women and men perceive and are affected differently by social isolation and loneliness. Evidence shows that some risks are greater for women. For example, they

are more likely to be affected by widowhood, to provide care and to have less income. As they live longer they are also more likely to live alone and suffer from worse health – factors that have been shown to be closely associated with increased loneliness and social isolation (Pantell et al., 2013). Women have therefore less chances to create new social contacts, but they can build on larger social networks, provide and receive more social support and are more appreciative of the existing support (Pinquart & Sörensen, 2001). Also, women tend to be negatively affected by retirement to a lesser extent than men (Milligan et al., 2013). In contrast, older men are more dependent on their partners, have less contact with children and extended family and are less likely to use support offered by the formal systems (Beach & Bamford, 2014). While it is still unclear which gender group is more affected by isolation and loneliness, the conclusions of various studies emphasize gender tailored policies and initiatives (Beach & Bamford, 2014).

People that belong to a minority, ethnicity or not speaking the language of the country of residence are at additional risk of isolation (Morgan, 2017; Clarke & McDougall, 2014). Migrants report higher rates of loneliness and isolation compared to general population in the host country (Victor et al., 2012).

Loss of health, in any form, is closely associated with social isolation and loneliness. Poor physical health, impaired mobility, disability and sensory impairments are all significant risk factors (Valtorta & Hanratty, 2012; Ong et al., 2012; 2016; Rico-Uribe et al., 2016). The risk of social isolation is more significant for people with dementia (Durcan & Bell, 2015).

Additional individual circumstances associated with loneliness are marital status (being single, divorced or widowed), the availability of a close confiding relationship and retirement (Hansen & Slagsvold, 2015). People that live alone are more exposed to loneliness and isolation, and people living in residential care can also feel more isolated and lonelier compared to people living in the community (Davidson & Rossall, 2015). Becoming or stopping to be a carer (Ekwall et al., 2005), low education, income and wealth are also associated with higher prevalence of loneliness and isolation (Cohen-Mansfield et al., 2016; Niedzwiedz et al., 2016). Research shows that loneliness is greatly influenced by the size of personal social networks. Older persons were found to have a smaller social network and less social contacts in comparison to younger age groups, which is mainly linked to life events, such as retirement, loss of family and friends, hospitalisation, as well as to declining health and increasing functional impairment (Kemperman et al., 2019). Previous studies also consistently show that having a large social network is not sufficient to avoid isolation and loneliness – the frequency and quality of social contacts are also important (Fernández-Ballesteros, 2002).

Community factors

Some risk factors of isolation and loneliness are beyond individual control as they are shaped by particularities of communities people live in. Neighbourhood characteristics, such as safety, access to local services and amenities, the availability of recreational areas as well as social and cultural activities are important preconditions for the local population to get engaged, thus preventing or alleviating social isolation and feelings of loneliness (Kemperman et al., 2019; De Jong Gierveld et al., 2015). Indeed, there is evidence that residents who were more satisfied with the physical quality of their neighbourhoods, e.g. attractive public spaces and parks, a larger variety of amenities (shops, community centre, church, etc.) as well as street lightning, walking paths and pavements, were less likely to experience loneliness (Kemperman et al., 2019; Kearns et al., 2015).

Distance and limited access to means of transportation (public or private) and/or loss of the ability to drive are important isolation factors as well. People living in remote areas could be particularly affected. Some studies show that older people in rural areas with functional impairments have reduced capacity to maintain a social connection (Victor et al., 2012). However, also living in cities can trigger risks of isolation. In particular, those older people who are living in deprived and unsafe urban neighbourhoods that do not offer recreation and green areas, are exposed (Scharf & De Jong Gierveld, 2008). Also, due to higher living costs in big cities older people may have less opportunities to access services or social and cultural events.

Poor local economies could also impact the isolation and loneliness status due to limited opportunities to access the labour market. Finally, lack of access to communication technologies, the internet and social media seem to have a negative impact on social isolation and loneliness (Cotten et al., 2013).

Societal factors

In addition to individual characteristics and community-level factors, social isolation and loneliness could be influenced by the wider socio-economic and cultural context. Studies show that material deprivation and lower income and wealth levels have an impact on the standards of living, including reduced possibilities to participate in social activities. A longitudinal study on ageing showed that people from disadvantaged economic groups are less likely to participate in social and volunteering activities compared to their more affluent peers (Jivraj et al., 2012). The general welfare regime under which people are living, therefore, has a direct impact, in particular as social protection and pension policies directly affect the income level of older people and thus their ability to actively participate in society.

General demographic trends related to population ageing along with declining health and functional mobility as well as the increasing number of single resident households also contribute to a growing share of older people experiencing loneliness and social isolation. Due to greater geographical mobility (emigration, urbanisation) of the population close relatives often end up living far from each other resulting in a lower number of social contacts, and reduced chances to receive care and support by family members.

Factors that contributed to increased loneliness during the COVID-19 pandemic

The measures to contain the spread of the COVID-19 virus limited social interactions and affected all age groups. Limited social interaction exacerbated the feeling of loneliness, but not in an equal way. Most affected are people living alone. The stay-at-home requirements increased the feeling of loneliness for this group by 23 percentage points compared with the pre-pandemic period.[1] The corresponding figure for people with a partner (and/or children) was significantly lower (9 percentage points) (Baarck et al., 2021). Pandemic-driven loneliness impacted more heavily people in poor health; in the first months of the pandemic the incidence of loneliness increased by 49% for respondents in poor health compared to 20% increase for people that reported good health (Baarck et al., 2021). Living in a care facility or any other institution increased the feeling of isolation during the pandemic (Atzendorf & Gruber, 2021). The degree of digital literacy also impacted the feeling of isolation and loneliness, at the same time, online communication was perceived as a poor replacement for face-to-face communication (Baarck et al., 2021).

2.2 Impact of loneliness and social isolation on older people

The impact of social isolation and loneliness on older people becomes manifest in particular in two dimensions, namely regarding the health status and the quality of life (Bolton, 2012). First of all, social connectiveness works as a stress regulator and provides incentives for healthier behaviour. A recent meta-analysis of 148 studies showed that people with weaker social ties are at a greater risk of premature

[1] Data for the pre-pandemic period was measured based on the Eurofound 2016 EQLS survey and data for the pandemic period was measures based on Eurfound's COVID-19 survey, reference period April to July 2020.

mortality (Tilvis et al., 2011) while those with strong social connections have double chances of survival (Holt-Dunstad et al., 2010). Isolated and lonely people are more exposed to the risks of heart disease and hypertension (Ong et al., 2012). Socially isolated people are characterised by poor resilience, less physical activity and impaired sleep, and they are more likely to report poor diet, smoking and addiction (Durcan & Bell, 2015). Weak social connections actually carry a health risk that is more harmful than not exercising and twice as harmful as obesity (Cacioppo et al., 2015).

Table 1: Impact of social isolation and loneliness

Dimensions	Impact (at-risk of)
Psychological	Depression, dementia, fear, lack of self-efficacy, poor immunity, poor nutrition, anxiety, fatigue, pessimism, vulnerability
Physical	Impairment, (chronical) illness, diabetes, cardiovascular disease, obesity and hypertension
Social	Poverty, inequality, limited access to support system

Source: adapted from Elder & Retrum, 2012.

Isolated and lonely people are more prone to depression (Cacioppo et al., 2010), to cognitive decline (James et al., 2011), and to anxiety and fatigue (Cacioppo et al., 2015). Solid social connections are likely to protect against dementia and Alzheimer (Bernard & Perry, 2013). Isolation and loneliness could also relate to feelings of pessimism, vulnerability, resentment, worthlessness (Griffin, 2010), low self-esteem or low levels of interpersonal control (Morgan, 2017). An analysis of the impact of loneliness on quality of life concluded that severe and moderate loneliness decreased the quality of life (Musich et al., 2015) both for people with physical and mental constraints.

