SILVER EMPOWERMENT

LONELINESS AND SOCIAL ISOLATION AMONG ELDERLY. AN EMPOWERMENT PERSPECTIVE

dr. Jasper De Witte
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Loneliness and social isolation among elderly. An empowerment perspective

dr. Jasper De Witte & Prof. dr. Tine Van Regenmortel

Project management: Prof. dr. Tine Van Regenmortel

Research commissioned by be.Source
Chair 'Empowerment of Underprivileged Elderly'

Abstract

According to scientific research, 46% of the Belgians of 65 years or older feel lonely and 32% have a small social network. This is alarming because loneliness and social isolation significantly affect other life domains (physical, psychological, social) and quality of life in general. In this research paper we gain more insight into loneliness and social isolation among elderly and into possible interventions that could alleviate this, based on an empowerment perspective. The latter is suitable because it focuses on the strengths and connections of elderly, and emphasizes that vulnerability can go hand in hand with mastery over one's life. Our study of the scientific literature indicates that the older population is a heterogeneous one, and that both feelings of loneliness and social isolation are complex and come in multiple forms. As a result, various interventions are needed which must be tailored around the specific characteristics of the loneliness and/or social isolation situation and around the unique needs of the individual and his or her context. Further, more research is needed about the effectiveness of interventions that target loneliness and/or social isolation due to various bottlenecks in the scientific research. Last, based on an analysis of eight programs that intend to contribute to the quality of life of elderly in Belgium, we find that the general empowerment framework and the principles of the 'empowerment flower' are very important for their practice. As a result, we conclude that 'silver empowerment' could form a common reference point and shared objective for these programs.

Published by
KU Leuven
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Executive summary

This paper is part of a broader research project 'Empowerment of Underprivileged Elderly', a KU Leuven chair commissioned by be.Source. The latter is a private foundation that aims to *'support and bring together actions that improve the living conditions of vulnerable senior citizens'*. The central research question of the be.Source chair is:

> How can we strengthen elderly living in precarious circumstances and improve their connection to their surroundings and society so that they can experience a higher quality of life?

In this research paper we gain more understanding about loneliness and social isolation among elderly, based on an empowerment perspective. This subject is of paramount importance because both loneliness and social isolation significantly affect various other life domains (physical, psychological, social) and quality of life in general. In 2013 about 25% of the elderly of 65 years or older in Belgium were confronted with feelings of loneliness.

The modernisation of the health and social care system for elderly

The last few decades a number of social trends like rising health and social care costs, de-institutionalisation, person-centred care, the emphasis on social inclusion and active citizenship, increasing chronical illnesses and the wish of elderly to live as long as possible in their own home, have led to the believe that the health and social care system for older people needs to be restructured and improved by developing an alternate philosophy or paradigm. Indeed, the contemporary organisation of the health and social care system which is strongly directed towards one-sided practical support to remedy problems in functioning that threaten self-reliance, is poorly aligned to the care needs of older populations. It accentuates physical vulnerability and does not (fully) include psychological and societal functioning, which is problematic in the light of increasingly ubiquitous concepts such as quality of life, positive health, vulnerability, frailty and self-reliance. All those concepts emphasise the importance of the interconnectedness of various life domains (physical, social, economic, psychological) when assessing health and health care, and thus surpass the one-sided focus on the physical domain. Emphasis is increasingly put on the effects of the illness instead of on the illness itself. The new vision on health care is characterised by holism, demand-oriented care, multi-dimensionality, and contains a subjective and dynamic view on health.

Empowerment

In the background of various social evolutions (de-institutionalisation, person-centred care, the focus on 'positive health', ...) empowerment comes to the foreground as a useful framework. This meta-paradigm entails a different philosophy, a drastic shift in the way we look at the health and social care system for elderly. Empowerment emphasises a shared responsibility with respect to mechanisms of exclusion on both the individual and societal level. Indeed, it supposes a relational picture of society where individual factors, social factors and societal structures are inherently interconnected. Hence, it is a multilevel paradigm that not only includes the psychological/individual, but also the organisational and community level. Further, empowerment does not try to realise maximal independency because people are said to be *inter*dependent and therefore maximal independence is unattainable. Essential in this respect is that vulnerability can go hand in hand with mastery over one's life. Rather, the overall aim of empowerment is to realise social inclusion and full citizenship for each individual

by supporting people in their searching process to gain mastery over the determinants of their quality of life. Empowerment can be defined as *'a strengthening process whereby individuals, organisations and communities gain mastery over their own situation and their environment through the process of gaining control, sharpening the critical awareness and stimulating participation'*.

The central focus of empowerment lays on the strengths of individuals, without neglecting their vulnerabilities. According to the empowerment paradigm, people gain strength and grow through connections with their surroundings (informal and formal social supporting ties), and inversely strength results in increased connectedness. Further, the strengths perspective is strongly related to the concept of resilience, i.e. *'patterns and processes of positive adaptation and development in the context of significant threats to an individual's life or function'*. By using one's own resources and being resilient, feelings of strength and connectedness, participation and independence arise. In this respect, the sources of strength that give rise to resilience are not only to be found in the individual, but also in the interactional and contextual domain. Last, a number of core principles are detected which are all inherently interconnected and contribute to the central twofoldness of empowerment, namely strength and connection: a positive attitude, participation, inclusiveness, integrality, structure, coordination and proactiveness.

Loneliness and social isolation

Loneliness and social isolation are of paramount importance because they significantly affect various life domains and quality of life in general. The importance of this subject is amplified by demographical trends (such as ageing and the increase of older elderly) and the process of individualisation which has led to more elderly living alone and who can count in a lesser degree on informal support. Indeed, due to their increased frailty, the resources of elderly decline through which they have more difficulties sustaining a supporting informal network, staying connected to the broader society, fulfilling their social needs and giving meaning to their lives, which can result in feelings of loneliness and social isolation.

Having sufficient social capital, a source of strength which is found within relationships, is essential to fulfil social needs and to give meaning to life. In this respect, various characteristics of social networks are important. First, diversity refers to the fact that social needs are subjective and concern individual perceptions and expectations, which are dependent on the individual's life experiences, culture and personality. Consequently, we find that interventions concerning social networks should be tailored around the unique needs of the individual. Second, the meaning or function of relationships differs: while social connectedness ('the presence of social ties') is more emotional, social support ('the emotional, instrumental, informational or appraisal support') is rather functional. Third, proximity refers to the distinction between intimate and peripheral relationships. While intimate relationships give elderly a feeling of love and belonging, peripheral relationships make them feel connected to society. Last, reciprocity within social relations is important because elderly also want to participate and contribute to society.

When the social capital of a person is (experienced) insufficient, feelings of loneliness and social isolation can arise. Loneliness can be defined as the unpleasant experience that occurs when a person's network of social relationships is deficient in some important way, either quantitatively or qualitatively. Hence, loneliness is a subjective evaluation of social relations that refers to the difference between the quantity and/or quality of existent relations and desired relations. Connectedness stands on the other side of the continuum with loneliness. Further, loneliness can be divided into social and emotional loneliness which are related to certain types of social relations, and give insight into the origins of loneliness and therefore helps to determine effective interventions strategies. While emotional loneliness refers to the absence of a meaningful, intimate and exclusive relationship which helps people deal with insecurities, social loneliness refers to the lack of an adequate, broad social network which impacts social integration. From this it is clear that social loneliness can be alleviated more easily (through new acquaintances) than emotional loneliness (through the formation of an intimate

bond), but also that both intimate and peripheral relationships are important. Further, social isolation refers to the lack or almost complete absence of relations with other people. It refers to the objective characteristics of social networks such as size, frequency, structure and functioning, and can be placed on a continuum with social participation. Although there is a strong association between loneliness and social isolation (when somebody is alone, the risk of feeling lonely increases), this is not a one-to-one relationship.

The scientific literature indicates that feelings of loneliness are correlated with characteristics on the personal, relational and societal level. On the personal level this refers to coping strategies, health, income, the place where people live, gender, education level, ... The relational level contains characteristics of the social network such as diversity, amount, frequency of contacts, ... Last, the societal level refers to solidarity between generations, culture, societal expectations and norms, wealth, family structures, ...

Loneliness and social isolation interventions

With respect to the existing knowledge about the effectiveness of interventions that target loneliness and/or social isolation, we find that more research is needed. In general, there is a lack of (qualitative) evidence due to numerous bottlenecks: generalisability, subjects are often self-selected, 'loneliness' is often not measured through which it is impossible to detect if it declined or increased after an intervention, inconsistencies in the definitions and measurements, a lack of theoretical bases of interventions, and the complexity of interventions through which it is difficult to single out the effective characteristics (when a 'mindfulness' group intervention is effective, is it mindfulness or the group setting that is effective?).

Research points out that loneliness can be alleviated in three ways. First, people can bring existing relations to the desired level by creating new relations or by ameliorating existing relations. When the cause of the loneliness is related to personal characteristics, improving those characteristics (through for example social skill training or psycho-education) seems an appropriate strategy. When loneliness is related to social network changes (a move, divorce), other approaches are probably more effective such as partaking in social activities and creating more contacts. Moreover, the intervention is strongly dependent on the type of loneliness: emotional or social. In general, this first approach is more appropriate when the senior still has sufficient possibilities to enhance existing relations. Second, elderly could try to lower their standards/expectations with respect to their social network (i.e. adjusting unrealistic desires). Third, elderly can learn to 'deal with feelings of loneliness' by accepting, relativising, denying or distraction. These latter two approaches are more suitable when the losses of social capital are of a certain importance (mostly when it concerns older, frail elderly). In sum, when the first strategy is not attainable, the latter two come to the foreground.

Social isolation interventions should also be tailored around the specific needs of the socially isolated senior since this concerns as well a heterogeneous group. In this respect, the duration of the social isolation is relevant because it gives an indication of the degree to which this person has gotten used to it and of the intensity and duration of the care. Second, the motivation of the senior to participate in societal contexts is relevant since it says something about the ambitions and expectations with respect to care: enhancing the social network or rather offering (practical) support. Third, the type of coping strategy of the elderly is important. A passive coping strategy (~ avoidance behaviour, a lack of social skills) is more difficult to alleviate, and therefore interventions could rather be directed to solving practical problems and prevention of further escalation. An active coping strategy lends itself better to the enhancement of the social network.

Research (cautiously) indicates that certain characteristics of loneliness and social isolation interventions are more often effective than others. First, group interventions that provide activities or support and that emphasise intra-personal resources are more effective because reflection of a group leads to more awareness, changing attitudes, (coping) skills and a sense of mastery. In this respect, a long duration is important because it offers the possibility to build a social network and have more

contacts. Second, one-to-one interventions are more effective when senior and care giver share values, culture and background, belong to the same generation and have common interests. Third, theoretically based interventions are more effective, just like interventions in which elderly actively participate, support is given or when an educational training is offered. Next, technology (computer and internet based, robots, ...) can have positive effects on loneliness and social isolation because it helps elderly to communicate, find news and practical information, realise a sense of social presence and companionship through social interaction, and it is related to cognitive and physical stimulation. Finally, facilitating social interventions with peers or other lonely elderly can be effective, just like psychological therapies and having pets.

