# The Project to Reduce and Cope with Feelings of Loneliness among Older Adults
## A Formative Evaluation

Michal Laron  Ittay Mannheim  Yafit Cohen
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The study was initiated by JDC–ESHEL, the National Insurance Institute's Fund for Demonstration Projects, and the Ministry of Labor and Social Affairs and Services, and funded with the assistance of JDC–ESHEL and the National Insurance Institute's Fund for Demonstration Projects

RR–818–20

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Jerusalem | September 2020

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Sharon, A., Brodsky, J., & Beer, S. (2013). *Social clubs for the elderly – National distribution patterns of activity and characteristics of visitors.* RR-630-13 (Hebrew).

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Berg-Warman, A. (2003). *Supportive Community: Evaluation study 2000-2001.* RR-392-93 (Hebrew).


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# Abstract

## Background

The phenomenon of loneliness in old age is currently receiving more attention from service developers and the research community than in the past, due both to its prevalence and to its connection to the health status and emotional well-being of older adults. In 2014, a request for proposals was issued for the development of programs to reduce loneliness in the framework of a national initiative known as the Project to Reduce and Cope with Feelings of Loneliness among Older Adults (in short, the Loneliness Project). It was headed by the National Insurance Institute's Fund for Demonstration Projects, JDC-ESHEL and the Ministry of Labor and Social Affairs and Services (MOLSA). The project included 23 different programs operated by 13 organizations[1] (for example, associations for older adults and social service departments) dispersed widely throughout Israel. The directors of the Loneliness Project commissioned the Myers-JDC-Brookdale Institute (MJB) to evaluate the project. The current study was conducted by MJB over three years.

## Study Goals

The study had three main goals: 1. To examine the contribution of each program implemented in a locality to the older adults participating (the individual level); 2. To examine each program's contribution to further addressing the issue of loneliness in every locality where it was conducted (the field level); 3. To formulate insights and recommendations about the programs to reduce loneliness (the policy level).

## Methods

The study included: Analysis of the intake records of participants in 21 programs;[2] interviews with the participants prior to the program (751 interviews) and 685 interviews six to nine months after the start of the program; 14 observations of activities and 14 focus groups with participants; 36 interviews with program coordinators and professionals in the localities where programs were conducted; 60 self-report

[1] Some organizations ran more than one program.

[2] In one of the programs, we conducted an observation and focus group and in another, we conducted face-to-face semi-structured interviews. The staff of both programs were interviewed.

questionnaires were sent to program implementers (group leaders, therapists, etc.). A comparison was made between the programs according to their intervention strategies; likewise, a comparison was made between the program participants and a control group comprising people who were meant to participate in a certain program but did not actually do so. The findings were analyzed using quantitative tools of descriptive and inferential statistics using bivariate analysis ($\chi^2$, Wilcoxon for paired samples, and t-test for dependent and independent samples) and multivariate analysis (probit regression, logistic regression and linear regression). Qualitative tools for thematic analysis were also used.

The contribution of the programs to the participants (individual level) was examined through the interviews with participants, program coordinators and implementers, and the observations and focus groups with the participants. The interviews with the professionals, coordinators and implementers were also used to evaluate the contribution of the program and the overall project to addressing the issue of loneliness in old age at the local level. Insights about strategies to address the issue of loneliness in old age at the national level were gleaned from all the sources of information.

## Findings

Seventy-three percent of the people enrolled in programs reported during intake that they frequently or sometimes felt lonely, compared with 34% of all people aged 65+ in Israel. Overall, 40% of the respondents dropped out of the programs (n=271), either at the beginning (23%) or after one or two meetings (17%). Among those who participated in all, or almost all, of the programs (n=414), there was a high level of satisfaction.

The respondents were asked to what extent they felt that the program had helped them in various aspects of their lives. Fifty-seven percent noted that it had helped reduce their sense of loneliness to a great or very great extent; 71% reported improvement in their general mood to a great or very great extent; 48% reported an improved feeling in their general health; 45% reported that the program had helped their ability to cope with difficulties and unpleasant feelings to a great or very great extent.