Research also shows that loneliness and social isolation affect service utilisation. For instance, a range of studies indicate that isolated and lonely older adults have longer stay in hospitals as well as higher emergency hospitalisation and re-hospitalization rates and are more likely to be admitted earlier into residential or nursing care (Bolton, 2012; Valtorta & Hanratty, 2012; Bernard & Perry, 2013; Ong et al., 2016).

3 Comparative analysis

3.1 Caveats in measuring social isolation and loneliness in a comparative perspective

Loneliness has been the subject of several national studies that, however, tend to use different terms, measures and approaches to operationalisation. Most often they draw on national datasets so that comparison is difficult if not impossible (Valtorta et al., 2016). Although the number of studies that investigate aspects of loneliness from a cross-national comparative perspective are more limited, they have the advantage of using harmonised survey data. In this case, issues of comparability may still arise due to different sampling schemes or because of variations in response rates. Respondents from different countries might differ in the extent to which they feel open to answer questions inquiring about negative feelings and experiences such as loneliness or limited social connectedness (Fokkema et al., 2012). Figures on loneliness thus tend to be underestimated because of the negative stigma associated with it (Pinquart & Sörensen, 2001), which may result in country differences in admitting loneliness. These caveats need to be borne in mind when interpreting the results.

The following analysis is based on data from the European Quality of Life Survey (EQLS) and the European Social Survey (ESS).[2] An overview of the indicators used in the analysis to measure loneliness and social isolation is presented in Table 2.

[2] European Quality of Life Survey (European Foundation for the Improvement of Living and Working Conditions., 2018. European Quality of Life Survey Integrated Data File, 2003-2016. [data collection]. 3rd Edition. UK Data Service. SN: 7348, http://doi.org/10.5255/UKDA-SN-7348-3), and European Social Survey Round 9 Data (2019). Data file edition 3.1. NSD - Norwegian Centre for Research Data, Norway – Data Archive and distributor of ESS data for ESS ERIC. doi:10.21338/NSD-ESS8-2016 and doi:10.21338/NSD-ESS7-2014.

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Table 2: Overview of indicators from the EQLS and the ESS

Dimensions	Description of survey items	Source
Loneliness	Please indicate for each of the statements which is closest to how you have been feeling over the last two weeks. I have felt lonely. Values and categories: 1: All of the time 2: Most of the time 3: More than half of the time 4: Less than half of the time 5: Some of the time 6: At no time 98: Don't know 99: Refusal	EQLS, 2016
Social isolation	How often do you meet socially with friends, relatives or work colleagues? Values and categories: 1: Never 2: Less than once a month 3: Once a month 4: Several times a month 5: Once a week 6: Several times a week 7: Every day 77: Refusal 88: Don't know How many people, if any, are there with whom you can discuss intimate and personal matters? Values and categories: 0: None 1: 1 2: 2 3: 3 4: 4-6 5: 7-9 6: 10 or more 77: Refusal 88: Don't know	ESS, 2018

Source: Source questionnaire for EQLS 2016 and ESS Round 9 Edition 3.1.

Following De Jong Gierveld et al. (2006), we distinguish between loneliness (as a negative, subjective experience) and social isolation, defined as an objective condition of lacking or having minimal social contact with other people. To measure the extent of loneliness, a single-item question is used asking respondents how often they feel lonely. Social isolation is assessed by two items, the frequency of meeting socially with family and friends and the question prompting individuals to quantify if they have someone they could talk to about intimate matters.

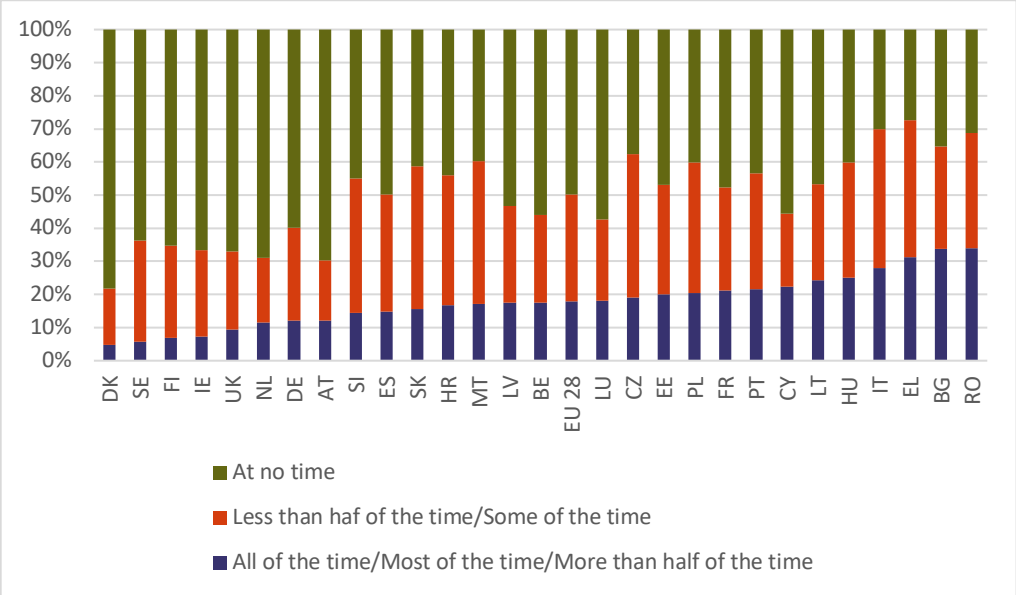
3.2 Results

The prevalence of loneliness among older people varies across Europe. While in all countries the majority of older people report that they have felt lonely "less than half of the time/some of the time" or "at no time" in the two weeks before the survey, there are a number of countries with relatively high levels of frequent loneliness (Figure 2). As many as three in ten older people in Romania, Bulgaria and Greece report being lonely "all or most or more than half of the time". Somewhat less, but still over 20% frequently feel lonely in five Eastern European countries (Czech Republic, Estonia, Poland, Lithuania and Hungary), as well as in Italy, Cyprus, Portugal, and France. The lowest share of lonely older people is found in the three Nordic countries (Denmark, Sweden, Finland) and in Ireland and the UK (all below 10%). Among the Southern European counties, Spain has the lowest figure with 15%.

The results confirm those from previous studies that, despite relying on different European comparative datasets, find loneliness to be more common among older people living in Southern and especially in Eastern Europe than In the Northern and Western parts (Sundström et al., 2009; Fokkema et al., 2012; Yang & Victor, 2011; Hansen & Slagsvold, 2015).[3] A number of explanations have been put forward to account for these cross-national differences including variations in individual characteristics and country-level characteristics (i.e., composition of older populations across different countries in Europe, the influence of cultural factors as well as of public policy regimes) as well as interactions between the two (Dykstra, 2009). One explanation points to differences in social norms and values concerning family obligations and relationships and/or erosion of these ties (Johnson & Mullins, 1987; Jylhä & Jokela, 1990). According to this, in countries of Eastern and Southern Europe, where family ties are traditionally strong, older adults may be more prone to experience loneliness when support from their adult children and other family members are not forthcoming (i.e. loneliness as the perceived gap between the expected and actual state of social connectedness). As loneliness and social isolation have also been linked to financial and health problems, higher level of reported loneliness may be a manifestation of welfare regimes with a weaker tradition of policies addressing socio-economic and health inequalities, albeit this aspect has been rarely studied (Fokkema et al., 2012).

[3] The Survey of Health, Ageing and Retirement (SHARE) in Sundström et al. (2009) and Fokkema et al. (2012). The European Social Survey (ESS) in Yang & Victor (2011), and the Generations and Gender Survey (GGS) in Hansen & Slagsvold (2015).