In short, with respect to loneliness and social isolation interventions, it is essential to bear in mind that the older population is a heterogeneous one, and that feelings of loneliness and social isolation come in multiple forms. As a result, one-size-fits-all measures do not exist and intervention strategies must be tailored around the specific situation. Strategies should take on a holistic perspective in which not only the specific characteristics of the loneliness and/or social isolation situation (causes, duration, variation, severity, ...) are taken into account, but also the personal characteristics of the elderly (perceptions and needs, coping strategies, motivation, health, ...) and their context (social support, financial situation, ...).

Inspiring programs

Based on an analysis of eight programs that aim to contribute to the quality of life of elderly (and other vulnerable groups), we find that the general framework of empowerment is deemed important: striving for more social inclusion and full citizenship, having an ethical ground, acknowledging a shared responsibility of individual and society, the empowerment paradox and the concept of 'relational autonomy'.

Further, we ascertain that the twofoldness 'strength and connection' is central to the working of most programs. Various programs explicitly make use of the strengths of participants which stimulates 'the power of giving' and positive identity formation. Moreover, they refer participants to other organisations through which access to care is enhanced and which contributes to their resilience and feeling of control. However, some programs do not explicitly make use of the strengths of their beneficiaries, and focus mainly on rendering them a valuable service (which indirectly also strengthens them). The programs also stimulate the connection of their participants with their surroundings in a direct manner by realising encounters or indirectly by enhancing their possibilities to engage socially (e.g. by increasing their mobility).

With respect to the empowerment flower, we first find that a positive relationship among the participants (based on respect and trust) is essential, whether in a group setting or in pairs. Therefore, it is important to realise a good match (between pairs) or a good ambience (in a group) by taking into account the personal characteristics of the participants. Further, it is said that while the relationship between professionals and participants should be authentic, based on respect, empathy and equality, professionals should also be able to take emotional distance. Second, the programs try to stimulate participation by implicating participants and letting them exert influence during the process. Nevertheless, in some programs participation could be enhanced. Third, the eight programs try to realise inclusiveness by creating maximal opportunities for vulnerable individuals to participate to their program. Next, although various programs explicitly work in an integral and holistic manner by taking into account various life domains of their participants, other programs explicitly avoid this and focus on their main activity (e.g. singing). Fifth, most programs offer some sort of structure through which knowledge is expanded and capacities are developed (e.g. by 'evaluative moments' with professionals, volunteers and/or beneficiaries, courses about certain themes, and various tools such as software, a help-desk or a care plan). Sixth, most programs ensure that all actors are aligned, and they often work together with other organisations to find participants, organise activities, make publicity, ... In doing so, they indicate the importance of coordination and collaboration. Last, although some programs

have a very outreaching and proactive working method to search participants, other programs only do this limitedly. And while various programs hold onto a proactive working approach in their day-to-day working (e.g. by home visits, detecting real needs by taking the time to listen to participants, contacting participants to evaluate first encounters, ...), other programs explicitly try to avoid a pro-active and 'intrusive' working method and simply concentrate on their main activity.

Finally, we ascertain that the effects of the investigated programs on loneliness and social isolation are not measured by 'hard' indicators or systematic data collection. Hence, it would be interesting to gain more insight into the effects of these programs on loneliness and social isolation, and into their working mechanisms. Nonetheless, the eight programs clearly respond to the increasing emphasis on 'aging in place', de-institutionalisation and demand-oriented care by formulating a personal response to specific problems they observe in practice. From this, again it becomes clear that one-size-fits-all interventions to alleviate loneliness and social isolation among elderly do not exist, and that various interventions are needed. Nevertheless, 'silver' empowerment could form a common reference point and shared objective for these eight programs.

Introduction

This paper is part of a broader research project 'Empowerment of Underprivileged Elderly', a KU Leuven chair commissioned by be.Source. The latter is a private foundation that aims to *'support and bring together actions that improve the living conditions of vulnerable senior citizens'*.[1] The central research question of the be.Source chair is:

> How can we strengthen elderly living in precarious circumstances and improve their connection to their surroundings and society so that they can experience a higher quality of life?

In this research paper we gain more understanding about loneliness and social isolation among elderly, based on an empowerment perspective. The relevance of this subject is illustrated by the prevalence of loneliness among elderly of 65 years or more in Europe, which ranges between 10% (Denmark) and 33.4% (Italy) in 2013. In Belgium about 25% of the elderly are confronted with feelings of loneliness. This subject is of paramount importance because both loneliness and social isolation significantly affect various other life domains (physical, psychological, social) and quality of life in general. The importance of this subject is further amplified by demographical trends (such as ageing) and the process of individualisation which has led to more (older) elderly living alone and who can count in a lesser degree on informal support.

In the first chapter of this paper we discuss the modernisation of the health and social care system for elderly. Various social trends (de-institutionalisation, person-centred care, the focus on quality of life and positive health, ...) have led to the believe that the health and social care system for older people needs to be restructured and improved by developing an alternate philosophy or paradigm. Emphasis is increasingly laid on *the effects* of the illness, instead of on the illness itself. It is in the background of all these evolutions that empowerment comes to the foreground as a useful framework. In the second chapter we define empowerment, and relate this to lonely and socially isolated elderly. We delineate the theoretical framework of empowerment and its core principles, and discuss the implications of this paradigm for practice and research. In the third chapter we first situate loneliness and social isolation among elderly in contemporary society, and describe the role of social capital. Next, we define loneliness and social isolation, and describe the characteristics of social needs and social networks. Based on the most recent scientific literature, we further describe the factors that are related to feelings of loneliness and social isolation, on both the personal, relational and societal level. We end this chapter by briefly discussing old age social exclusion. In the fourth chapter, we discuss the current scientific knowledge about interventions that aim to alleviate loneliness and social isolation among elderly. We first describe some theoretical and conceptual frameworks with respect to ways to tackle loneliness and social isolation, and subsequently discuss the characteristics of successful interventions. This is essential information for all stakeholders that want to tackle loneliness and social isolation among elderly. In the fifth chapter, we investigate eight programs that aim to contribute to the quality of life of elderly and other vulnerable groups. In this respect, we first describe these programs extensively to gain a good understanding of their functioning. Subsequently we analyse these programs with respect to the general theoretical empowerment framework and the principles of the empowerment flower: we verify if these programs find these principles relevant for their practices, and how they apply them.

1 For more information about be.Source: http://www.besource.be/

- PART 1 THEORETICAL FRAMEWORK -

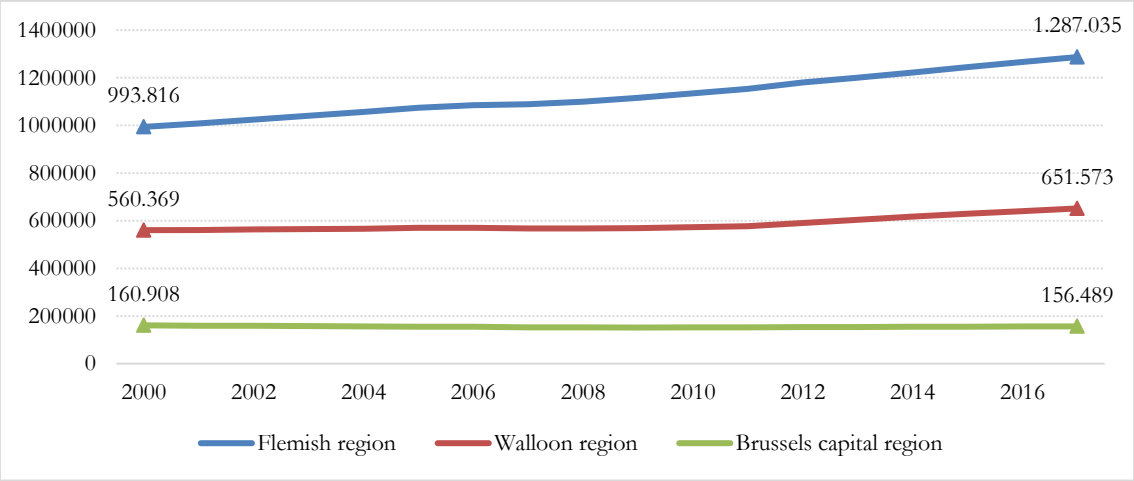
1 | The modernisation of the health and social care system for elderly

'The societal response to population ageing will require a transformation of health systems that moves away from disease-based curative models and towards the provision of older-person-centred and integrated care. [...] It will require a coordinated response from many other sectors and multiple levels of government. [...] Although these actions will inevitably require resources, they are likely to be a sound investment in society's future: a future that gives older people the freedom to live lives that previous generations could never have imagined' (World Health Organization, 2015, p. 223).

The last few decades a number of social trends like rising health and social care costs, budget cuts, workforce issues in the health care sector, increasing chronical illnesses and the wish of elderly to live as long as possible in their own house, have led to the believe that the health and social care system for older people needs to be restructured and improved by developing an alternate philosophy or paradigm (Janssen, 2013). Increasingly emphasis is laid on *the effects* of the illness, instead of on the illness itself (Gobbens, 2017).

The modernisation of the health and social care system for elderly is of paramount importance because it concerns a sharply growing population. On 1 January 2017 Belgium counted 11,322,088 inhabitants, of which the majority (57.6%) are living in Flanders, 31.9% in Wallonia and a smaller portion in the Brussels capital region (10.5%). Figure 1.1 gives an historical overview of the evolution of people aged 65 or older since 2000, and shows that the Belgian population is increasingly ageing (Statistics Belgium, 2018).[2]

Figure 1.1 Evolution of ageing in Belgium by region (> 64 years; 2000-2017)



Source Statistics Belgium

Furthermore, an important part of the elderly population is at risk of poverty. The indicator 'people at risk of poverty and social exclusion' (which was developed in the context of the Europe 2020

2 In this respect it is important to mention that the age groups in the data often differ according to the data source (60+, 64+, 65+, 67+).

strategy) shows that 16.2% of the Belgians aged 65 or older were at risk of poverty in 2015.[3] Although this is lower than the average of the total Belgian population (21.1%) and of the EU-28 population aged 65 or older (17.4%), it is higher than the poverty risk of elderly in most neighbouring countries like France (9.3%), Luxembourg (8.2%) and the Netherlands (6.1%) (European Statistics, 2018).

In short, since the elderly population is a growing one of which an important part is at risk of poverty, it seems appropriate to give this age group specific attention by investigating the health and social care system for vulnerable elderly.

1.1 A multi-dimensional and holistic view on health and health care

> *'Current health systems are poorly aligned to the care that older populations require [...]. A new framework [...] will need to encompass the great diversity of older populations [...] It must drive the development of new systems for health care and long-term care that are more in tune with the needs of older people, and it must ensure that all sectors focus on common goals so that action can be coordinated and balanced. Above all, it will need to transcend outdated ways of thinking about ageing [...]. These [...] should look to strengthen the ability of older people to thrive in the turbulent environment they are likely to live in'* (WHO, 2015, p. 18).

The contemporary organisation of the health and social care system is still strongly directed towards one-sided practical support to remedy problems in functioning that threaten self-reliance. In this respect the current policy vision sees vulnerability mostly from a medical point of view where the accent lies on physical vulnerability, whereas psychological and societal functioning are not included (Machielse, 2016). This is problematic in the light of increasingly ubiquitous concepts in the health and social care sector, such as quality of life (QOL), positive health, vulnerability, frailty and self-reliance. All those concepts emphasise the importance of the interconnectedness of various life domains (physical, social, economic, psychological) when assessing health and health care, and thus surpass the one-sided focus on the physical domain. In short, a restructuration of the health and social care system and a shift in paradigm seems necessary, in which more attention goes to vulnerability with respect to the physical, psychological and social domain (Gobbens, 2017).