The various programs were based on two intervention strategies: an opportunity for social integration and the strengthening of social competence. The characteristics of the participants were different in each of the strategies. The participants were matched to take account of their background characteristics and selection bias – selection bias of the program and self-selection bias. This matching made it possible to compare the strategies. The comparison did not find that either of the strategies had a significant

advantage over the other in reducing loneliness or depression. In other words, for the "average participant" – an individual with average levels of loneliness and depression – no significant difference was found between the strategies for reducing loneliness and depression.

As to the association between the participants' background characteristics and the contribution of the intervention strategy to reducing the levels of loneliness and depression, we found that the social-interaction strategy was better suited to people characterized by a relatively low level of initial loneliness, who are socially active and have no financial difficulties.

A comparison between the level of loneliness and depression among participants before and after joining the program found an average decline in the UCLA Loneliness Scale and the PHQ-2 depression measure, in contrast to respondents who did not participate in the programs, where these measures increased over the same period. A multivariate linear regression analysis found that beyond all other explanatory variables, participation in the programs of both strategies significantly reduced the level of the indicator of depression of the participants compared with non-participants. As for reducing loneliness, participation in programs to strengthen social competence significantly reduced the level of loneliness of participants compared to those who did not participate, but in social interaction programs no significant difference was found between participants and non-participants in reducing loneliness.

Furthermore, the project helped to raise awareness about loneliness in old age among professionals in the localities, to dispel taboos and to professionalize the field. It raised the matter on the social agenda and led to assimilation of programs and activities at the locality level.

## Conclusions and Recommendations

The study findings show that the various programs were able to reduce loneliness in different ways and that for the "average participant," neither intervention strategy was preferable to the other. It is recommended that the program strategy be chosen according to the characteristics of the target population and that the particular contents of the program be determined together with the participants according to their areas of interest. It is also recommended that in each locality at least two programs based on different strategies to reduce loneliness that can respond to different needs, be implemented. We recommend that the programs be implemented according to the principles set out in the full report. It is further recommended that the subject of reducing loneliness among the older adults be introduced in in-service and other training programs for professionals. It is recommended to structure cooperation

among the care agencies in order to identify older adults living alone, particularly those who are not socially active, and reintegrate them into the community and to implement a structured intake process, while developing different versions suitable for the needs of the different professionals. We recommend preparing a compendium of programs for reducing loneliness, based on the knowledge accumulated during the project. We also advise allocating resources and bolstering the projects in the geographic and social peripheries and in small localities.

# Executive Summary

## Background

The phenomenon of loneliness in old age is currently receiving more attention from service developers and the research community than in the past, due both to its prevalence and to its connection to the health status and emotional well-being of older adults. In 2014, a request for proposals was issued for the development of programs to reduce loneliness in the framework of a national initiative known as the Project to Reduce and Cope with Feelings of Loneliness among Older Adults (in short, the Loneliness Project). It was headed by the National Insurance Institute's Fund for Demonstration Projects, JDC -ESHEL and the Ministry of Labor and Social Affairs and Services (MOLSA). The directors of the Loneliness Project commissioned the Myers-JDC-Brookdale Institute (MJB) to evaluate the project. The current study was conducted by MJB over three years.

Three steering committees, which convened between June 2015 and January 2016, approved 23 programs submitted by 13 organizations[3] (such as associations for older adults and social service departments), dispersed widely throughout Israel.[4] The characteristics of the program were varied: 17 organizations were active in urban areas, six in rural areas, three in Arab cities and one in a Bedouin locality. With regard to the programs implemented by the organizations, three were one-on-one programs, while the rest were designed for groups. Nine programs were short-term (up to 15 meetings) and the rest were longer, with four programs comprising several stages. With regard to intervention strategies,[5] 14 programs offered opportunities for social interaction (e.g., interest groups), five were based on behavioral-cognitive change (cognitive behavioral therapy – CBT) (such as the *Hosen Zahav* ["golden resilience"] program), three offered professional support (such as the life stories group) and one program was designed to improve social skills.