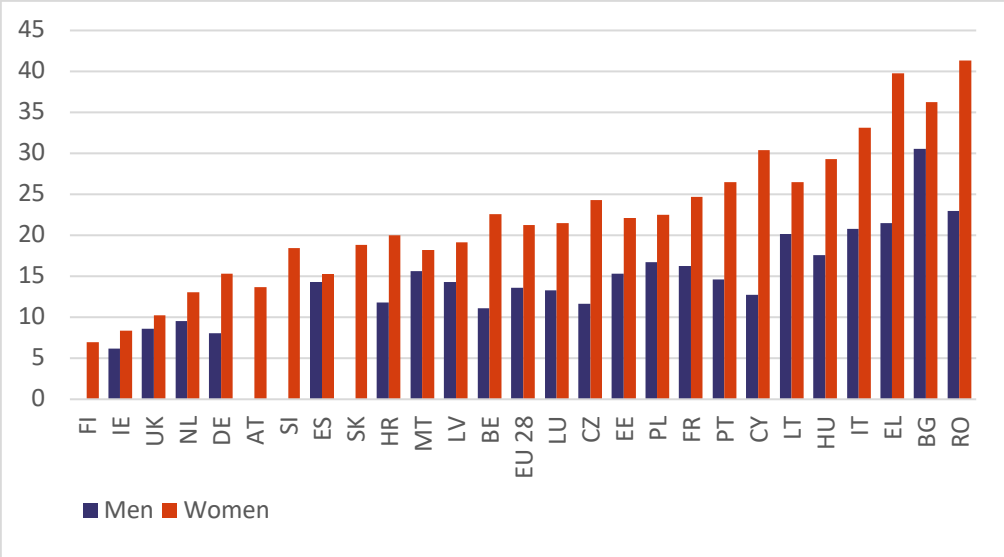
Figure 2: Share of older people aged 65 and older reporting feeling lonely (%), 2016



Source: EQLS 2016
Note: For list of country abbreviations see Annex.

In all countries for which data for men and women are shown, women are more likely than men to report feeling frequently lonely (i.e., feeling lonely all of the time, most of the time or more than half the time) (Figure 3). Spain, along with the UK and Ireland, are the countries with the smallest gender gap.

Figure 3: Frequent loneliness among older (65+) men and women (%), 2016

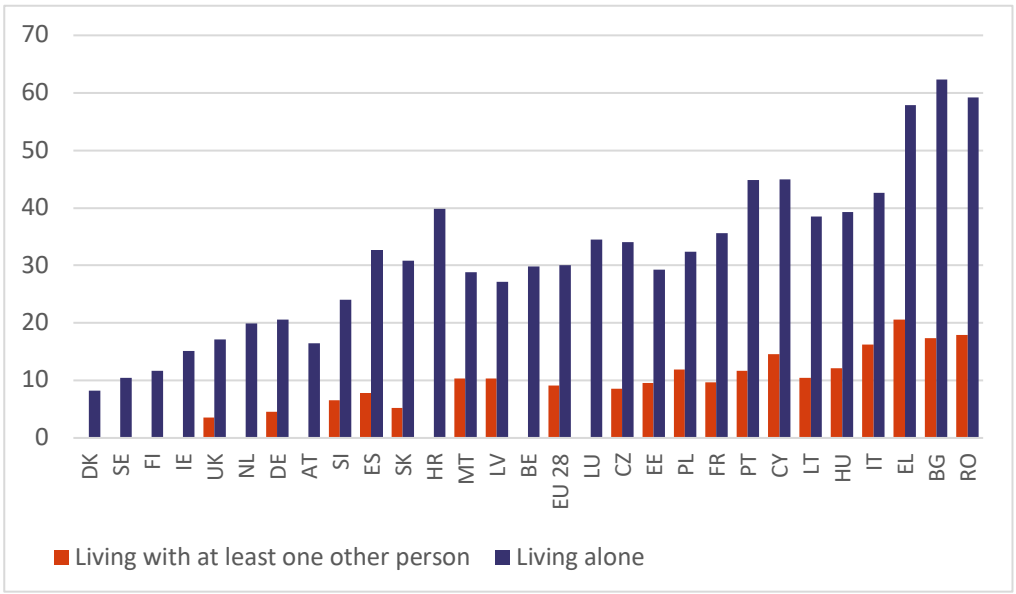


Source: EQLS 2016
Notes: Countries are ordered according to Figure 2. For Finland, Austria, Slovenia and Slovakia, data for men are not included due to small number of observations.

Generally, countries with a higher prevalence of loneliness tend to be also those with the largest difference between men and women. The review of previous literature indicates several individual, household and life course characteristics to which this gender difference in loneliness can be linked to. The higher prevalence of loneliness among older women can be partly explained by the fact that women are more likely to live longer, and because of their greater longevity, are also more likely to be widowed, live alone and have bad health and less financial resources.

As Figure 4 shows, a significantly higher share of older persons living alone report being frequently lonely compared to those who are sharing the household with at least one other person. In Slovakia, single-living elderly are 6 times more likely to be affected by feelings of loneliness than their counterparts living together with one or more persons. The difference is also substantial (4 times) in 8 out 28 EU Member States, including in Germany, Spain, the Czech Republic, France, Portugal and Slovenia. Despite the low prevalence of frequent loneliness among lone older people in the UK, the difference is more than 5 times compared to those not living alone. Given that in most countries single elderly households account for around or over a third of the older population (in some, such as Italy, Spain, Portugal and Poland it is less, i.e. around 25%), the significance of loneliness should not be underestimated.

Figure 4: Frequent loneliness among older people (65+) living alone and living with at least one other person (%), 2016



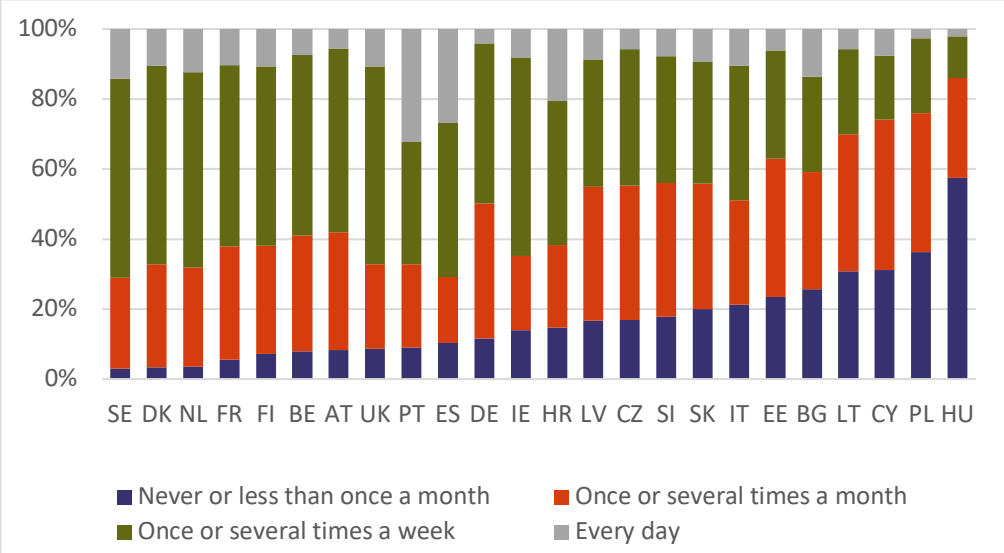
Source: EQLS 2016.

Notes: Countries are ordered according to Figure 2. For a number of countries (DK, SE, FI, IE, NL, AT, HR, BE, LU) data for those living with at least one other person are not included due to small number of observations.

Social isolation, measured by the frequency of meeting socially with friends, relatives or work colleagues, appears to affect considerably more older adults than does self-

reported loneliness. More than half of older people in Hungary and over 30% in Poland, Cyprus and Lithuania, state that they socialise less than once a month or never (Figure 5). In Slovakia, Italy, Estonia and Bulgaria, this figure is between 20% and 26%. By contrast, few older persons (less than 5%) report this to be the case in Sweden, Denmark and Netherlands. While in Spain, the majority of the older population meet socially more than once a week, the share of those with a low level of personal social contacts (i.e., meeting less than once a month or never) still reaches 10%.