1.1.1 Quality of life and positive health

Although the concept of QOL became increasingly popular during the last decades, since long there has been a lack of consensus on how to define and measure it. This concept is strongly related to the definition that the World Health organization (WHO) gave to 'health' in 1947, namely as a *'state of complete physical mental and social well-being, and not merely the absence of disease and infirmity'* (Post, 2014, p. 168). The reference to well-being in this definition is essential because it broadened the view on health significantly: more and more importance was given to subjective aspects of living such as *'the patient's subjective improvements in terms of mood and attitude; general feelings of well-being; and activity, appetite, and the alleviation of distressing symptoms, such as pain, weakness, and dyspnea'* (Post, 2014, p. 168). In relation to this changing perspective on health, QOL became increasingly important as a subjective concept, namely the individual's own evaluation of various life domains (Post, 2014). The WHO defines QOL as *'an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment'* (WHO, 2018). QOL encompasses various domains such as the physical, mental (from a positive sense of well-being to non-pathological forms of psychological distress),

3 This indicator refers to people who are at risk of poverty, are severely materially deprived and are living in a household with a very low work intensity.

social (social contacts and interactions) and functional health domain (physical functioning in terms of self-care, mobility and physical activity level, and social role functioning in relation to family and work) (Post, 2014).

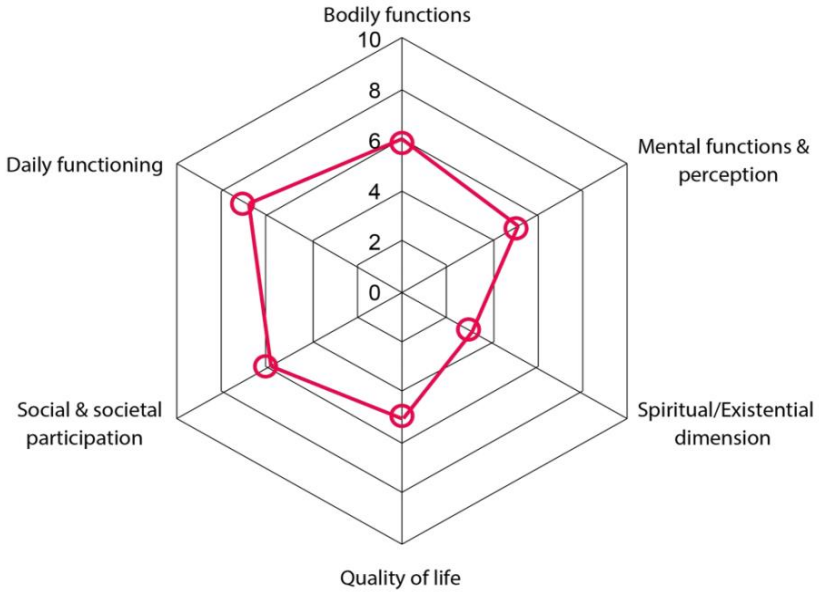
In this respect, the WHO has created a QOL measurement instrument http://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/that consists of more than 100 questions that have to be answered using a response scale and which concern areas of life such as health (World Health Organization, 2018). And since QOL for elderly might differ from the rest of the population, the WHO gives special attention to particular characteristics of this population in the Quality of Life Assessment for Older Adults (WHOQOL-OLD), which is developed to investigate the quality of life of older adults. This tool contains six domains: sensory abilities, autonomy, past, present and future activities, social participation, death and dying and intimacy, and 24 items that are rated on a five point Likert scale (Margis et al, 2010). Recently this scale was validated in the Netherlands (Gobbens, 2017).

Although the WHO definition of health was groundbreaking at the time because of its broadness and it surpassing the negative definition of health (focused on the absence of disease), Huber et al. (2011) state that this definition is no longer suitable because of ageing and changes in the pattern of illnesses. Indeed, by focusing on 'complete' health it contributes to the medicalisation of society because it implies that large groups would be considered 'unhealthy' and could become eligible for expensive screenings and interventions, which could lead to higher levels of medical dependency and risk. Secondly, the demography of populations and the nature of diseases have changed: ageing with chronic problems has become the norm which makes the WHO definition problematic because it would consider all those people definitively ill and minimises coping strategies to handle life's ever-changing circumstances. Third, the definition is said to be impractical to operationalise because of the reference to 'complete' health which is not operational nor measurable (Huber, Knottnerus, Green, van der Horst, Jadad, Kromhout & Schnabel, 2011). As a result, Huber introduces the concept positive health which refers to *'the ability to adapt and to self-manage, in the face of social, physical and emotional challenges'* (Huber, van Vliet, Giezenberg, Winkens, Heerkens, Dagnelie & Knottnerus, 2016, p. 1). This concept embraces terms like resilience, functionality and participation because health is not regarded as an end-goal, but rather as a means that allows people to give meaning to their lives (Gobbens, 2017). With the definition of positive health, emphasis is laid on *'the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of wellbeing'* (Huber et al., 2011, p. 344), and this with respect to the physical, mental and social domain. On the physical domain, when confronted with risk, a healthy organism is able to mount a protective response in order to restore an equilibrium (Huber et al., 2011). On the mental domain, Antonovsky's concept 'sense of coherence' is useful to situate the role of stress in human functioning (Janssen, Van Regenmortel & Abma, 2011). He defines this as *'a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement'* (Antonovsky in Janssen, Van Regenmortel & Abma, 2014, pp. 84-85). A sense of coherence implies the capacity to cope with difficult situations, to recover from psychological stress and to prevent stress disorders. It entails the subjective faculties that enhance the comprehensibility, manageability and meaningfulness of a difficult situation (Huber et al., 2011). Comprehensibility refers to *'a belief that things happen in an orderly and predictable fashion and a sense that you can understand events in your life and reasonably predict what will happen in the future'*. Manageability is *'a belief that you have the skills or ability, the support, the help, or the resources necessary to take care of things, and that things are manageable and within your control'*. Meaningfulness refers to *'a belief that things in life are interesting and a source of satisfaction, that things are really worth it and that there is good reason or purpose to care about what happens'* (Janssen, Van Regenmortel & Abma, 2014, p. 85). The last element 'meaningfulness' is said to be the most important because when a person does not believe that there is a reason to survive and confront challenges, he will neither be motivated to comprehend nor

manage events (Janssen et al., 2014). With respect to the social domain, dimensions such as the capacity to fulfil one's potential and obligations, the ability to manage life with some degree of independence, and participation in social activities are important. In short, health can be regarded as a dynamic balance between opportunities and limitations, shifting through life and affected by external conditions such as social and environmental challenges. *'By successfully adapting to an illness, people are able to work or to participate in social activities and feel healthy despite limitations. [...] Extensively monitored patients with chronic illnesses, who learnt to manage their life better and to cope with their disease, reported improved self-rated health, less distress, less fatigue, more energy, and fewer perceived disabilities and limitations in social activities after the training. [...] If people are able to develop successful strategies for coping, (age related) impaired functioning does not strongly change the perceived quality of life, a phenomenon known as the disability paradox'* (Huber et al., 2011, p. 344).

'Positive health' contains a broad range of health indicators that are categorised into six dimensions: bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning.

Figure 1.2 Positive health as a concept



Source Huber et al., 2016

This broad view on health could support shared decision-making in medical practice, help policymakers bridge the gap between healthcare and the social domain, and demedicalise societal problems. Positive aspects of this concept are that it emphasises that a person is more than his illness and has a large potential for being healthy, the strength focus, the reference to self-management, individual responsibility, health as a dynamic state and that it may lead to a more balanced relationship between patient and healthcare provider. However, negative is that it is a very broad concept, requires major personal input which is not always feasible, entails personal responsibility while not everybody wants this, ignores the importance and impact of real illness, and the fact that it can be used as an excuse by policymakers in that people just need to adapt to existing, poor living conditions (Huber et al., 2016).

1.1.2 Vulnerability, frailty and self-reliance

While the current policy vision sees 'vulnerability' still mostly from a medical point of view in which the accent lies on physical vulnerability, this concept is increasingly interpreted as a multi-dimensional one that not only includes physical limitations, but also psychological, cognitive and environmental factors. This multi-dimensional perspective regards vulnerable elderly as older people that are more susceptible for multiple negative health effects due to a brose balance that is related to a decline in physiological and/or psychological reserves (Machielse, 2016). The decline in social reserves could be added to this description.

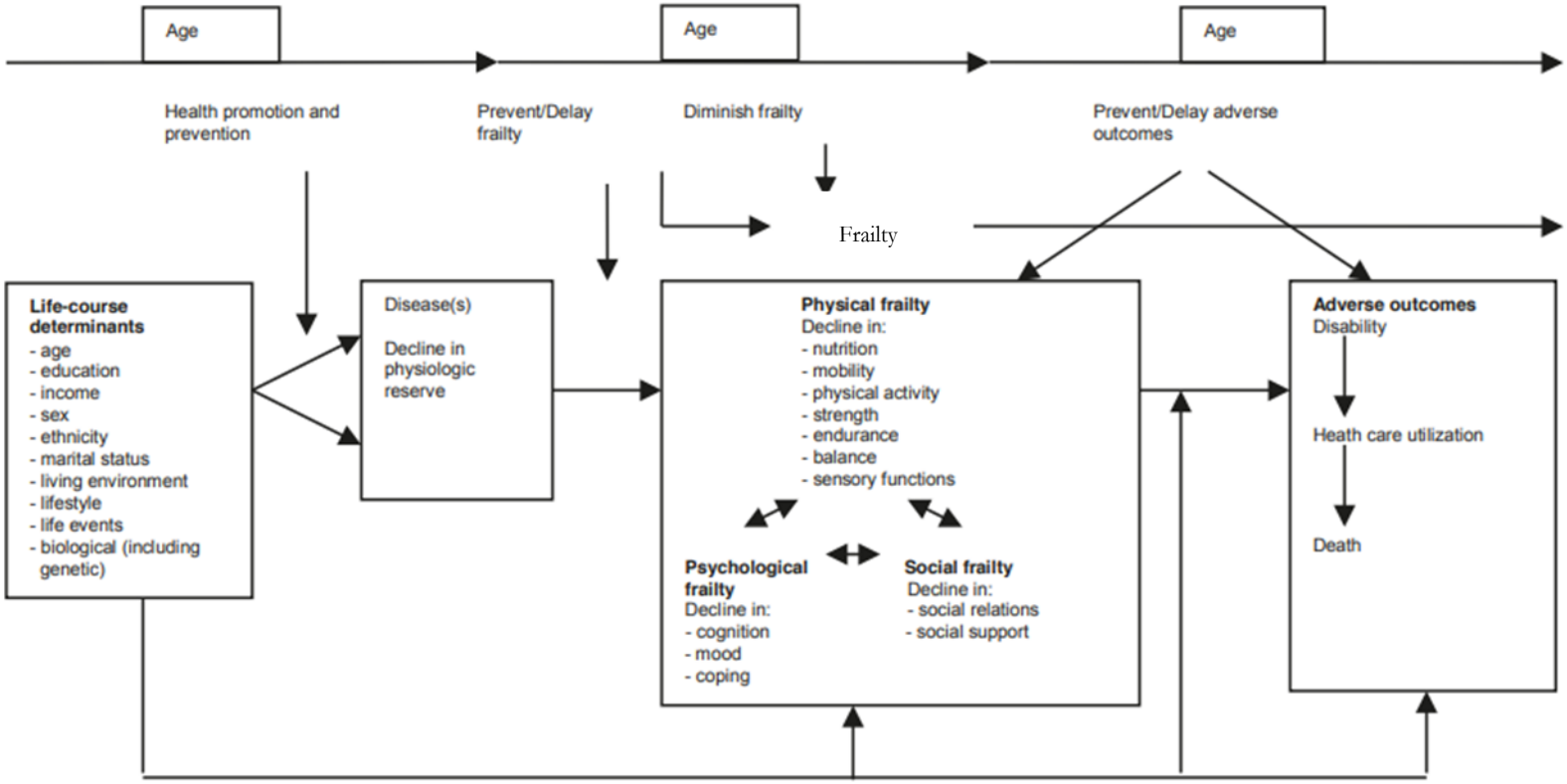
Next, frailty is seen as a distinct multifactorial clinical syndrome that implies vulnerability (Sutton, Gould, Daley, Coulson, Ward, Burler & Howard, 2016), and can be described as *'increasing vulnerability associated with aging [...], as a syndrome in which more areas of functioning decline with aging. In this way frailty is a precursor state of functional limitations and disability associated with the aging process itself; the comorbidity of chronic diseases; and multiple risk factors, including psychosocial and functional limitations'* (Slaets, 2006, p. 594). Indeed, frailty does not only refer to physical conditions that affect elderly, but also to psychological and/or social deterioration. Gobbens defines frailty as *'a dynamic state affecting an individual who experiences losses in one or more domains of human functioning (physical, psychological, social), which is caused by the influence of a range of variables and which increases the risk of adverse outcomes'* (Gobbens, 2017, p. 12). Physical frailty includes inexplicable weight loss, difficulties with walking, little strength in the hands, physical exhaustion, ... Psychological frailty consists of memory problems, feeling down, anxiety and problems with coping. Social frailty refers to living alone, loneliness and a lack of social support. Research indicates that frailty is associated with limited activities of daily living (ADLs), hospitalisation, being admitted to a nursing home, premature death, a lower QOL (Gobbens, 2017), older age, being a woman, lower education, lower income, being a tenant, living alone, having multiple chronic conditions, region and socio-economic status. From a research about Belgian frail elderly, we find that 9.3% of the respondents were classified as frail, 30.7% as prefrail and 60% as robust (Hoeck, François, Geerts, Van der Heyden, Vandewoude & Van Hal, 2011). According to Gobbens, frailty is a better term than multimorbidity (i.e. *'when a single person is suffering from at least two chronic illnesses at the same time'*), because it refers to functioning in a general sense (Gobbens, 2017).