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[3] Some organizations proposed more than one program.

[4] Initially there were 15 organizations, but two (one in Jerusalem, one in Sderot) left the project for various reasons).

[5] The classification of the programs into intervention strategies is according to the theoretical classification of Masi, C. M., Chen, H. Y., Hawkley, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review 15*(3), 219-266.

The year 2016 was dedicated to establishing the organizational and professional infrastructure and getting organized to implement the programs. Every organization accepted to the project recruited a coordinator (to manage the programs initiated by the organization) and program implementers (who trained and instructed the groups in each of the programs). During this time, programs were constructed and the group facilitators trained. Implementation of the programs began at the end of that summer. For the next two years, the study followed activity in the field and collected data.

## Study Goals

1. To examine the program's contribution to its participants (individual level): expand social networks and reduce loneliness and social isolation; increase participation in social activities, both formal and informal; and improve emotional well-being.
2. To examine the program's contribution to further addressing loneliness in each locality (field level): raise awareness of the issue of old-age loneliness; develop professional expertise; develop work procedures and screening tools for future use.
3. To formulate insights and recommendations regarding programs to reduce loneliness (policy level): provide tools to address the issue of loneliness in old age; identify principles for best-practice implementation of the programs; identify intervention strategies that best suit specific target populations.

## Study Design

Sources of information:

- Intake records
- Interviews with participants prior to the program ($T_o$)
- Interviews with participants 6-9 months after the start of the program ($T_1$)
- Observations of the activity and focus groups with the participants
- Interviews with the program coordinators
- Interviews with professionals in the locality where the program took place
- Self-administered questionnaires for program implementers (group leaders and therapists)
- Participation in the steering committees and review of minutes and documents.

## Study Method and Process

The program's contribution to the participants (individual level) was examined using several methods and the study proceeded as follows:

1. The study team analyzed all the intake forms at the stage when participants were admitted to the program. Using the intake forms, the coordinators channeled the people into the program that they seemed suited to. At this stage, the coordinators drew up a list of participants and sent them to the study team.
2. The study team interviewed the people on the participants list at the starting point of the program ($T_o$).
3. About 6-9 months after the first interview, a second interview was conducted ($T_1$). The time interval was standard for all the participants, although in this time frame from the starting point of each program, some of the programs were still in operation and some had been completed or were near completion.
4. During the second interview with the participants, we examined their satisfaction with the program and their perception of its contribution. We also examined outcome measures (mainly the change in the average levels of loneliness and depression) of the participants 6-9 months after the start of the program by means of a t-test of dependent samples.
5. The programs were classified into four strategy categories according to the theoretical classification of a research team at the University of Chicago.[6] Three strategies were grouped into one strategy named "strengthening social competence" and a comparison was made between that strategy and the fourth strategy – "opportunity for social interaction."
6. The people who participated in the programs make up the study's intervention group, while the control group comprised people who had gone through the intake and were supposed to participate in a particular program, were interviewed at the start of the program, but when interviewed 6-9 months later, it turned out that in fact they had never participated. Since their characteristics were similar to those of the participants, we decided to make use of them as a comparison group, even though they had not been randomly assigned to this group.

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[6] Masi et al., idem

7. The difference in the average levels of loneliness and depression between the participants and non-participants was examined with a t-test for independent samples. A comparison was also made between the outcome measures of the intervention group before and after the program, using a t-test for dependent samples.
8. A propensity score matching analysis and a probit regression were conducted to compare the two intervention strategies.
9. A linear regression multivariate analysis was conducted to examine the change in both main outcome continuous variables, in the level of loneliness and in the level of depression, 6-9 months after the start of the program.
10. A logistic regression multivariable analysis was conducted to predict the following outcome measures: change in the feeling of not having a connection with someone close, change in the feeling of not having a connection with a social group, and to predict the change in satisfaction with life, 6-9 months after the start of the program. These outcome measures were measured as ordinal variables and for the purpose of the analysis were changed to binary.
11. Additional data were collected through observation and focus groups that included open group discussions with the participants.
12. Interviews were conducted with coordinators and professionals in the localities where the programs took place, as was an online survey among program implementers.