Figure 5: Share of older people (65+) meeting socially with friends, relatives or work colleagues (%), 2018



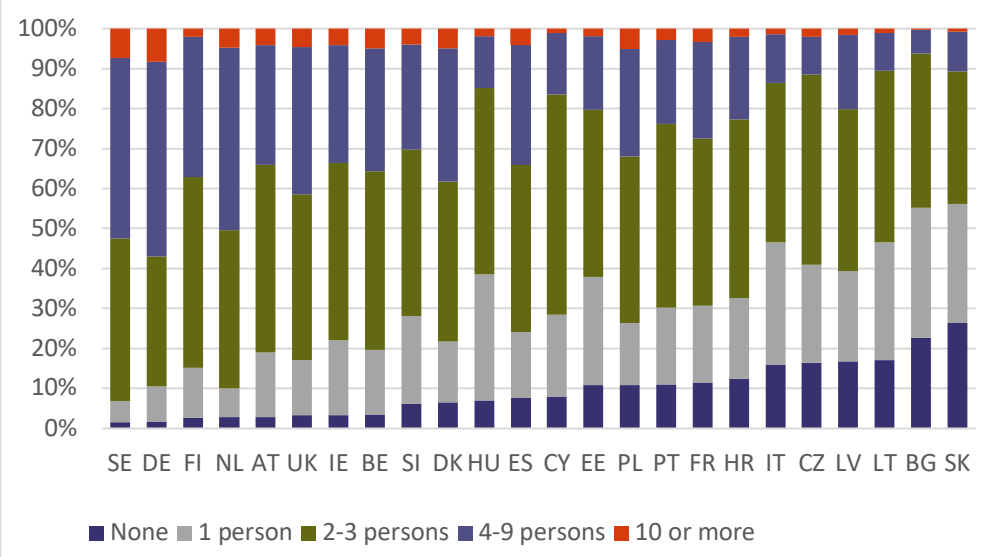
Source: ESS Round 9 Edition 3.1

It is noteworthy that, while we find some of the same countries at the higher (e.g. Hungary, Cyprus, Lithuania, Poland) and at the lower end of the spectrum (e.g. Sweden, Denmark, Finland, Netherlands) as in the case of loneliness, the two measures, i.e. loneliness and social isolation, do not necessarily overlap. This finding corroborates existing literature which shows that, while the two concepts are related, they are not the same: people may feel lonely despite having a broad social network and regular contacts and conversely be socially isolated without necessarily feeling lonely. For instance, in Portugal and France, a higher percentage of older people express subjective loneliness than social isolation. Indeed, previous evidence suggests that loneliness is less about the quantity and more about the quality of social contacts (Valtorta, 2016).

Figure 6 offers some indication on the quality of social relationships, specifically the lack of emotional support, measured by the lack of having anyone with whom to discuss personal or intimate matters. Lack of emotional support affects more older persons in Eastern European Member States, but also in Portugal, Italy and France.

In these countries, more than one out of ten older people report that they have none to discuss their private affairs with. In Spain, around two-third of older people have two or more persons they can lean on for emotional support. Although in Hungary, Poland and Cyprus, a high number of older people are isolated in terms of the frequency of personal social contacts, most of them tend to have someone with whom they can talk about personal matters.

Figure 6: Share of older people (65+) reporting having someone with whom to discuss personal matters, (%), 2018



Source: ESS Round 9 Edition 3.1

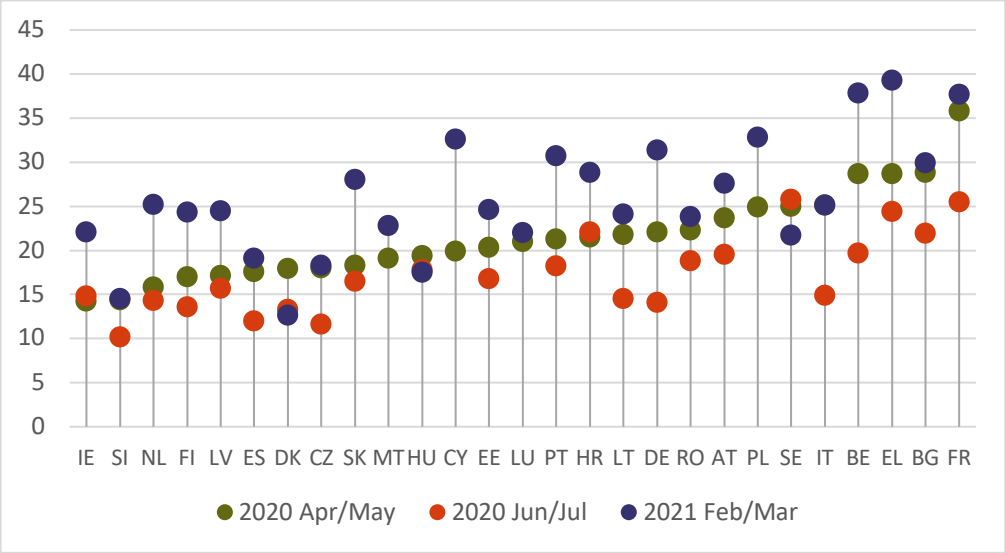
3.3 Loneliness among older people during COVID

As already mentioned in section 2.1, a number of studies show that loneliness has increased in Europe since the outbreak of the COVID-19 pandemic with older people living alone at an especially high risk of increased loneliness (Baarck et al., 2021; Santini & Koyanagi, 2021; Atzendorf & Gruber, 2021). There is also some evidence for a greater risk of feeling depressed or lonely among older persons in countries with higher rates of mortality due to COVID-19 and with strict epidemic control measures (i.e., lockdowns, mobility restrictions etc.) following the first wave of the pandemic (Atzendorf & Gruber, 2021).

Figure 7 provides snapshots of frequent loneliness among the 50+ population at three different points in time during 2020-21. Data come from the Eurofound Living, Working and COVID-19 study that has so far collected information in three online survey rounds. Compared to the first data point (2020 Apr/May), when most Member States were in their first lockdown, levels of frequent loneliness generally decreased in 2020 Jun/Jul as most countries started reopening, only to increase again in early

2021. There were, however, some outliers, namely Sweden, Croatia, Hungary, Denmark and Ireland, which differed from this general pattern. In 2021 February-March, nearly one year after the COVID-19 pandemic began, more than 30% of those aged 50 years and older reported feelings of frequent loneliness in Greece, Belgium, France, Poland, Cyprus, Germany and Portugal. Even in the three Nordic countries and Ireland, where pre-pandemic loneliness among those aged 65+ was the lowest (see Figure 2), a relatively high proportion reported in early 2021 to have felt lonely more than half of the time (the figure ranging from 13% in Denmark through 22% in Ireland and Sweden to 24% in Finland).

Figure 7: Share of people aged 50+ reporting to have felt lonely more than half of the time in the last two weeks preceeding the survey, (%), 2020-2021



Source: Eurofound COVID-19 dataset

Notes: No data for Cyprus, Luxembourg, Malta and Poland for 2020 Jun/Jul. Low reliability of data for AT and LV for 2020 Apr/May, and for BG, DE, FI, HR, LT, NL and SI for 2021 Feb/Mar.

4 Policies, measures and interventions

4.1 Government policies, action plans and interventions

Addressing social isolation and loneliness among older people from the policy perspective is challenging due to the complexity of the issue, difficulties in identifying the vulnerable individuals as well as the often poor health status of the targeted population (Davidson & Rossall, 2015).

National-level policies do only seldom refer directly to aspects of social isolation and loneliness of older people. Social inclusion aspects are scattered in strategic documents that refer to active ageing, de-institutionalisation and inclusion of people with disabilities. This is the case, for instance, in *Portugal's National Strategy for Active and Healthy Ageing*, the *Equality Act in England*, the Italian *Dementia National Plan*, the *National Memory Programme 2012-2020* in Finland or the *Strategy for Social Protection and Social Inclusion of Austria*. Netherlands, France and the UK are an exception to this general assessment. For instance, a *Reinforced action plan against loneliness* was launched in 2014 by the Dutch Ministry of Health, Welfare and Sport in cooperation with municipalities. France has started a national programme to mobilise against social isolation of older people a few years ago, and in the UK, the so-called 'Jo Cox Commission on Loneliness' produced a report to outline ways to combat loneliness in the UK in 2017. One of the recommendations of this commission was to nominate a responsible minister who was eventually nominated by increasing the remit of the Minister for Sport and Civil Society. In this context, the Scottish government developed a *National Strategy to tackle Social Isolation and Loneliness* (2017), and some local governments in the UK published more focused strategies, e.g. the Medway Council *Strategy to reduce Social Isolation* (with 3 strategic themes: raising awareness, action to support individuals and community action), and the South Ayrshire *Social Isolation and Loneliness Strategy* 2018-2027 (with 3 strategic themes: preventative, responsive and restorative).