The concept of 'frailty' can be measured by the validated Tilburg Frailty Indicator (TFI). From an international research in which 38 instruments were compared, the TFI came out to be the best instrument (with respect to reliability and validity) to measure vulnerability among elderly. *'The TFI has the most robust evidence of reliability and validity and has been the most extensively examined in terms of psychometric properties. However, there is insufficient evidence at present to determine the best tool for use in research and clinical practice'* (Sutton et al., 2016).[4]

The conceptual model of frailty (Figure 1.2) shows the path taken by frailty, which can lead to adverse outcomes. This model serves as a basis for research and shows when healthcare professionals can intervene (vertical arrows). Life-course events affect the course of the human ageing process and the possibility to be confronted with disease. Physical, psychological and social frailty are distinct, but also interconnected through which we find that focus must lay on the person as a whole. Disability is an adverse outcome that refers to the limitations in performing ADL, and instrumental activities of daily living (IADL). These latter are essential for an individual's self-reliance and in order to be able to function independently (Gobbens, 2017).

4 This measurement instrument is brought out in 2010, and consists out of two parts. In the first part 10 short questions are asked about age, living environment, ... In the second part, 15 questions about the vulnerability of elderly are asked, which treat physical, psychological, social aspects of the life of elderly (Gobbens, 2018).

Figure 1.3 **Frailty conceptualised**



Source Gobbens, 2017

According to Machielse, the level of self-reliance is presumably even more important for quality of life than the level of frailty. Self-reliance means that *'people are able to execute the necessary daily tasks and wage a structured household'*, and presumes the physical, cognitive, mental and financial ability to deal with societal expectations (Machielse, 2016, p. 18). Indeed, self-reliance as a concept emphasises just like QOL and 'positive health' the importance of various interconnected life domains. Research shows for example that the possibility of 'ageing in place', *'the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity'* (WHO, 2015, p. 36), is not only determined by physical, psychological, and financial factors, but also by social factors which impact the level of dependency of elderly (Van Regenmortel, 2011). In this respect, self-management abilities (SMA) come to the foreground, which refer to '*abilities that are needed by an elderly person to prevent the loss of resources, to manage the decline and loss of resources, and to sustain well-being. [...] They play a key role in the complex adaptive systems that are needed for successful aging. [...] Any intervention that is aimed at maintaining and improving well-being in elderly patients should incorporate aspects of SMA's'* (Slaets, 2006, p. 596).[5]

1.2 A restructuration of the health care system

> *'Instead of having their needs and problems cared for by professionals, people will be encouraged to manage their own health and life within their home environment, supported by professionals, family, neighbours and friends'* (Jacobs, 2015).

Parallel to the increased importance of a multi-dimensional, holistic view on health and health care, a number of evolutions have taken place that significantly impact the organisation of the care system: the shift towards de-institutionalisation and demand oriented care, and the focus on social inclusion and active citizenship.

Firstly, de-institutionalisation developed simultaneously with the increasing stimulation of 'ageing in place', and refers to *'the shift from care provided in institutions to care provided in the home environment of the care recipient'* (Janssen, 2013, p. 11). Not only does this concede to the wish of elderly, it is also said to have a positive effect on well-being (Van Regenmortel, 2011). In this respect, the existing home and/or community is often seen as a source for connectedness, security and familiarity, and is related to a sense of identity and autonomy of elderly. Furthermore, institutional settings are not rarely seen as dehumanising and can pose structural and cultural barriers that counteract social interactions (WHO, 2015). As a result, the care relationship changes drastically towards a coaching relationship and the care setting becomes a sociocultural community and physical neighbourhood (Jacobs, 2015). In this respect, the WHO's movement of 'Age-Friendly Communities' tries to develop infrastructure and facilities that promote active participation, support and the valueing of older adults (Gobbens, 2017). The WHO defines 'Age-friendly cities and communities' as *'a good place to grow old. Age-friendly cities and communities foster healthy and active ageing and, thus, enable well-being throughout life. They help people to remain independent for as long as possible, and provide care and protection when they are needed, respecting older people's autonomy and dignity'* (WHO, 2015, p. 161).

Secondly, a shift from supply-driven to demand-oriented care is taking place. In demand oriented care the respect for the unicity of each individual and their well-being is placed central, and emphasis is laid on supporting vulnerable citizens by optimising their sense of mastery, but without making them unnecessarily dependent. Demand oriented care entails a holistic, psychosocial and preventive approach rather than a medically oriented one, and presumes that people can still lead an autonomous and meaningful life despite certain care needs (Janssen, 2013). Person-centred care contains a rela-

5 These coping strategies can be tested by a SMA-test.

tionship that is experienced as meaningful and empowering to the involved, and person-centred practices are characterised by participation, openness, engagement and reciprocity. In this respect, participatory, creative and interactive methodologies are central (Jacobs, 2015).

Thirdly, the emphasis on social inclusion and active citizenship impacts the organisation of the care system. Social inclusion *'refers to the actual incorporation of vulnerable groups in the local community, the feeling of actual belonging'*, and active citizenship refers to *'the social behaviour and self-direction of citizens and the way health and social care and policy invite citizens to social behaviour and self-direction and support them in achieving this'* (Janssen, 2013, p. 13). This is strongly linked to the concept of active ageing which refers to *'the actual continuation by older people to social, economic, cultural and spiritual activities and not only to the physical ability to participate. Even when older people have physical limitations, they, according to the WHO, should be of significance for their relations, their contemporaries, direct environment and the local community'* (Janssen, 2013, p. 16).

On the micro level, the modern vision on care presumes a shared responsibility of care recipients, the informal social network and professionals. Elderly themselves are expected to realise their own care needs by using their own competencies, qualities and strengths. When this is not sufficient, the social network is summoned. Afterwards, professionals come to the foreground who increasingly need to provide care in the home setting of people and help them maintain their capacity and well-being. In this respect a shift is taking place *'from cure to a balance between cure and care by strengthening the sense of mastery of older people and to support them to activate and/or enlarge their social network. Professionals are, in other words, expected to support care recipients in making the right choices that is in accordance with their wishes and expectations and on overcoming paradoxes that are inherent to human life'* (Jannsens, 2013, p. 15). On the meso level - the organisational structure of the health and social care system - policymakers wish to create a strong and integrated primary care by realising more coordination between formal and informal care, by bringing care closer to the people, by a combination of specialised teams and informal caregivers, and by jointly considering the most appropriate intervention strategies (Janssen, 2013; Janssen, 2015). On the macro level - policy measures and legislation - policymakers can stimulate programs that aim to involve and activate elderly in society: *'by optimising opportunities for health, participation, influence and security, it is reasoned, the quality of life will enhance as people age'* (Janssen, 2013, p. 16).

1.3 A policy shift towards a multi-dimensional view on health (care)

> *'To meet the needs of ageing populations, significant changes are required in the way health systems are structured and health care is delivered. [...] They will have to be redesigned to deliver the comprehensive and coordinated care that has been shown to be more appropriate and more effective. The starting point will need to be to put older people at the centre of health care. This will require focusing on their unique needs and preferences, and including them as active participants in care planning and in managing their health states'* (WHO, 2015, p. 114).

The increasing importance of a multi-dimensional view on health and health care in which not only physical but also psychological and social dimensions are included, imply that policy can no longer suffice by simply taking away limitations and taking on declining self-reliance. After all, QOL and positive health are not only dependent on sickness and limitations, but possibly even more on a person's coping strategies to deal with difficult situations (Machielse, 2016). When we assess the social domain for example, we find that policymakers often see the social network simply as a resource for practical functioning and the self-reliance of elderly. That way, the contemporary policy vision surpasses the fact that human beings are interconnected and that social networks give meaning to life and are an important resource for QOL. Indeed, a social network concerns involvement, love, friendship and interest, and creates a feeling of safety, proximity, the feeling of 'belonging', self-confidence and self-esteem. Social networks are of paramount importance for dealing with difficult situations in that they give meaning to life despite certain limitations that may always remain. A social network is even more important for elderly who are more often confronted with problems in functioning,

declining possibilities, changing role patterns and the loss of loved ones. Indeed, those adversities can lead to increased dependency, feelings of loneliness and social isolation, and so negatively impact well-being. Consequently, it is essential that policymakers take into account those psychosocial domains when assessing health care policy for elderly (Machielse, 2016). In this respect, the focus on possibilities, positive self-appreciation, positive identity, personal meaning, hope and belief in themselves become increasingly central to policy (Van Audenhove, pp. 14-15). In short, the goal is to improve QOL and emotional and social functioning, by helping care recipients dealing with the cognitive, emotional and social consequences of the illness. In this respect, care is tuned to the individual's possibilities and the subjective experience of care recipients (Janssen, 2010).