The interviews with professionals, coordinators and implementers also served to evaluate the impact of the programs and the project in general at the local level. Insights regarding how to cope strategically with loneliness in old age at the national level were gleaned from the totality of the study's sources of information.

The study was a mixed-methods study and the findings were analyzed with quantitative tools of descriptive and inferential statistics using bivariate analysis ($\chi^2$, Wilcoxon for paired samples, and t-test for dependent and independent samples) and multivariate analysis (probit regression, logistic regression and linear regression). Qualitative tools for thematic analysis were also used.

# Main Findings

## Preparations for Implementation of the Programs

The study examined the preparations made by the authorities and organizations running the programs in order to learn about best practice from the experience acquired, so as to ensure successful implementation of similar programs in the future. These findings are based on the interviews with the coordinators and professionals in the localities, the questionnaires to the program implementers, and on minutes of the steering committee meetings.

1. **Creating partnerships:** Service providers in the community could be helpful in identifying participants and volunteers for the program, providing solutions for people not joining the program, referring participants to additional services offered in the community and sustaining the program over time.
2. **Identifying participants:** Candidates were identified through a variety of methods, which can be divided into two main types – those using existing platforms, particularly those belonging to the initiating organization, i.e., people already participating in some service such as Supportive Community[7] or a club run by a nonprofit organization; and those aimed at the general public at large, in an attempt to identify people experiencing loneliness. From the reports of the coordinators and implementers it appears that ultimately, in most cases, most of the recruiting was from a pool of people already known to the organizations running the programs. The coordinators found it difficult to persuade the candidates to agree to participate in the proposed program. Some feared exposure, or being branded as lonely, some were afraid to leave their home, or simply were not used to participating in a program. The intake, i.e., the face-to-face interview with the candidates to assess their suitability for the program, was, in the opinion of most of the coordinators, an important stage in preparing for the program, in building the group, in identifying needs and in adjusting expectations. Nevertheless, some of them complained about the length of the questionnaire and the difficulty of finding the time and manpower to administer it.
3. **Presenting the program to potential participants:** There is stigma attached to loneliness. Therefore, some people are unwilling to admit to themselves or to others that they are lonely.

[7] The Supportive Community program is designed to provide community-dwelling older adults with a sense of security as well as social and cultural activities, inter alia to help them cope with loneliness and the need for meaningful leisure activity.

When presenting the program to potential participants, some of the coordinators avoided talking openly about loneliness in order to avoid branding the candidates as lonely and for fear that identifying loneliness as the subject of the activity might deter them from participating (and even threaten the opening of the program). As opposed to this, the focus groups revealed that the participants spoke openly about loneliness. The avoidance of an honest explanation of the goals of the program undermined the ability to adjust expectations and sometimes caused embarrassment, misunderstandings and program dropout.

4. **Training for professionals and fine-tuning the programs**: The online questionnaires completed by the implementers (n=60) revealed that 48% of them had professional experience in the field of loneliness and old age. During the project, the professionals running the programs received training and instruction. In some cases, existing programs were adjusted to focus more exclusively on loneliness, with new lessons devised or a new course developed.
5. **Logistics:** Preparations included activities such as securing a meeting venue, organizing equipment, placing volunteers and arranging for refreshments. We found that arranging transport for the participants was important but required much effort.