There exist a variety of policy interventions and measures aimed at reducing social isolation and loneliness ranging from intervention directed at improving social skills, enhancing social support and increasing opportunities to socialise, such as befriending or social and cultural activities and clubs, to those focusing on social cognition, e.g. counselling, cognitive-behavioural therapy (Masi et al., 2011; Gardiner et al., 2018). Interventions can be provided on a one-on-one basis, delivered at a group setting or at broader community level (Table 3).

Table 3: Types of interventions tackling loneliness and social isolation among older people

One-on-one interventions	Group interventions	Community interventions
• Information services (websites and directories with information about social support) • Help lines (tele-help and tele-check) • Reaching and needs assessment services (post questionnaire and home visits), community navigators, volunteers to identify frail or vulnerable individuals • Gatekeeping programmes • Befriending (visits and phone contacts, assistance with small tasks) • Mentoring services and support services to reengage with the existing social network • Supportive therapy and crisis intervention • Computer literacy programmes and internet-based initiatives • Telehealth interventions	• Day care centres, lunch clubs, community art and craft activities • Social group support (interest groups) • Cultural/creative activities (use of libraries, museums, local tourism and history activities) • Tele-conferencing, virtual senior centre (interest group, support groups) • Lifestyle re-design occupational therapy • Education programmes on friendship enrichment • Cognitive-behavioural therapy	• Volunteering opportunities at the community level • Community education campaigns for general population on risks of isolation and loneliness • Retirement village living • Ageing in place programmes • Age-friendly cities programmes
Heath promotion-focused interventions		
• Sports classes for older people, healthy eating classes, action and mobility programmes		

Source: adapted from Centre for Policy on Ageing, 2014.

In reality, most interventions to reduce loneliness are complex, often combining various elements and targeting different sub-groups of the population, which makes it difficult to draw general conclusions regarding their effectiveness. Some studies show however that there are common characteristics of interventions with a positive impact, namely adaptability to the specific local context, a community development approach, activities that support active engagement (Gardiner et al., 2018), a well-defined target population (Siette et al., 2017), a theoretical framework underpinning

the initiative (Valtorta & Hanratty, 2012) and group-based rather than one-on-one delivery (Masi et al., 2011).

4.2 Targeted interventions and good practices from across Europe

Good Practice Example 1 **Living well programme Cornwall, UK**	
Type of intervention	Living well is a new person-centered approach to assist people in taking control of their lives and reduce their dependency on health and social care services. The programme has established a set of services/activities to help people build self-confidence and self-reliance through practical, navigation and coordination support. The intervention had an initial pilot phase in one area and was expanded to few other localities (2014 to present).
Target groups	People with two or more long-term conditions or people receiving social care at risk of dependency and hospitalisation.
Description	The living well initiative consists of a set of health and care services designed to meet the particular needs and aspirations of each beneficiary. The support is provided by a multidisciplinary team of professionals and volunteers. An individual support plan is developed through a guided conversation with the client/beneficiary. The individual plan consists of activities and services aimed at maintaining the health and well-being of the person as well as contribute to his social integration.
Services/ activities	• Prevention services (e.g. falls prevention, memory cafes) • Education activities/services (e.g. group exercises to reduce dependence on the social care services) • Participation and integration (e.g. volunteer support to build a social network for everyone, community connection activities) • Physical support (e.g. accompanied walks, in-the household mobility support)
Outreach principles/ measures	• Good understanding of the needs of the target group (risks stratification techniques) • Community knowledge and possibility to identify the at-risk individuals (multisectoral referring mechanism) • Clear targeting criteria (people at risks of hospitalization and people with unplanned hospital admission, people at risks of exclusion and loneliness, people having two or more

	long-term health conditions, people depending on the formal care support system)
Steps on programme implementation	• Needs assessment through guided conversation • Community involvement and mapping, joint engagement to identify the needy • Community involvement in identifying the resources (formal systems, volunteers) • Coordinated intersectoral support (joint protocols, access to data, joint management plans)
Type of partners involved/role	The innovative element of the intervention is the unique partnership of several actors (authorities at different levels, volunteer associations, foundations and health and social care providers). Implementation partners: Age UK Cornwall, NHS Kernow Clinical Co Commissioning Group, Cornwall Council, Age UK, the voluntary sector and community matrons. The following professionals are involved: district nurses, GPs, social workers and mental health nurses.
Impact	An internal evaluation showed that the emergency hospital admission within the target group reduced with 34%, the emergency department attendance with 21% and the overall hospital admission with 32%. About 20% of the beneficiaries self-reported improvement in their well-being, and one in five beneficiaries decided to volunteer for the initiative themselves. About 87% of the medical professionals said that the initiative works and think that their work is meaningful.
Evidence on costs	The cost per person is approximately £400 (for the pilot phase)
Source/ references	• Kernow Clinical Commissioning Group: https://www.kernowccg.nhs.uk/news/2015/09/minister-hears-about-innovative-living-well-approach/ • Leyshon, C., Leyshon, M. & Kaesehage, K. (2015) *Living well Penwith Pioneer. How does change happen? A qualitative process evaluation.* Exeter: AgeUK, Nesta, Living Well, Exeter University.
Key words	Long-term care needs, needs assessment, prevention, education

Good Practice Example 2 **Organised support in the neighbourhood with time-banking, Switzerland**	
Type of intervention	KISS Switzerland is promoting the establishment of cooperatives to run a non-monetary time-banking system in Switzerland, in particular to create an additional incentive for volunteering in befriending, household chores and shared leisure time. KISS Switzerland is an association that supports

	and coaches the local/regional cooperatives across the entire country.
Target groups	• People who are ready to provide help and support in the local setting • People living at home who are asking for support in the household or due to loneliness
Description	Time exchange models are striving to address individual and societal challenges of ageing at low cost by organizing meaningful civic engagement. In the local setting (cooperative) there is only one central address (office) where people in need and people offering their services may turn to. Supply and offer are connected by professionals with the aim to strengthen the autonomous organisation in the neighbourhood. People providing help (befriending, gardening, shopping, transport …) are earning time-credits that they can redeem in case of own need at a later stage.
Services/ activities	• Promotion of time-banking across Switzerland • Support to local/regional time-banking cooperatives (currently around 10) • Networking with relevant stakeholders • At the local level: awareness-raising, networking, organisation of time-exchange (documentation) as a complementary activity to classic volunteering and formal support services • Support offered only entails normal activities of daily living, no personal care
Outreach principles/ measures	• Proactive search for 'time-givers' and 'time-consumers' in the neighbourhood • Matching of demand and supply • Public meeting-place (Café) where members can also meet in an informal atmosphere
Steps on programme implementation	• An interest group takes action and addresses the local public • Development of organisation, funding (public, sponsoring, membership fees) • Foundation of a local cooperative • Start of the time-brokering activities, networking, marketing etc. – and further development
Type of partners involved/role	Interested citizens, civil society organisations, formal social services, public administration, sponsors
Impact	Currently there are about 10 local cooperatives across Switzerland. An evaluation of the two first cooperatives in