It is in the background of all these social evolutions (de-institutionalisation, person-centred care, the focus on QOL, positive health, ...) that empowerment comes to the foreground as a useful framework. This paradigm entails a different philosophy, a drastic shift in the way we look at the health and social care system for elderly: *'the multidimensional concepts of patient empowerment, patient participation and patient-centredness all illustrate an important ideological shift from a paternalistic health care to an increasingly participation-based health care'* (Castro, Van Regenmortel, Vanhaecht, Sermeus & Van Hecke, 2016, p. 1930).

2 | Empowerment

'No matter how old we are, we can still play our part in society and enjoy a better quality of life. The challenge is to make the most of the enormous potential that we harbour even at a more advanced age' (European Commission, 2018).

Empowerment is a meta-paradigm that flew over from the United States of America, where Julian Rappaport introduced this term within the community psychology. It is strongly related to the social movements of the 1960s (civil right movement, black movement, feminism, ...) (Van Regenmortel, 2002). With respect to the war on poverty it was for example stated that to combat poverty not only the structural barriers (lack of employment, education, ...) must be taken away, but the poor also had to be 'empowered' by focusing on psychological and social factors such as their strengths and possibilities, their coping strategies, value-orientations, ... (Van Regenmortel 2002; Janssen, 2013). Empowerment is thus associated with attempts to increase autonomy, power and influence (Castro et al., 2016). Although originated in the community psychology, empowerment as a framework leans itself also perfectly to the care sector that is increasingly characterised by demand-oriented care, de-institutionalisation, 'ageing in place', quality of life, active citizenship, a multi-dimensional and holistic vision, positive health, ...

2.1 Theoretical framework and definition

'Empowerment is a paradigm: a framework for thinking and action with an underlying value orientation which should constantly be used as a general guiding framework' (Steenssens & Van Regenmortel, 2007, p. 7).

Empowerment as a meta-paradigm is ethically grounded and based on values such as democracy, pluralism, respect, diversity, solidarity, a warm and inclusive society, equality, self-determination, ... (Van Regenmortel, 2011; Van Regenmortel, 2013). In this respect, social justice is an important underlying value which is displayed by the attention given to vulnerable groups (Janssen, 2013). The empowerment paradigm encompasses numerous theories concerning resilience, system theory, locus of control, attachment, outreaching, vulnerability, contextual theory, ... (Van Regenmortel, 2011; Van Regenmortel, 2013). Furthermore, it places a shared responsibility with respect to mechanisms of exclusion on both the individual and the societal level: social problems are said to emerge as a result of a combination of factors on the micro, meso and macro level. Indeed, empowerment supposes a circular causality that breaks through the classical cause-and-effect thinking and consequently avoids 'blaming the victim' and 'blaming the system'. It implies a fundamental shift in the way social problems and their solutions are looked at (Van Regenmortel, 2011). From this follows that empowerment is a multilevel paradigm which includes not only the psychological/individual, but also the organisational and community level (Steenssens & Van Regenmortel, 2007).

The overall aim of empowerment is to provide social inclusion and full citizenship for each individual, by supporting people in their searching process to gain mastery over the determinants of their quality of life (Janssen, 2013; Van Regenmortel, 2013; Steenssens & Van Regenmortel, 2007). Central to this meta-paradigm is gaining mastery over one's own situation and environment by gaining more control and insight into a situation and environment, and by participation and influencing (Van

Regenmortel, 2011). We use the following definition of empowerment, which is based on the theory from Rappaport and Zimmerman (Rappaport in Zimmerman, 2000):

> *'Empowerment is a strengthening process whereby individuals, organisations and communities gain mastery over their own situation and their environment through the process of gaining control, sharpening the critical awareness and stimulating participation'* (Van Regenmortel in Janssen, 2013, p. 20).

Mastery is defined as 'the extent to which one regards one's life chances as being under one's own control in contrast to being fatalistically ruled' (Janssen, 2013, p. 20) and to stimulate mastery means 'improving the understanding that individuals hold about their ability to control the circumstances of their lives' (Janssen, 2013, p. 20). Mastery is said to be positively influencing various determinants of quality of life such as physical, material and emotional well-being, and is itself operationalised by gaining control, sharpening critical awareness and stimulating participation. 'Control refers to perceived or actual capacity to influence decisions. Critical awareness refers to understanding how power structures operate, decisions are made, causal agents are influenced and resources are mobilised [...]. Participation refers to taking action to make things happen for the desired outcomes' (Janssen, 2013, p. 20).

When we decompose the concept of empowerment, a number of elements emerge that form this meta-paradigm.

2.1.1 A strengths perspective and resilience

> *'All must be seen in the light of their capacities, talents, competencies, possibilities, values and hopes, however dashed and distorted these may have become through circumstances, oppression, and trauma'* (Janssen, 2013, p. 21).

Empowerment's central focus lays on the strengths of individuals, without neglecting their vulnerabilities, demands and needs (Janssen, 2013). It is a positive concept that emphasises society's responsibility to utilise the strengths of vulnerable elderly more (Van Regenmortel, 2011), in a sphere of respect and confidence (Steenssens & Van Regenmortel, 2007; Van Regenmortel, 2013). This is relevant because the strengths of vulnerable groups are not always fully made use of, which leads to a dysfunctional balance of giving-and-taking and to vulnerable groups being too dependent, which causes integration and participation problems (Van Regenmortel, 2013; Van Regenmortel 2011). Indeed, making use of strengths can increase reciprocity and lead to a more positive balance of giving-and-taking, which is especially important for vulnerable elderly. By using one's own resources, feelings of connectedness, participation and independence emerge (Ten burggencate, Luijkx & Sturm, 2018).

> *'The outcomes of these resilience processes may ultimately contribute to the stabilisation or the improvement of a (general) sense of mastery and that those with a greater sense of mastery are able to show resilience in times of crisis and hardships'* (Van Regenmortel in Janssen, Abma, & Van Regenmortel, 2012, p. 344).

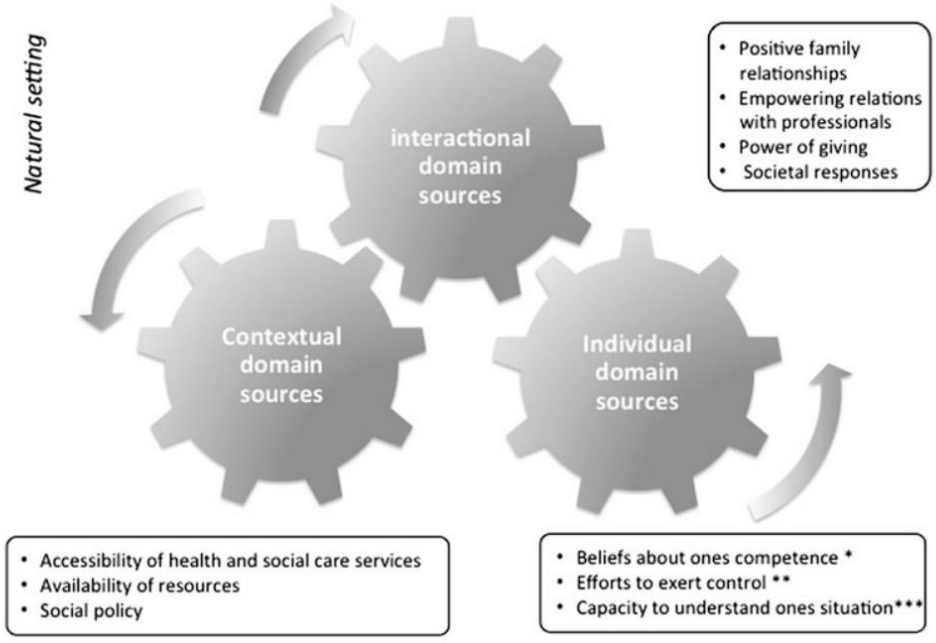
The strengths perspective is strongly linked to the concept of resilience, which is a form of psychological capital (that concords with the positive psychology of Seligman), and which is also a precondition for empowerment (Van Regenmortel, 2013; Van Regenmortel 2011). By giving meaning to problems and looking at strategies one has developed to deal with those problems, strength arises. This contributes to the fight against exclusion (Van Audenhove, 2013, pp. 14-15). Resilience helps us understand the process and mechanisms through which individuals strive to maintain or regain mastery over the determinants of the quality of their lives (Janssen et al., 2012). While 'coping' refers

to the abilities to handle certain circumstances, 'resilience' serves more as a framework for understanding healthy development *in the face of risk*. Resilience can be defined as *'patterns and processes of positive adaptation and development in the context of significant threats to an individual's life or function'* (Janssen, 2013, p. 21). It refers to the ability to maintain a stable and good way of psychological and physical functioning during difficult circumstances, and to even become stronger by learning from adversities (Geraerts, 2013).

The mobilisation of sources of strength influences the extent to which a threat affects other dimensions such as subjective well-being and health (Janssen et al., 2011). In this respect it is important to acknowledge both internal and external sources of strength and difficulties. *'Maintaining mastery in old age is a symbolic and interactional process, and a shared responsibility for older persons and their social environment'* (Janssen at al., 2012, p. 343). Resilient people do not take on a subordinate position or see themselves solely as a victim, nor do they seek to internalise adversities. On the one hand, it is important not to put adversities each time out of the personal responsibility because it could result into alienation and a lack of bonding. On the other hand, by acknowledging the contextual factors, social actions can emerge and people can protect themselves from negative self-evaluation. Appropriate thus is to regain grip on one's own life without feelings of self-reproach and without neglecting structural causes. Through this specific attitude which encompasses both giving and receiving help, the repair of self-respect is stimulated by positive identity forming (Van Regenmortel, 2013).

From the scientific literature we find that the sources of strength that give rise to resilience can be found not only in the individual, but also in the interactional and contextual domain (Van Regenmortel, 2013). *'The three domains are represented here as three gearwheels that need to interact favourably in order to create an optimal climate for development (i.e. resilience) to occur'* (Janssen et al., 2011, p. 152).

Figure 2.1 The sources of strength that give rise to resilience among elderly



Source Janssen, Van Regenmortel & Abma, 2011

First, the individual domain refers to *'the qualities within older people and comprises of three subdomains, namely beliefs about one's competence, efforts to exert control and the capacity to analyse and understand ones situation'* (Janssen et al., 2011, p. 145). In this respect, a positive relation is found between socio-economic

status and a sense of control over one's life and environment, and a sense of self-efficacy (Janssen et al., 2012). Sources of strength in this domain are:
- pride about one's personality;
- acceptance and openness about one's vulnerability;
- anticipation on future losses;
- mastery by practicing skills;
- acceptance of help and support;
- having a balanced vision on life;
- not taking on the role of a victim;
- carpe diem (Janssen et al., 2011).

Second, the interactional domain is defined as *'the way older people cooperate and interact with others to achieve their personal goals'* (Janssen et al., 2011, p. 145). It concerns how people interact with significant others like relatives and friends, neighbours and professionals. Sources of strength in this respect are:
- empowering (in)formal relationships;
- the power of giving ('reciprocity')

Third, the contextual domain refers to *'a broader political-societal level including the efforts on this domain to deter community threats, improve quality of life and facilitate citizen participation'* (Janssen et al., 2011, p. 149). From this, it is clear that the environment plays a significant role in gaining resilience, by offering possibilities and by stimulating collective and individual participation (Van Regenmortel, 2013). This contextual domain includes sources of strength like:
- accessibility of care;
- availability of material resources;
- social policy (Janssen et al., 2011).