## Participant Characteristics

1. The participants selected during intake were those with characteristics known in the literature to be congruent with feelings of loneliness (for example, a higher rate of widowers and widows and of people living alone than in the overall population of people aged 65 and over). Indeed, 73% of them reported having feelings of loneliness often or sometimes, compared to 34% in the overall 65+ population. While 64% of the people included in the programs were participating in social activities before the start of the project, 74% were interested in making social contacts.
2. According to the sampling plan, the study team interviewed 58% of the people who had been placed in programs and there was representation of all individuals from all the localities and programs in the project except for two programs. One of them was the Porter Club in Tel Aviv – a program that is open to anyone who wishes to participate. An observation was conducted but the participants were not interviewed. The other program is at the Israeli Center for Legal Guardianship, which serves individuals who have legal guardians. The participants had very different characteristics from the other programs in the project and had difficulty responding to the structured questionnaire. Consequently, this program was analyzed separately and is not included in the analyses in this report. The quantitative analysis based on the interviews relates to 21 of the programs in the project.

3. Because of the similarity among the programs based on support strategies (3 programs), behavioral and cognitive change (5 programs), and improvement of social skills (one program), during the data analysis these were considered as a single strategy, which we called "enhancing social competence." We conducted a comparison between the characteristics of the participants in programs using this strategy (n=289) and those of the individuals placed in programs based on the strategy of providing an opportunity for social interaction (n=396). The participants in the social competence programs were characterized by higher initial levels of loneliness and depression and had lower self-esteem, a lower sense of belonging and lower satisfaction with life and with their use of time than participants placed in programs offering the opportunity for social interaction programs (all the differences were statistically significant). One possible reason is that the coordinators and professionals were more meticulous in selecting people for the social competence programs (selection bias of the program). Another possibility is that those who had higher levels of loneliness and depression were more likely to respond to the proposal of joining programs that strengthen social competence in smaller, more intimate groups than those that offer less therapeutic and intimate social activity. And in contrast, people who had lower levels of loneliness and depression were less interested in strengthening their social skills and in receiving support (self-selection bias). Because of the biases and the differences between the populations, we matched the participants, which made it possible to compare the two strategies.

## Respondents' Satisfaction with the Program

1. Forty percent of the respondents left the program (n=271), either at the beginning of the program (23%) or after 1 or 2 meetings (17%), mostly for reasons of health (n=65, 24%), accessibility (n=45, 17%) or lack of interest in the program content (n=37, 14%). In some cases, the participants had not been informed that the activity was beginning (n=51, 19%).
2. Among the respondents who had participated in the entire program or in most of it (n=414), satisfaction with the activity was high: 93% said that in general they were satisfied or very satisfied with the activity; 97% said that the staff had treated them respectfully and pleasantly; 92% reported that the activities were well organized; 81% said that they felt a high or very high sense of belonging to the group; 66% had learned new things: 53% had acquired tools and skills to a great or very great extent; 85% said that if there were a continuation of the program they would be interested in participating; 90% of all participants reported that they would recommend the program to a friend.

## Contribution of the Program to the Participants (the Individual Level)

1. The participants were asked to what extent they felt the program had contributed to various aspects of their lives: 57% of the respondents said that the program had contributed to reducing their feeling of loneliness to a great or very great extent; 71% reported that their mood in general had improved; 48% reported an improvement in their general feeling about their health; 45% reported that the program had helped them cope with unpleasant feelings and difficulties; 37% reported that it had helped them create social contacts; 43% said that it had contributed to contact with friends and 19% said that it had contributed to their relationship with service providers (for example, the local association for older adults). In addition, 27% of the respondents noted that after participating in the program they were going out more (for purposes other than the program), and 17% said that after the program they were currently participating in more leisure or social activities.
2. In the comparison between the two main intervention strategies on which the various programs were based – an opportunity for social interaction vs. strengthening social competence – neither was found to have a significant advantage over the other in reducing loneliness or depression for the "average participant," i.e., an individual with average levels of loneliness and depression. In other words, after the matching, which took into account the background characteristics of the participants and the selection bias, no significant differences were found between the strategies to reduce loneliness and depression. As to the question of the association between the participants' background characteristics and the contribution of the intervention strategy for reducing the levels of loneliness and depression, we found that the social-interaction strategy was better for people characterized by a relatively low level of initial loneliness, socially active and without financial difficulties.
3. The change in the level of loneliness, i.e., the difference in the UCLA Loneliness Scale[8] (range 0-60) before and after participation in the program, was examined by means of a t-test for the independent samples of those who participated in the program and those who did not. The findings indicate a significant difference between the averages. Among the respondents who participated in the program, we found an average decline of 1.5 points in the UCLA Loneliness Scale (a decline of 8% against the initial level of loneliness) compared with respondents who did not participate, among whom there was an increase of 0.16 points in the Loneliness Scale (an increase of 1% over the initial level). A similar check (i.e., t-test for independent samples) conducted for each strategy separately revealed