	2015 (Künzi et al., 2016) showed that each of them gathered about 200 members, of which about 50% were active 'time-givers' providing on average about 1,500 hours per year per site. The number of members has since continued to rise.
Evidence on costs	Costs of the two cooperatives assessed in 2015 were about 200,000€ of which about 30% were covered by local authorities. A return on investment would already be reached if only 2% of 'time-consumers', mainly older people living alone at home, would postpone a transfer into residential care by 6 months. Furthermore, regular social contacts significantly increase the quality of life of 'time-consumers' and their relatives as well as of 'time-givers', a majority of which had hitherto not been involved in voluntary work (Künzi et al., 2016).
Source/ references	• Wehner, T., Güntert, S.T. (2017). *KISS Schweiz – Zeitvergütete, organisierte Nachbarschaftshilfe. Ein Evaluationsbericht.* Zürich: ETH Zürich (Züricher Beträge zur Psychologie der Arbeit, Nr. 1) • Künzi, K., Oesch, T., Jäggi, J. (2016). *Quantifizierung des Nutzens der Zeitvorsorge KISS.* Bern: BASS. • www.kiss-zeit.ch (in German only)
Key words	Neighbourhood support, civic engagement, mutual exchange, intergenerational exchange

Good Practice Example 3 **LinkAge National Programme, UK**	
Type of intervention	One to one support, group intervention and wider community engagement
Target groups	Lonely and isolated older people living at home or in institutions
Description	LinkAge Network is a national initiative that connects individuals, groups and organisations, facilitates knowledge, resources and skills sharing, thus strengthening community provisions for older people. The programme encourages older people to transfer experience and skills to younger as well as to other older people by means of so-called 'community hubs' Each hub is managed by a local advisory board, which is the link between people in need and the wider community, and comes with suggestions on activities and services.
Services/ activities	• Holistic therapies, yoga, cooking, choirs, archery, golf, walking, football, IT classes etc. • Several sub-programmes have been put in place to meet needs and explore inclusion opportunities. For instance, LinkAge ACE (Active, Connected and Engaged) is a peer

	support programme (old age to old age) in the neighbourhood with a positive impact on both providers and beneficiaries and an important preventive component. Another sub-programme is LinkAge Plus offering support to people in residential institutions (counselling, money management, IT skills, social activities, health promotion and prevention classes, physical activities etc.). LinkAge also offers opportunities to acquire new skills, e.g. the 'Talking Tables' activity that organises cooking classes in neighbourhoods.
Outreach principles/ measures	Outreach is ensured through the local advisory board consisting of people aged 55. Beneficiaries are referred by individuals as well as by other stakeholders (service providers, local authorities, non-profit organizations).
Type of partners involved/role	Non-profit organisations, service providers, local authorities.
Impact	An internal qualitative evaluation showed that the programme helps people to feel more connected, improves the well-being of vulnerable older adults and contributes to increased physical activities.
Evidence on costs	The costs vary across activities and communities and are covered by the programme with a small contribution from the users.
Source/ references	• LinkAge Network • LinkAge Plus • Talking Tables
Key words	Support units, individual approach, age to age support, residential care

Good Practice Example 4 **MONALISA National Programme, France**	
Type of intervention	One to one support, group intervention and wider community engagement
Target groups	Lonely and isolated older people, the acronym stands for 'MObilisation NAtionale contre L'Isolement des Agés'
Description	The programme, initiated in 2013 by the Minister responsible for older people and autonomy, concentrates the commitment of volunteers, family members and professionals to reduce social isolation of older people in a sustainable way. It is based on individual engagement in the community as well as on simple measures of joint living and reciprocity. The programme supports the creation of individual or collective

	relationships, all by acknowledging the choices and differences of each individual. Regular interaction is creating social opportunities for all involved. The programme helps mobilise volunteers and puts in place 'citizen teams' (*équipes citoyennes*) that provide support to older isolated people. The citizen teams are trained and exchange experience, approaches, solutions, methods of interactions, etc. A national committee is managing the network to ensure broad partnerships and the transfer of local outputs into national policy. The committee is also responsible for piloting different activities and initiatives.
Services/ activities	Activities include accompanied trips to the hospital or markets, support with various administrative issues and documentation, personal monitoring. All teams are part of the national network that organises mutual support and the exchange of experiences.
Outreach principles/ measures	• Proactive approaches to attract users and the community • Strong motivation of the volunteers and professionals • Continuous support of local groups and exchange of good outreach practice within the programme • Creation of a strong identity within the citizen teams
Steps on programme implementation	• Creation and support of citizen teams • Each citizen team builds a relationship with the beneficiary through a defined set of activities contributing to prevention and reduction of social isolation • Cooperation with local authorities to put in place sustainable strategies against social isolation
Type of partners involved/role	• National Ministry for Older People and Autonomy • Territorial partnerships • Municipalities and local institutions, stakeholders
Impact	The programme started its implementation in 2017, in March 2019 there were about 287 citizen teams registered, 63 territorial partnerships contributed to the mobilisation of volunteers, and 474 organisations signed up to the MONALISA Charter.
Evidence on costs	A total budget of 2 mio. € has been assigned for 3 years (2018-2020)
Source/ references	MONALISA website: https://www.monalisa-asso.fr (in French only)
Key words	National programme, citizen teams, territorial partnerships

Good Practice Example 5 **Support in difficult life situations: *Time for Life* and *Touchstones*, UK**	
Type of intervention	One to one, group intervention
Target groups	Older people (65 plus) going through a difficult period, e.g. after events such as illness, divorce or bereavement, but also as carers or persons in need of care
Description	*Time for life* is a programme that tackles social isolation linked to particularly difficult stages or situations in the life-course like bereavement, illness or disability. The programme is targeted and limited in time and offers individual support by a personal coach. The goal is to increase the well-being of the beneficiary, to help him or her getting involved in positive contributions to the community, exercising choice and control, and enhancing the ability to care or self-care. *Touchstones* provides support to bereaved older people to acquire new skills in their daily living and to offer them opportunities for volunteer work within their communities. The practical skills sessions and trainings are provided by peers who faced similar situations in the past, i.e. each user may also become a trainer if s/he wants so. The beneficiaries are involved in the choice of what they want to learn or engage in (themes, activities, subjects).
Services/ activities	*Time for life* helps beneficiaries to re-engage in personally meaningful and enjoyable activities, to develop skills and experiences to further engage in social life and activities, and to re-connect with the wider community. The coach also accompanies users to participate in activities they want to attend, e.g. social support group discussions, activity groups or physical exercise. *Touchstones* offers practical skills sessions and trainings to better cope with daily life after bereavement.
Outreach principles/ measures	In the *Time for Life programme* the eligibility criteria are defined by the local consortium that initiated the programme. Referrals are made by local councils and individual coaches. *Touchstone programme* is reaching out to potential beneficiaries through advertisements in local radio and newspapers as well as on-line via social media. There is a high rate of self-referral, but users are also referred by GPs and social workers.
Type of partners involved/role	Non-profit organisations, local stakeholders
Impact	The impact of the *Time for Life programme* is measured through a self-reporting method on the various support dimensions (well-being, control, participation, abilities etc.).

	Improvements of the individual situation have been reported on all dimensions. A user survey showed that in the *Touchstone programme* about 90% of beneficiaries felt more connected to their community, 80% felt more confident in meeting new people and spend time outside of their homes.
Evidence on costs	n/a
Source/ references	• Time for Life • Touchstone
Key words	Bereavement, coping strategies, skills sessions, coaching

Good Practice Example 6 **Carers Support Groups, UK**	
Type of intervention	One to one, group intervention
Target groups	Older carers of people with LTC needs
Description	According to a survey in the UK (Carers UK, 2017) more than 8 in 10 (81%) surveyed unpaid carers described themselves as "lonely or socially isolated" due to their caring responsibilities. The Carers Support Group initiative therefore offers individually tailored support to persons that provide care to a partner on regular basis. The support group usually consists of people living in similar care situations that meet twice a month in a friendly setting. The focus of the initiative is to offer respite and opportunities for social contact.
Services/ activities	Each group has a group coordinator offering one-to-one support, including the referral of beneficiaries to other types of support. The group decides on the activities (e.g. bowling, pool, mini-golf, fishing, cinema, shared meals) that are offered free of charge. The group is flexible regarding time schedules that always consider the caring roles of participants. Transportation costs of the group members are also covered by the initiative.
Outreach principles/ measures	The group coordinator plays an important role in identifying older carers in the municipality who are in need of support.
Type of partners involved/role	Local carers' organisations