Since the sources of strength can be found in various domains, caregivers also address resilience in various domains by appealing to and mobilising strengths. In this respect, empowering care is the least intrusive care that departs from the wishes of the individual: it starts with having insight and interest in the life world and 'insiders perspective' of the involved. Caregivers help care recipients fully discover and experience their authenticity and identity (Janssen, 2013). Furthermore, they stimulate resources and support in the environment, by using, strengthening and/or repairing the social network of elderly (Van Regenmortel, 2011).

From this perspective, a number of recommendations are formulated concerning resilience of elderly. Caregivers should be aware that resilience is a process: accepting aid and one's own vulnerabilities takes time because a period of doubt, talking and considering one's options precedes such acceptance. Also, caregivers should consider the impact of their help on the feelings of elderly, and adapt their manner of communication so they take into account these feelings. Elderly in turn should speak earlier about their wishes and expectations, and try to accept help. Governments must try to be aware of the contextual barriers and make sure elderly can maintain in control of their situation as long as possible. (Janssen et al., 2011). Further, formal and informal caregivers should develop recommendations that are consistent with the values of the senior. Finally, significant others should be aware that reciprocity is important for the sense of mastery of elderly. *'Only when sources of individual strength and the interactional domain are attuned to each other can resilience, and thus a perceived sense of mastery, take place in older people in need of long-term community care. In order to promote the perceived sense of mastery, significant others need to approach older, vulnerable people in a positive way and regard them as resilient persons with their own identity, values and past.'* (Janssen, 2012, p. 353). With respect to the latter, it is found that an optimistic view of ageing has a positive effect on subjective health and life satisfaction (Janssen et al., 2011).

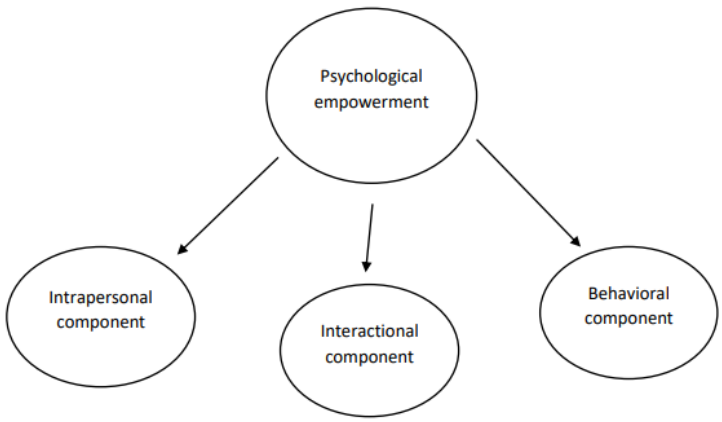
2.1.2 A relational and multi-level perspective on society

'Patient empowerment and patient participation are multilevel concepts. They are mostly situated at the micro level but can also take place at the meso- and macro level' (Castro et al., 2016, p. 1930).

Empowerment supposes a relational picture of society where individual factors, social factors and societal structures are inherently interconnected and influence the quality of life (Steenssens & Van Regenmortel, 2007). Although most empirical work on empowerment has been on the individual/psychological level (Peterson & Zimmerman, 2004), the ecological nature of empowerment implies giving attention to the broader context within a community. Only focusing on individual empowerment could result in neglecting important social, structural and physical factors in the environment and the organisation (Maertens, Desmet & Defrenne, 2015). This could result in bias and a tendency to reduce problems to the individual dynamic whereby individuals are blamed and interventions are mainly directed towards individual behaviour change (Peterson & Zimmerman, 2004). Therefore, both individual and collective empowerment are essential: *'Individual empowerment means that individual patients take action to improve their life, while collective empowerment refers to patient groups taking action to improve their situation'* (Castro et al., 2016, p. 1932). Empowerment is a multi-level concept that includes the psychological/individual, organisational and community level.

First, Zimmerman, one of the founders of psychological empowerment, distinguishes three components of empowerment on the individual/psychological level: the intrapersonal, the interpersonal and the behavioural dimension (Zimmerman, 1995). This is presented in Figure 2.2.

Figure 2.2 Psychological empowerment



Source Zimmerman, 1995

The intrapersonal, cognitive component *'refers to how people think about themselves and includes domain-specific perceived control and self-efficacy, motivation to control, perceived competence, and mastery'* (Zimmerman, 1995, p. 588). It refers to the perceived control, the belief in one's ability to influence a situation and environment (self-perception), and the motivation to exert influence. The interpersonal component (interactional) involves critical awareness of societal norms and possibilities, the mobilisation of resources and the skill to use them. The behavioural dimension refers to involvement in the community, participation in society and organisations, and constructive behaviour (resilience, coping, assertiveness, solving, ...) (Zimmerman, 1995). This is associated to theories such as the Patient Activation Theory that aims to stimulate activation to ameliorate self-management and health (Castro et al.,

2016). This individual level implies that elderly need to receive psychological help that benefits their well-being, effectiveness, resilience, self-confidence, control, participation, critical awareness, ... (Steenssens & Van Regenmortel, 2007). In this respect, it is said that to realise patient empowerment, it is essential to have a dialogue between healthcare providers and patients, in order to co-create knowledge. A patient-centred approach is important so that care is customised in alignment with the needs of the patient. In this respect, participation is essential, which can be seen *'as a strategy to achieve a patient-centred care, which in turn can promote patient empowerment'* (Castro et al., 2016, p. 1931).

Second, on the organisational level empowerment refers to *'organisational efforts that generate psychological empowerment among members and organisational effectiveness needed for goal achievement'* (Peterson & Zimmerman, 2004, p. 130). It concerns *'processes that ensure that individuals get greater control within the organisation, but on the other hand also that organisations, for their part, can also influence the policies and decisions of the wider community'* (Maertens et al., 2015). In this respect a distinction is made between empowering organisations which are *'those that produce psychological empowerment for individual members as part of their organisational process'* and empowered organisations which are *'those that influence the larger system of which they are a part'* (Peterson & Zimmerman, 2004, p. 130). Empowering organisations need to give caregivers sufficient discretionary space and support them by creating 'enabling niches', the framework through which they can empower themselves (e.g. by formation and vision) (Van Regenmortel, 2011; Janssen, 2010). *'Organisations can provide opportunities to their employees for learning new skills, building a sense of control and improving community life'* (Janssen, Snoeren, Van Regenmortel & Abma, 2015, p. 2). The intra-organisational component on the organisational level refers to *the ways organisations are structured and function as members engage in activities that contribute to individual psychological empowerment and organisational effectiveness needed for goal achievement'* (Peterson & Zimmerman, 2004, p. 135). It assumes connections between employees within the same organisation, by stimulating collaboration between teams and groups (Janssen, 2010). The internal structure of a team can for example stimulate a better coordination of care and reflection on ethical questions by supporting collective deliberation: *'a good intraorganisational structure should include good connections between internal units, leadership, a group-based belief system and have resolved ideological conflicts'* (Janssen et al., 2015, p. 6). Further, mutual trust (between professionals, and professionals and management) and clear working routines are also empowering organisational features (Janssen et al., 2015). The inter-organisational component *'provides the infrastructure for members to engage in proactive behaviours necessary for goal achievement'* (Peterson & Zimmerman, 2004, p. 131). It involves exchanging information between organisations and the coordination of services between organisations (e.g. implementing networks that have a signal function for isolated elderly, multidisciplinary teams, ...) (Janssen, 2010). Improved linkages between participating organisations and gaining more insight into each other's tasks are important empowering features on this level (Janssen et al., 2015). The extra-organisational component refers to *'actions taken by organisations to affect the larger environments of which they are part'*, such as policy change, creating alternative services or successful advocacy (Peterson & Zimmerman, 2004, p. 131). It involves the relation of the organisation with the broader environment and the way influence is exerted upon that environment (Janssen, 2010).

Third, on the community level empowerment *'includes efforts to deter community threats, improve quality of life, and facilitate citizen participation'* (Peterson & Zimmerman, 2004, p 130). An empowering community *'is one in which individuals and organisations can use their skills to address their respective needs'* (Maertens et al., 2015). Empowerment on the community level refers to policy stimulating (or hindering) empowerment by employing the strengths of individuals, organisations and communities (Van Regenmortel, 2011, p. 29): policymakers should ensure people can participate in society by emphasising their strengths (Janssen, 2010). In this respect, first, a sense of community is important, which refers to a sense of belonging/connectedness (i.e. having something in common). This is a subjective interpretation of identity where people share the same values, norms, needs, objectives and expectations. Important here is that communal needs and goals are recognised. Second, the social quality dimension refers to the quality and quantity of informal and formal interactions within the community that make sure that strengths are linked together and developed into capital. Third, combined capacity refers to

the revealing and connecting of the resources of people, groups and organisations since the whole is more than the sum of its parts. Fourth, collective action means individuals using their combined strength to exert influence on community life and on social decision-making processes (Steenssens & Van Regenmortel, 2007). This community dimension is strongly related to the power to institute social change: benefits, accessibility of resources and provisions, a better quality of care, influencing law and decision making, ... (Van Regenmortel, 2011).

Finally, the vision of society also impacts the possibilities of elderly to get a grip on their lives. To this day, very stereotypical language is used to conceptualise elderly and to communicate about them. This is problematic because stereotypes form the basis for age discrimination or 'ageism', and they prevent breaking from the taboo surrounding all aspects of growing older.[6] Therefore, society gains by communicating on a more conscient manner about elderly and ageing (Van Gorp, 2013). Indeed, socialisation and striving for an inclusive society means dealing with elderly in a respectful manner and letting them fully participate (Janssen, 2010). In this respect, framing comes to the foreground, which means that *'a voluntary or involuntary decision is taken to choose a specific perspective to look at a situation and in this context some aspects of the situation receive more attention than others'* (Van Gorp, 2013, p. 47). While frames problematise and stigmatise ageing and elderly, counterframes do the opposite because they regard growing older to a lesser extent as inherently problematic. It is best to use both frames and counterframes when presenting elderly: thanks to the stigmatising frames the urgency of the issue is indicated, whereas the counterframes propose an action-based approach that does not neglect the welfare of individual older people. An example of a frame is 'decreasing benefit', where older people are considered of no use because their economical and social benefit decline. A counterframe in this respect is 'silver gold', which emphasises the opportunities and potential added value provided by elderly (Van Gorp, 2013).

2.1.3 Empowerment as both a process and an outcome

Empowerment it is both **a** process and an outcome. Fundamental aspects of the process are acquiring control, creating and expanding access to resources, involvement in the community and the development of critical awareness of one's own socio-political context. The result of empowerment is formed by the effects of the process: perceived control, access to resources, involvement in the community and critical awareness (Steenssens & Van Regenmortel, 2007). By letting elderly for example participate in decision-making processes they can experience control (which is an empowering process). In turn the experienced control or belief in their own possibilities or mastery to impact decisions forms a result of empowerment (Noordink, et al.). From this follows that empowerment as a process does not have an end because one can always keep growing. Moreover, empowerment is an open-ended construct, a continuous variable, which means that for each context, person or population it can entail a different content. What works for one person not necessarily works for the other: it can vary and change in time, which necessitates to investigate together with the involved what empowerment can mean for them (Noordink, Verharen, Schalk & Van Regenmortel, *in press*).