[8] UCLA Loneliness Scale – a tool to measure loneliness in common use in the USA and other countries

that in the strategy for strengthening social competence, a significant difference was found between the averages – the average level of loneliness of the participants declined by 1.56 points in the UCLA measure (a decline of 7% against the initial level), while the loneliness of non-participants increased during the time that elapsed between the two measurements by 1.95 points (an increase of 9%). No significant difference was found between the averages of the participants vs. the non-participants in the strategy offering an opportunity for social integration, but the average change among the participants before and after the program (t-test for dependent samples) was found significant – an average decrease of 1.46 points on the Loneliness Scale, i.e., the average level of loneliness before the program was higher than the average level after participation in the program.

4. The change in the level of depression, i.e., the difference in the PHQ-2 (Personal Health Questionnaire),[9] which gives an indication of the mental state of depression (range 0-6), before and after participation was also examined using a t-test for independent samples, between participants and non-participants in the program. The findings indicate a significant difference between the averages. Among the respondents who participated in the program, there was an average decline of 0.22 points in the measure indicating the level of depression (a decline of 14% over the initial levels), while the level of depression among respondents who did not participate rose by 0.5 points (an increase of 27% over the initial level). A similar examination (i.e., t-test for independent samples) conducted for each strategy separately revealed that in both strategies there was a significant difference in the averages – in the strategy to strengthen social competence, there was a decline of 0.14 points in the measure among participants compared with an increase of 0.62 points in the measure among those who did not participate, and in the strategy indicating an opportunity for social integration there was a decline of 0.27 points in the measure among participants compared with an increase of 0.42 points among the non-participants in those programs.
5. The association between participation in the program and a change in the level of loneliness (UCLA Scale) and the indication for depression (PHQ-2) was examined using a linear regression multivariable analysis. It was found that apart from all the other explanatory variables, participation in the programs significantly reduced the level of the depression index of participants in contrast to non-participants. Participation in programs to strengthen social competence significantly reduced the level of loneliness of participants as opposed to non-participants, but no significant difference in

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[9] The PHQ-2 (Personal Health Questionnaire) gives a general assessment as to whether a person is suffering from depression

the reduction of loneliness was found between participants and non-participants in social integration programs. Other characteristics that were found to have a significant effect on reducing loneliness and depression were the duration of the program (more than 15 meetings), the initial level of loneliness and indicators of depression, and the stability of the participant's health status throughout the program.

## Contribution of the Program to the Professionals (the Field Level)

1. The program raised awareness of the issue of loneliness in old age among professionals at the local level.
2. The professionals developed expertise in the area of loneliness. This also contributed to a change in the professional discourse and to reducing the taboo on talking about loneliness.
3. The issue of loneliness was put on the public agenda, so that their area of activity receives more attention at the locality level and often also more budgets.
4. Programs and further activities are now being implemented in the localities.

## Action Principles

One of the study goals was to learn from the experience of the current programs the best practice principles to follow when implementing programs to reduce loneliness.