Impact	An annual evaluation is done through on-line questionnaires and results show that the initiative helped beneficiaries to reduce stress, depression and the feeling of isolation.
Evidence on costs	None
Source/ references	• Carers UK (2017). State of Caring 2017, https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-report-2017 • Carers UK/Jo Cox Loneliness Commission, The world shrinks: Carer loneliness, https://www.carersuk.org/images/News__campaigns/The_world_Shrinks_Final.pdf
Key words	Individual support, older carers

Good Practice Example 7 **Social Inclusion of older people in urban areas (Paris, France)**	
Type of intervention	Community initiatives
Target groups	Older isolated people living in urban areas
Description	Economic problems are one of the key drivers of social exclusion – this is also true for income-poor but asset-rich people living alone in cities. Various programmes to tackle social inclusion of the older population were launched recently in Paris with a focus on intergenerational exchange, housing and transport.
Services/ activities	• Intergenerational cohabitation supporting seniors over 65 in offering accommodation to students, apprentices or work-study students under 30. This initiative helps seniors and students both financially (students pay a rent of less than 200€ per month) and socially. • The city of Paris is planning to engage in a "viager" service, i.e. public authorities in Paris will be inviting older people to sell their property on the basis of a life annuity, i.e. safeguarding the right to remain in the property, while after their death these dwellings would become apartments under conditions of social housing. • Free public transport (Navigo Pass) is offered to people 65+ on the basis of means-testing to increase their mobility within Paris. This is accompanied by an expanded personal support system that includes attendance to the doctor, at the station, etc.

Outreach principles/ measures	No information
Type of partners involved/role	Public authorities, public transport, universities, student organisations
Impact	n/a
Evidence on costs	n/a
Source/ references	SilverEco, Les 4 mesures de la Mairie de Paris pour le bien-vieillir https://www.silvereco.fr/les-4-mesures-de-la-mairie-de-paris-pour-le-bien-vieillir/3197646
Key words	Inclusive cities, intergenerational cohabitation, economic support

Good Practice Example 8 **Social Inclusion of older people by creating an age friendly society (Norway)**	
Type of intervention	Community initiatives
Target groups	Older people living in the community
Description	The Norwegian government's strategy for an age-friendly society highlights a number of initiatives that will be further developed to involve older people in society, e.g. in cultural activities, by enhancing local participation and opportunities for intergenerational exchange.
Services/ activities	• *Aalesunds Museum* offers the possibility for older people to volunteer as a museum educator. A special interest group is created, training is offered, and the museum educators participate in various tasks, including interaction and support to tourists. • The *Bruket arts centre in Malvik* municipality constructed a bridge to a nearby residential care centre, thus facilitating the use of different facilities (meeting rooms, outdoor spaces) and participation in cultural events for residents. As also several schools in the area benefit from the same connection, opportunities for intergenerational exchange are enhanced. • The *Norwegian Red Cross* and the *Norwegian Trekking Association* are cooperating to organise hiking groups for older people, in particular to engage lonely older people in social and physical activities. The Ministry of Health and Care Services will provide financial support to group

	leaders, who will reach out for participants and organise hiking tours in areas and on foot trails that are suitable for older people.
Outreach principles/ measures	Outreach should be realised by municipal authorities, NGOs and dedicated leaders
Type of partners involved/role	Municipal authorities, NGOs, cultural and sports organisations
Impact	n/a
Evidence on costs	none
Source/ references	Ministry of Health and Care Services (2017). *More Years – More Opportunities.* The Norwegian government's strategy for an age-friendly society, https://www.dataplan.info/img_upload/5c84ed46aa0abfec4ac40610dde11285/strategy_age-friendly_society.pdf
Key words	Age-friendly society, intergenerational exchange, cultural activities, physical activities

Good Practice Example 9 **Befriending networks, Ireland**	
Type of intervention	Befriending and support service
Target groups	Older people living in the community
Description	The Befriending service provides companionship to older people who feel socially isolated or experience loneliness through weekly volunteer visits and telephone calls and offers additional practical support for older people to age at home.
Services/ activities	• *Befriending and support visitation service:* trained, vetted and supported local volunteers visit older people in their homes at least once a week to provide companionship. • *Befriending and support telephone service:* it offers daily contact by a trained and vetted local volunteer to alleviate loneliness and improve overall well-being. • *Support coordination service:* each older person is assigned a support coordinator, a trained professional, who assists them with coordinating the support services they need, including health and medical, financial, social welfare and housing-related needs.

Outreach principles/ measures	Outreach is based on a referral process, including self-referrals, as well as by family members, neighbours, health and social care professionals, social workers, voluntary and statutory organizations. To help people looking for support in their area, a national online directory on befriending services and providers was established in 2014 and is hosted by ALONE, a national charity organization that supports older people to age at home.
Steps involved	• After referral for services, the older person is contacted by a support coordinator to discuss the services and next steps. • After an assessment is carried out in the person's home, the support coordinator will match the older person with a suitable volunteer, ensuring compatibility and common interests, and will be introduced to each other by an experienced member of staff or volunteer (in case the referral concerns support coordination services, the coordinator will set up a plan to help the older person with the necessary services and will remain in contact until the issues are resolved). • If both the older person and the volunteer are happy with the match, they agree on future visiting (or call) times between themselves. • The support coordinator regularly carries out checks through phone calls to ensure that the visits (or phone calls) are going well.
Type of partners involved/role	The Befriending Network Ireland (BNI) was established in 2015 and today has more than 60 member organisations across the country. Through its members, BNI provides befriending services and support; it also offers training for coordinators and volunteers, an online shared learning platform, and regional network and support meetings. The network is supported by an Advisory Group. BNI is coordinated and hosted by ALONE, which has a long history providing befriending services.
Impact	In 2015, an external evaluation of ALONE's Befriending service was undertaken which showed that an increased share of older persons reported not feeling lonely after using the services. A full impact evaulation with a control group is planned in the future.
Source/ references	ALONE website: https://alone.ie/our-work/#support-befriending
Key words	Companionship, one-on-one intitiative, local volunteers

Good Practice Example 10 **Men in Sheds (Ireland, UK, Sweden, Spain, Netherlands)**	
Type of intervention	Community initiatives
Target groups	Older men living in the community
Description	There is evidence that older men are less likely to participate in generic social activity than women. Men in Sheds has therefore been developed as an intervention designed to promote social activity amongst older men. The precise history of Men's Sheds is unclear, but it seems that already in the late 1970s the Australian gerontologist Leon Earle identified that older men were going to community-based sheds and noted the wider health and social benefits they derived from the activity. The first Men's sheds in Europe were established in Ireland in 2011. Since then, the Men's Sheds movement has spread to the UK, Netherlands, Sweden and recently also to Spain. Although not explicitly mentioning the fight against loneliness, this initiative and related projects help raise awareness and promote health and well-being among men while contributing to their integration in the community
Services/ activities	• Men in Sheds provide a space for older men to meet to take part in woodworking, upcycling and other socially beneficial activities. Older men are thus given the opportunity to engage in practical activities such as woodwork or other do-it-yourself activities they could no longer do at home or do not want to do them alone. • Initiatives usually develop in local communities and provide opportunities – a shed with appropriate tools in an informal setting – for repairing and making nesting boxes, public benches, children's toys, notice boards or furniture. • Several other projects and activities in the context of volunteering and community work.
Outreach principles/ measures	Local word of mouth, websites
Type of partners involved/role	NGOs, municipalities
Impact	"The existing evidence base consists largely of observational, qualitative studies with relatively small sample sizes that draw on subjective self-report accounts of health and well-being." (Miligan et al., 2013)
Evidence on costs	none

Source/ references	• WHO (2018). *The health and well-being of men in the WHO European Region: better health through a gender approach.* Copenhagen: WHO Regional Office for Europe. • Milligan, C., Dowrick, C., Payne, S., Hanratty, B., Neary, D., Irwin, P., Richardson, D. (2013). *Men's Sheds and other gendered interventions for older men: improving health and wellbeing through social activity A systematic review and scoping of the evidence base.* Lancaster: Lancaster University, Centre for Ageing Research. • http://menssheds.eu
Key words	Gender, do-it-yourself activities, group intervention, local

Good Practice Example 11 **Assistive technologies to prevent and overcome social isolation (France, Norway, Greece)**	
Type of intervention	Technical tools and devices
Target groups	Older people in general, in particular those feeling lonely or being socially isolated

Various technical tools and programmes are available to help socially isolated and lonely adults. These technologies can be used to improve access to information and resources, family communication, to serve as memory aids, as support to caregivers or to influence behaviour, to increase safety, to support with medication management and to track personal health records (Grossman et al., 2018). Several applications and devices that may help reduce social isolation of older people are listed below.