2.1.4 The empowerment paradox

> *'One cannot be given empowerment: one has to acquire it. However, it is up to those who have more empowerment to create the conditions to make empowerment possible for those who are less empowered'* (Steenssens & Van Regenmortel, 2007, pp. 16-17, translated).

6 The WHO defines ageism as *'the stereotyping of and discrimination against individuals or groups based on their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs'* (WHO, 2015, p. 11).

The 'empowerment paradox' refers to the notion that one cannot receive empowerment, but that one has to acquire it himself. The empowerment paradigm states that people should not just be cared for by society nor should they be able to fully care for themselves, but that one needs to find a balance between self-care and support (Van Regenmortel, 2013). At the moment caregivers sometimes (well-intendedly) take on certain tasks to quickly while the care recipient elderly are still able to perform those tasks. As a result the dependence of those latter increases. Therefore, it is better 'to support' than 'to take over' because performing tasks themselves improves self-esteem of elderly (Janssen, 2010). In sum, society needs to create 'enabling niches' in which people can employ their strength and empower themselves through a growth process. Enabling niches are places where choices are expanded and new (growth) opportunities are offered ('window of opportunities'), especially to socially vulnerable persons or groups. It are places where people are not stigmatised, where there is attention for the person as a whole, and with strong expectations of personal growth and change. These social niches are stimulating and not restricting environments: they invite social contact, social support and the use and learning of skill (Van Regenmortel, 2011, p. 28). In these niches people feel themselves physically secure and socially appreciated, and can develop a sense of self-esteem (Van Regenmortel, 2011). From this follows that central elements of empowerment are solidarity, taking care of each other, interdependence, reciprocity, positive dialogue and encounter (Van Regenmortel, 2013).

2.1.5 Relational autonomy

> *'Mastery is much more than just making decisions over one's life; rather, it includes being a moral agent, directing one's life with the help of others'* (Janssen et al., 2012, p. 351).

Although empowerment emphasises independence and gaining mastery over one's life, its goal is not to realise *maximal* independence for all (Steenssens & Van Regenmortel, 2007). From such a point of view it would be impossible to achieve empowerment for elderly for example, who are often confronted with remaining physical problems and will continuously need support (Machielse, 2016, p. 39). Empowerment states that people are *inter*dependent and nobody is fully autonomous in that he or she alone can provide for their own needs. Therefore, it speaks of 'relational autonomy': people gain strength and grow through informal and formal social supporting ties and embedding, which shows the close relationship between empowerment and social cohesion and solidarity (Steenssens & Van Regenmortel, 2007). Empowerment should be interpreted as a liberation process that is focused on the enhancing of social inclusion and full citizenship for each individual, especially for people who find themselves in a vulnerable position. It can be seen as a process through which vulnerable persons no longer feel alienated or powerless, but are again able to make conscious choices concerning their own lives (Machielse, 2016, p. 39). Essential in this respect is that vulnerability and dependence can go hand in hand with control and mastery over one's life. Vulnerable elderly for example are active agents who are aware of their limitations and who, despite their vulnerabilities, find ways to give their lives form so they experience meaning. In this respect, empowerment does not refer to a strengthening process that is aimed at the possibility to influence certain results during the course of one's life, but to developing and strengthening control strategies and internal motivational processes to maintain or amplify the current level of control. This can help people adjust their expectations and leave unrealistic goals in concordance with their environment. Therefore, empowerment does not solely focus on remedying limitations, but also on the support during adaptation processes and the maintaining of mastery (Machielse, 2016).

2.2 Empowerment in practice

2.2.1 Core principles of empowerment and the relationship between caregiver and care recipient

When we consider empowerment in practice, a number of inherently interconnected principles are detected that could be regarded as criteria by which one can evaluate practices and programs that intend empowerment: a positive attitude (equality, respect, presence, encounters, trust), participatory (having a say, influence, ownership), inclusiveness (involvement), integrality (broad view, multilevel), structure (methodical, transparent, short and long term goals), coordination (collaboration, equalisation, management) (Van Regenmortel, 2011) and 'proactive' (Van Regenmortel in Gravesteijn & Aartsma, 2015). Strength and connection oriented are central: they form the twofoldness of empowerment to which all the other principles contribute. The principles are present on all levels and form a whole for the building process of empowerment. Moreover, they influence the relationship between caregiver and care recipient (~ 'principles shaped practice') (Van Regenmortel, 2011).

Figure 2.3 Empowerment Flower

Source Van Regenmortel, 2015

Strength and connection form the central focus of empowerment. The focus on strengths tries to improve negative aspects (illness, social isolation, ...) of a situation by directing attention to the positive aspects (existing opportunities, resources and capacities) (Steenssens & Van Regenmortel, 2007). According to the empowerment paradigm, people must be able to effect changes with respect to their personal behaviour, their social environment and organisations in order to be healthy (Castro et al., 2016). In this respect, it is said that change is only possible when one appeals to the strength, capabilities, motivations and knowledge of persons. As a result, it is essential that care recipients actively partici-

pate in the empowerment process (Janssen, 2010). Moreover, people gain strength by being connected to their surroundings (other persons, groups, organisations, neighbourhoods, communities), and strength results in increased connectedness. Those connections are especially important for vulnerable groups because they are often characterised by broken connections with themselves, others, society in general and the future (Van Regenmortel, 2009). On the individual level, emphasis lays on interests, needs, motivations, knowledge, competencies and psychological resilience (Steenssens & Van Regenmortel, 2007). The organisational level emphasises a strength-based culture of growth which stimulates psychological empowerment of employees (~ empowering organisations) (Peterson & Zimmerman, 2004). Last, on the community level emphasis lays on shared needs and interests, natural meeting places and neighbourhood initiatives (Steenssens & Van Regenmortel, 2007).

With respect to the principles, first, a *positive attitude* is essential. A good bond between caregiver and care recipient is important without it being one of friendship. Indeed, vulnerable people assume equality on the domain of the relationship, but a hierarchical distinction on the domain of content: they should view caregivers as their equal and need to trust them in order to see and recognise their expertise. In this respect presence (encounters, realness, attention and openness), partnership and respect for their individuality are important (Van Regenmortel, 2011). The latter presumes openness to differences, attunement to specific circumstances and freedom of choice (Steenssens & Van Regenmortel, 2007). Such a positive attitude stimulates the feeling of 'belonging', motivates, gives support, amplifies the belief in one's own possibilities, and thus strengthens care recipients (Van Regenmortel, 2011). Furthermore, by appealing to a positive identity and getting people to recognise their own expertise, the target group will be more able and willing to give input (Steenssens & Van Regenmortel, 2007).

Second, *participation* refers to the active involvement of the target group in the process of care, by exerting influence (choice and control) based on information and insight (critical awareness). Participation expands the range of choices and creates the perception of influence (Steenssens & Van Regenmortel, 2007). Such involvement implies a changing power relationship between caregiver and care recipient with a shift towards partnership: the caregiver is no longer the expert, and the care recipient becomes an equally important actor with his or her own input. The relationship is marked by involvement (by the caregiver), equality, connection and reciprocity (Van Regenmortel, 2011). On the individual level this implies that the relationship with the caregiver must be a collaborative one which is constructed around the exchange of expertise (Steenssens & Van Regenmortel, 2007). On the organisational level participation involves influencing public policy and practice, creating alternative community programs and the deployment of resources in the community through the implementation of community actions and the dissemination of information (Peterson & Zimmerman, 2004). On the community level, the care recipients should be able to exert influence on their surroundings (Steenssens & Van Regenmortel, 2007).

Third, an *inclusive* approach refers to involving all subgroups and actors by creating maximum opportunities for participation, with particular attention for the vulnerable (Steenssens & Van Regenmortel, 2007). Indeed, by including all individuals silent voices can be heard which is essential. With respect to organisational empowerment, this implies for example the creation of a climate that facilitates input of employees into decision-making processes. Also, it is important to realise collaboration of co-empowered subgroups within the organisation, which implies that different groups having the capacity to influence decisions and issues affecting the organisation (Peterson & Zimmerman, 2004).

Fourth, the *integral* principle states that it is important to take into account the different dimensions, contexts and domains when assessing a situation: material (housing, public buildings, infrastructure), economic (financial resources), social (social networks, meeting possibilities), psychological (neighbourhood's image, feelings of insecurity), health, ... Furthermore, it implies including different levels (micro, meso and macro) and both the past and the present when assessing a situation (Steenssens & Van Regenmortel, 2007).

Fifth, *structuration* refers to the structured creation of associations that intend to result in a better understanding of the subject, and this by knowledge expansion, critical awareness, development of self-comprehension, and the development of capacities (Steenssens & Van Regenmortel, 2007). Structure is important in order to act in a methodical manner, which results in more chances for participation, giving all individuals a voice, increased transparency (and no hidden agenda) and thus also in a feeling of mastery. Organisational empowerment refers in this respect to opportunity role structures and subgroup linkages (Peterson & Zimmerman, 2004).

Sixth, *coordination* refers to forming collaborative associations that amplify a sense of belonging and mutual understanding of common strengths and qualities, and the motivation and will to exercise influence (Steenssens & Van Regenmortel, 2007). With respect to organisational empowerment, this involves accessing social networks of other organisations and participating in alliance-building activities with other organisations to realise more collaboration and the acquisition of more resources (Peterson & Zimmerman, 2004).

Last, the *proactive* principle is an instrument to combat under protection, where the initiative does not come from the client, but rather society, professionals and/or organisations. In this respect, an outreaching work method is central (through home visits, actively approaching methods, contacting clients when they miss an appointment). By moving into the environment of the client more possibilities are created to detect strengths and talents and to build a relationship that is based on equality and partnership (Van Regenmortel in Gravesteijn & Aartsma, 2015).

2.2.2 Changing instruments and techniques

As a result of an empowerment approach, not only the relationship between caregiver and care recipient changes, but also the applied techniques and instruments through which empowerment can be enabled.