As noted, the study examined 23 different programs to reduce loneliness. The study findings show that the various programs succeeded to reducing loneliness in different ways, and for the "average participant" there was no preference for one strategy over another. For the professionals at the locality level who are interested in implementing programs to reduce loneliness, it is recommended they base their choice of strategy in accordance with the background characteristics of the target population and determine the particular contents of the program together with the participants according to their areas of interest. However, a number of recommended action principles can be formulated based on an analysis of all the study findings, which may serve professionals in organizations as guidelines when initiating programs aimed at reducing loneliness in old age, as follows:

1. **Raising the awareness** of community-based professionals (e.g., family physicians, social workers) about loneliness in old age, taking account of its characteristics, implications and risk factors in order to assist in creating partnerships between them so that the issue can be addressed jointly.

2. **Breaking the taboo** and developing a professional discourse that would make it easier for professionals to initiate an open discussion about loneliness, which would give it legitimacy and reduce the sense of shame that people feel about being lonely.
3. **Conducting an intake process** to refer candidates to suitable services: Further, under certain circumstances, it may be worthwhile carrying out a needs assessment for all the older adults in the locality, in order to develop solutions that suit the residents' characteristics and the needs of the community.
4. **Matching intervention strategies to the participant's needs and characteristics**: If a program is to succeed, it is highly important to correctly define the specific target population. Optimally, **programs with different intervention strategies** should be implemented **for populations with different characteristics and needs.** Programs that offer opportunities for social interaction are more suited to people who are socially active with lower levels of loneliness and depression and with no financial difficulties. These programs contribute to reducing loneliness among men more than women. Based on the study's qualitative data, apparently the explanation is that men prefer program content to be based on activity (e.g., social interaction programs) and less on discussion. Finally, programs to strengthen social competence contribute to the reduction of depression among older adults (age 80+) more than among those below age 80. Based on the qualitative study data, a possible explanation is that those below age 80 sometimes have ageist attitudes and are disinclined to talk about loneliness (relative to those over the age of 80).
5. **Constructing a multi-component program** based on different intervention strategies: These types of program generate a gradual process, where each stage is based on the preceding one, in order to build up the abilities of the group and the participants.
6. **Social and cultural adaptation**: During the process of creating partnerships and selecting programs, various particular characteristics of the population and the locality need to be considered.
7. **Social mix of the group**: Is it better to establish a heterogeneous group, where the participants may enjoy the variety of people, or should different populations with their own particular characteristics be separated into homogenous groups? This is a dilemma for which there is no unequivocal answer.
8. **Selection of content that is relevant to the participants**: A structured framework can be set but, at the same time, there should be some flexibility and choice, allowing the participants to help plan the activities and incorporate their preferences.

9. **Creating a "safe space"** and establishing trust among the participants as well as between the participants and the staff: This is especially true when dealing with people whose communication skills and self-esteem are underdeveloped.
10. **Creating continuity**: As part of the process of establishing trust, the professional staff should not change from meeting to meeting and each meeting should open with a reference to the previous one.
11. **Implementing sustainable (long-term) programs** is another aspect of continuity. Changing thought processes and habits takes time, particularly at an older age. We recommend finding funding to support programs over time, and when this is not possible, having the participants implement the program themselves while providing support, guidance and logistic assistance.
12. **Allocating an appropriate budget:** As an example, programs aimed at enhancing social competence are usually intended for small groups and require highly skilled manpower (such as trained group leaders or psychotherapists) and therefore tend to be more expensive. However, these programs can be targeted toward those who need them most, while other, less costly, programs can be offered to people with fewer, simpler needs.
13. **Ensuring accessibility through selection of an appropriate venue and provision of transportation** particularly in places where the population is spread out over a large geographic area, where the topography is difficult, or where the participants lack a sense personal security in the streets: Furthermore, providing transport to and from the activity helps participants overcome functional difficulties and barriers as well as psychological ones.
14. **Encouraging meetings outside of the program** in order to allow the participants to practice their social skills and increase their sense of belonging to the community and so that social activity becomes part of their routine.