APPs	• **SnapMiam**, **France**, is an APP to link older people who offer a meal to students that would like to buy it at reasonable price. The student and the older person meet at the agreed place for a joint meal. • **Yvelines Etudiants Seniors, France,** is an APP that serves as a platform to link older people with young people (high school and university students) who are hired by the community council to offer communication and support services (100,000 visits per year/ 1,700 students). • **iConnect, Greece,** is an APP that serves as a platform to bring together students from several selected educational institutions and older people with dementia. In this educational and support programme students are offered a module that is designed to help with the long-term memory through cultural activities (poetry, theatre, music).

Devices	• **Papot'âge, France** is a device (phone) that links isolated older people with professionals, volunteers, people from community and other older people in a user-friendly manner. The connection works from both sides. • **KOMP, Norway,** is a user-friendly family device that connects an older person with his/her family and friends. The device requires no digital skills, has a high contrast screen, no touchscreen, clear audio connection, and a one button physical interface.
Source/ references	• https://www.noisolation.com/global/komp • https://www.silvereco.fr/tag/lutte-contre-lisolement-des-ages • http://www.gezelschapp.nu/
Key words	Assistive technology, social isolation

Good Practice Example 12 **Additional measures to reduce social isolation and loneliness in times of COVID-19 restrictive measures**	
Type of intervention	mixed
Target groups	All people affected by loneliness and social isolation during the COVID-19 stay at home requirements

The interventions during COVID-19 pandemic are designed to provide emergency support, to compensate for reduced social interaction and disruption of in-person services. Most of the interventions were designed to provide online support.

Increase in digital literacy	• Helplines for older people for communication, advice, counselling and other necessary support during stay-at-home measures. One example is Cyprus where a dedicated helpline for older people and people with disabilities was set and a taskforce was organised which would support these people by getting food, medicine, etc. In the UK several organisations launched dedicated webpages with resources for isolated older people, people with dementia, people with disabilities and their families on how to cope with COVID-19 pandemic and the imposed restrictions. In Spain an alarm system composed of a network of pharmacies was set up as an emergency support measure. • Additional integration and socialisation support. For example, in Poland, a radio programme was launched where older people could call and share their thoughts and communicate with one another. In the UK part of the

	'Invisible Talents' project a video series was launched where older people shared how to make staying at home as pleasant and diverting as possible under the pandemic conditions. • Adjusting public services to accommodate isolated old people, in Ireland the national post introduced emergency temporary agents who would distribute the pensions to people directly at home. During the pandemic several organisations in various countries provided IT support through calls to older people to support them with paying bills, accessing internet banking and other necessary services online.
Source/ references	• AGE platform compendium of practices, Human Rights in times of COVID 19 https://www.age-platform.eu/sites/default/files/COVID-19_%26_human_rights_concerns_for_older_persons-April20.pdf • Loneliness in the EU, overview of good practices in times of COVID 19 https://publications.jrc.ec.europa.eu/repository/handle/JRC125873 • Age UK, Older people's lives during the pandemic https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/behind-the-headlines/behind_the_headlines_coronavirus.pdf
Key words	Loneliness relief, COVID-19 pandemic, emergency support

5 Conclusions and policy recommendations

This study has addressed issues of rising policy relevance in the context of ageing populations, namely the spread of social isolation and loneliness, and measures to combat related social risks. Although loneliness as a rather subjective perception of a gap between desired and actual social relationships has to be distinguished from social isolation as an 'objective' measure of social interactions and support, both concepts are intertwined. Therefore, both concepts are getting policy relevant due to unintended individual and societal effects in terms of poor health, increasing vulnerability and exclusion from public life. For instance, rising numbers of social isolation are indeed alarming when considering evidence that weak social connections carry a health risk that is comparable to smoking and twice as harmful as obesity.

While it is already challenging to measure the extent of social exclusion in a given society and/or to compare individual countries' performance, it is even more difficult to gauge the level of loneliness that is usually assessed by means of surveys. Almost by definition, it is demanding to identify and contact this population group, and there are a wide range of factors driving the feeling of loneliness or at least the propensity to communicate this feeling. The factors that contribute to the perception of loneliness and/or to social isolation might be individual, but they also stem from diverse community, societal or environmental factors. Moreover, they are both influencing and influenced by health as well as by social and socio-demographic features.

Available studies and surveys show a vast variety of data on the prevalence of loneliness across Europe – with a tendency to growth, consistently higher shares in Eastern Europe and Mediterranean countries. Women are reporting loneliness to a higher degree than men, and older people living alone are much more likely to be affected by frequent feelings of loneliness than those living with one or more persons in the same household. It is important to note, however, that feelings of loneliness and social isolation do not necessarily overlap. If social isolation is measured in terms of a low frequency in meeting with friends, it is also important to consider the quality, rather than the mere quantity of relationships.

The complexity of factors influencing feelings of loneliness and social isolation, often deep-rooted in experiences and events over the life-course, sometimes caused by a single and recent event at older age, is challenging policies that aim at addressing

roots, causes and their impact, when designing and implementing measures to combat loneliness and social isolation.

The study of academic literature and good practices across Europe has shown that both bottom-up and top-down strategies have developed over time, ranging from complex interventions to roll-out programmes across jurisdictions to small-scale initiatives at the local level that try to enhance the participation of specific target groups in the community. At the national level, some countries such as France, the UK or Netherlands have launched national strategies with an explicit focus on combating loneliness, while others have partly addressed related issues in national strategies of 'Active Ageing', 'Dementia strategies', policies targeting informal carers or other programmes focusing on intergenerational exchange. At the regional and local level, many bottom-up initiatives can be identified, including new forms of volunteering, befriending and civic engagement in the neighbourhood. In some cases, new information and communication technologies have been designed to support initiatives. A common feature of all initiatives is, however, the establishment of responsibilities and leadership taken over by individuals or organisations (both public and voluntary private).

Due to the complexity of factors influencing loneliness and social isolation there is a dearth of research to provide clear evidence on 'what works' in different social and cultural contexts. Given the general lack of awareness and related services it is, however, important to promote initiatives that aim at enhancing social capital and social cohesion at all levels – and ideally over the entire life-course. There is no 'one size fits all' solution to tackling loneliness and social isolation, but a range of approaches that need to be piloted and adapted to the respective local environment:

- To further raise public awareness of loneliness and social isolation policies at national and regional level need to further spread information about the potential impact and social harm that may be caused by these situations.
- To develop social relations also beyond traditional family bonds policies at local level need to create opportunities for social exchange, formal and informal services to identify the various target groups as well as support mechanisms for bottom-up initiatives. This includes funding, but also the provision of public spaces and trained personnel in places of cultural, recreational, health and social work.
- To combat loneliness and social isolation of specific groups, national and regional policies need to integrate targeted activities within existing strategies, e.g. in urban and rural development, in health and social care policies, in 'Active and Healthy Ageing', but also in infrastructure, technology, housing and cultural policies.

- To take a more proactive approach to combat loneliness and social isolation, interventions over the life-course as well as decent social security systems should be ensured.
- To enhance knowledge about loneliness and social isolation, national policies should strive to promote participative research with target groups as well as evaluation and implementation research.

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7 Annex

Country abbreviations in alphabetical order

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HR	Croatia
HU	Hungary
IE	Ireland
IT	Italy
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	Netherlands
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
UK	United Kingdom