## Recommendations for Developing Policy to Reduce Loneliness – the Policy Level

At the policy level, steps can be taken to assist in the various stages of addressing the issue of loneliness in old age. These stages are: preparation and identification of participants; and implementation and sustaining of the programs. The following are the main policies:

1. **Raising awareness about loneliness and providing training** by introducing content dealing with loneliness in old age in the instruction and training sessions on old age provided to both social workers and health professionals (physicians, nurses). These training sessions would address, among

other things, the importance of identifying lonely people, developing tools for assessing their needs, and finding possibilities for them to join existing activities.

2. **Creating an inter-ministerial and inter-organizational "loneliness forum**" that would lead to cooperation among professionals at the local level in finding and re-integrating older people into the community
3. **Identifying lonely older adults** including those who make little use of associations or social services such as the housebound, men, and people living in institutions
4. **Introducing an intake tool to identify lonely older adults**: To this end:
   a. We recommend adapting and shortening the intake questionnaire. Moreover, various versions can be created to meet the needs of different professionals (for example, a longer version for social workers and a shorter one for family physicians).
   b. The questionnaire should be disseminated, and training and instruction conducted about how it should be completed
5. **Preparing a "roadmap" or compendium**, based on this study and the knowledge that has been developed in the context of the project: This document would include the following components:
   a. A list of the recommended principles for implementing programs addressing loneliness
   b. A list of principles for matching a program's intervention strategy to its target population and to the characteristics of the locality and community. We recommend developing a local repertoire and package of services that would include more than one program (similar to the flexible package of services in the upgraded Supportive Community program[10]).
   c. A description of the 23 programs that were developed as part of the project. Professionals and older adults at the local level would be able to choose their preferred program and the one that best meets their needs and abilities.

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[10] The upgraded Supportive Community program is an experimental program to broaden the package of services of the Supportive Community program and make it more flexible. The upgraded program was implemented from 2016 to 2018 as a pilot in 9 local authorities, and allowed members of the upgraded program to exchange the existing programs (apart from the community facilitator) for a broader selection of programs or to select and purchase additional services. The pilot was conducted in partnership with MOLSA, JDC-ESHEL, local authorities and nonprofit organizations (Berg-Warman, A. & Cohen, Y. (2020). *An upgraded supportive community: Evaluation study*. Jerusalem: Myers-JDC-Brookdale Institute. RR-802-20 – Hebrew).

d. Highlighting the issue of loneliness in existing programs and solutions: reworking of existing programs. Raising the awareness of professionals would help them redesign existing services (such as day centers, clubs, cultural events) to better address the issue of loneliness.

6. **Allocation of resources** and provision of programs that respond better to the needs of the geographic and social periphery and to smaller localities, since the supply of programs and activities is poorer there than in central Israel.

## Study Limitations and Options for Follow-up Studies

Since this project included 23 very varied programs, some of which had only a small number of participants, no comparison was made between them. In the analysis of the programs, we grouped together two main strategies and compared the two, after matching the participants in the programs. Furthermore, for each strategy (programs offering social interactions versus programs enhancing social competence) we created a comparison group whose participants were similar in their initial levels of loneliness and depression to the program participants but their allocation to the group was not random.

As noted above, all of the participants in the study were living in the community, most of them were socially active, and women were overrepresented. Consequently, the conclusions of the study are valid mainly for those populations. Caution is therefore advised when applying them to people living in institutions, to more socially isolated populations, and to men.

Future studies on loneliness could be longitudinal, using the same participants; or could focus on an examination of the scaling-up of a small number of programs. To examine the programs' contributions, future studies could incorporate objective measurement tools from the health and function areas, within an experimental study layout, in order to examine the impact of loneliness-reducing programs on these aspects. It is worth examining in greater depth programs based on strategies to strengthen social competence and examine the characteristics of people for whom the programs would be helpful. Finally, it would be possible to examine how changes in policy, with emphasis on creating inter-ministerial cooperation, as well as awareness-raising processes, may affect the identification of lonely older adults and improve services for them.