In this respect, it is stated that *facilitating activities* have a more 'empowering' potential through support, openness, ... than authoritative activities that are rather directed towards regulation and control. First, experience knowledge and expertise have a central place in the enablement of empowerment because they form the motor of participation (Van Regenmortel, 2011), and can lead to improved care and quality of life (Castro, Van Regenmortel, Sermeus & Vanhaecht, 2018). Experience knowledge entails knowledge of the own body, mind, acting repertoire, the functioning of the health and social care system, therapies and side effects, the accessibility of care, societal responses to limitations and knowledge of how people can support each other (Janssen, 2010). *'Patients' experiences and knowledge are considered as complementary and equal in importance to professionals' knowledge, both in individual care contexts and in healthcare organisation'* (Castro, Malfait, Van Regenmortel, Van Hacke, Sermeus & Vanhaecht, 2018). In this respect, collaboration between professionals and patient organisations could produce synergies and may result in a complementary type of care and information for both patients and caregivers (Castro et al., 2018). Indeed, patient participation has increasingly been proposed in the background of the augmented importance of empowerment: *'Patients or patient organisations are increasingly invited to take an active role in their own care as well as at more strategic levels, such as the organisation of care. Patients have come to be seen as experts on their own bodies, symptoms and situations'* (Castro et al., 2016, p. 1924). Therefore, is important that caregivers recognise the experience of care recipients and take into account their perspectives and strengths (Janssen, 2010) because this results in better policy by tuning policy measures better to the needs and wishes of the involved. Furthermore, it reduces the dependency of elderly (by increasing reciprocity), and through such an 'insider-perspective' outsiders get more understanding of the situation which results in a more positive image (Van Regenmortel, 2011). In this respect, *outreaching aid* is essential to detect the strengths and possibilities of elderly, and listening to *narratives* is important to understand the meaning and experience that are given to certain happenings (Van Regenmortel, 2013). Moreover, to include patients' experiences and knowledge when creating patient participation interventions, 'co-design' comes to the foreground, in

which both patients and healthcare professionals contribute to designing complex services. Although co-design until this day is mainly used in health care, the idea that services can be improved by involving the end-user in their design could be interesting for social (formal and informal) care provision as well. *'We consider co-design a useful tool for designing, evaluating and implementing complex patient participation related interventions. [...] co-design can be considered as the future method for quality improvement, research, intervention development and implementation'* (Castro et al., 2018, p. 1305). Second, the subject of reflexive practices is the exploration and clarification of the problem, rather than problem solving. Third, empowering techniques like methodic acting are important because structure and ordering give rise to transparence and participation. In that respect, structural consultation, collective participation forms and empowering group work are important. Indeed, empowerment is facilitated through group work because it supports people in creating a positive self-image, learning new skills, forming social networks, gaining critical awareness, ... Last, collaboration between formal and informal care (self-help organisations, volunteer caregivers, experience experts) is deemed appropriate because it stimulates subsidiarity (Van Regenmortel, 2013). Indeed, the least intrusive care is preferred and should fit the specific individual and contextual situation (Van Regenmortel, 2011).

2.3 Empowerment research

Empowerment research is action oriented research because it aims to positively influence practice (professionals and/or the target group), and not only science: 'to prove and to improve' (the quality of care/life). It is characterised by evidence-based practice, practice based evidence, experience based evidence and value based evidence (Van Regenmortel, 2011).[7] The use of different forms of knowledge (experience, scientific and professional knowledge) seems appropriate because the discrepancy between research and practice in social work has been present since long (Steens, Van Regenmortel & Hermans, 2017; Van Regenmortel in Gravesteijn & Aartsma, 2015).

When we consider the impact of the empowerment paradigm on research itself, we first find that this paradigm influences the research subject which is strongly focused on vulnerable groups. Second, it impacts the character and nature of the research questions, which are more about subjective perception and experience. Third, the research method is strongly linked to the 'insider perspective' because empowerment not only relies on scientific and professional knowledge but also on *experience knowledge*. Consequently, although all research methods are accepted, the accent lies on practice oriented, responsive, dialogic, participatory and *qualitative research methods* (Van Regenmortel, 2013), and often the research is done in natural settings in which narratives are important. In this regard, empowerment research is done 'with' and not simple 'about': professionals and researchers inform each other, and the target group participates. Stakeholders co-determine the research design, implementation and valorisation, and become partly-owners: the design is for example developed along the way, and not fixed a priori ('emergent design'). In this respect, the researcher takes on the role of the 'critical-friend': he is not the expert nor an outsider, but rather one of the involved. He facilitates and brings about a *learning process* by searching for common ground within different perspectives. He is like a friend that gives confidence and partly exposes himself (reciprocity), but also hands out a mirror and ideas that generate critical reflection and development. In sum, all stakeholders form a sort of *research-community* that fits the idea of 'partnership practice', an open and reflexive culture where learning and improvement are central. This is a dynamic and circular process (Van Regenmortel, 2011). Although the use of research knowledge to guide decision making by social workers in practice is seen as beneficial and ethical, the available scientific knowledge is still often underutilised (van der Zwet, 2018). Therefore, long-term partnership structures between research and practice (such as academic collaborative centres) have potential value to surpass the gap between research and practice

7 Evidence-based practice can be defined as 'a decision-making process that involves the integration of best research evidence with clinical expertise and patient values' (van der Zwet, 2018, p. 124).

(Steens et al., 2017). Furthermore, in empowerment research data analysis is often inductive, and the following core principles are essential with respect to empowerment evaluation: improvement, local ownership, inclusion, democratic participation, social justice, local knowledge, evidence-based strategies, capacity building, learning organisation and responsibility (Van Regenmortel, 2011).

2.4 Empowerment measurement instruments

It is desirable and necessary to evaluate the effects of social work that has empowerment as goal. For this, measurement instruments are needed that measure empowerment, and so the process and/or outcomes of social work. However, since empowerment is an open-ended construct that can mean something different for each individual, it is very complex to develop a universal measurement instrument. Moreover, because of the multiple levels of analysis and it's the underlying dimensions, it is very difficult to give a comprehensive picture of empowerment. As a result of these difficulties, there is no generic instrument that measures patient empowerment: most of the existing instruments are developed for a specific target group within social work (Noordink, Verharen, Schalk & Van Regenmortel): they focus on particular conditions (diabetes, cancer, ...) or on specific contexts (rehabilitation). Moreover, most outcomes are limited to one aspect of empowerment, often activation levels, self-management abilities, self-efficacy (Castro et al., 2016). In this respect examples of generic validated instruments are the Health Care Empowerment Questionnaire, the Patient Enablement Instrument and the Patient Activation Measure (Castro et al., 2016).

Research points out that measuring empowerment should be context-specific, and thus that the instrument is designed for one specific context. Most existing instruments focus mainly on psychological/individual empowerment. Examples of these are the EMPO, the NEL and the MPE, three validated instruments that measure empowerment in social work practice. The EMPO consists of 12 items and has as target group parents in their role as educators, and measures psychological empowerment of those parents. The MPE (in English studies referred to as the Service User Psychological Empowerment Scale - SUPES) consists of 28 items and is used to measure empowerment within the context of social work in Belgium with respect to poverty, mental health problems and parents. The NEL (the Netherlands Empowerment List) consists of 40 items and is meant for clients of the mental health sector (Noordink et al.). Finally, the PES (Personal Empowerment Scale) is a valid and reliable instrument to measure empowerment for people with severe mental illness (Castelein, van der Gaag, Bruggeman, van Busschbach & Wiersma, 2008).

3 | Loneliness and social isolation among elderly

'The absence of supportive relationships that people can fall back on in case of adversity is a serious threat to self-reliance, especially for seniors, who are particularly vulnerable to social isolation owing to loss of family and friends, health, or mobility' (Machielse, 2015, p. 352).

Feelings of loneliness and social isolation among elderly are of paramount importance because they significantly affect various other life domains and quality of life in general (Janssen, 2013). The importance of this is amplified by demographical trends (such as ageing) and the process of individualisation which have led to more (older) elderly living alone, and who can count in a lesser degree on informal support. The latter is problematic because people acquire numerous capabilities and skills through social relations (social capital), which strongly impacts the possibilities for 'autonomous acting', social embeddedness and quality of life.

3.1 Social evolutions related to loneliness and social isolation

Various social evolutions have resulted in loneliness and social isolation becoming increasingly important research and policy subjects: demographical trends, and the individualisation process which led to an increased need for 'autonomous acting' and a decline of informal social support possibilities.

3.1.1 Demographical trends

In western society the number of elderly increases sharply and elderly are getting older: the proportion of people of 65 years or older in the European Union will rise to about 30% of the total population in 2060, and elderly aged over 80 years will reach 12% of the population (Niedzwiedz, Richardson, Tunstall, Shortt, Mitchell & Pearce, 2016).[8] This implies that a growing proportion of the population is dependent on others (Janssen, 2010) since old age is related to an increase of comorbidity (Slaets, 2006) and vulnerabilities due to physical and functional problems (Machielse, 2016). These vulnerabilities in turn can lead to loss experiences, a diminished sense of mastery, social isolation (Janssen, 2013) and feelings of loneliness (Machielse, 2016).

3.1.2 The need for autonomous acting

As a result of the process of individualisation during the last decades, individuals came to stand looser from various social bonds and are now more than ever presumed to be independent, autonomous subjects. In this respect, disembedding refers to the loss of the normative meaning of traditional, all-encompassing value and social control systems (like the church, society and the neighbourhood), and that people are no longer provided with an acting repertoire for daily life. As a result, value-systems and acting repertoires become increasingly individual choices that *must* be made: 'we have no choice but to choose' (Machielse, 2016). This implies that giving meaning to life, which is made possible

8 For more information about demographic evolutions see Appendix 1.

through social networks, becomes an individual responsibility. However, the process of re-embedding means that people in reality are not so independent and are still strongly connected to society in numerous ways (which limits individual acting possibilities). The most important difference is that now we can choose which guidelines to follow. So although life plans are individually chosen, they must meet numerous unwritten rules that fit contemporary society. This refers to the process of re-embedding where our liberty is limited by new sorts of social commitment and standardisation (Machielse, 2016).

The process of individualisation supposes that individuals are able to make rational and conscious choices and can actively relate to institutional expectations and obligations. 'Autonomous acting' refers to dealing flexible and reflexive with numerous acting repertoires and lifestyles that we think are important and attainable, in order to be able to use the possibilities at hand and to execute our plans. This ability to steer independently ensures we use the liberties of society to the fullest extent, and that we interpret our life as meaningful (Machielse, 2016). The importance of autonomous acting for elderly is demonstrated by concepts like 'active ageing' and 'ageing in place', which have become central policy objectives in Europe (Janssen, 2013). Already in 1994 policymakers stated their objectives in the United Nations International Conference on Population and Development as *'to enhance [...] the self-reliance of elderly people, and to create conditions that promote quality of life and enable them to work and live independently in their own communities as long as possible or as desired'* (United Nations in Fokkema, De Jong Gierveld & Dykstra., 2012).

A precondition for autonomous acting is *self-efficacy*, the feeling of being competent and effective in our acting. Further, *social relations* with others are important because they enable us to defend our identity. Machielse states that the capacities modern society asks of each individual can be captured by 'identity capital' (i.e. knowing what you want and having the confidence to realise it), and by 'communicative self-steering' (i.e. giving direction to own developments in interaction with surroundings). In this respect, appreciation and affection given by family members is important for the feeling of confidence and self-respect, which in turn are important for giving direction to one's own life (Machielse, 2016).

From this we find that elderly need to steer their life in a way they find meaningful, which is determined by the extent to which they can exert control on it, the feeling of competence and mastery. Control with respect to vulnerable elderly is about understanding and accepting their vulnerability (more than factual control), which results in competence (even dough they cannot always change their situation). Further, identity formation is important to give meaning to life, and is influenced by the development of a coherent life story, the feeling of continuity, and the need to bring a number of self-made choices into a coherent whole. Meaning is also determined by the way people can deal with adversities (through coping strategies) and thus by self-esteem, self-respect and self-acceptation. In this respect, 'meaningful others' are essential for one's own autonomy and development because a positive self-image emerges through recognition of intimate relationships and social appreciation for the lifestyle one has chosen (Machielse, 2016). *'Under these conditions, abundant social competencies and skills are necessary to participate in society and build up and maintain supportive social relationships'* (Machielse, 2015, p. 341).

3.1.3 The decline of informal social support

The process of individualisation has resulted in significant changes with respect to social networks: family structures have changed, people live further from each other, networks have become smaller and family and neighbourhood relationships have become less self-evident (Machielse, 2016; Machielse, 2015). We find for example that social relations of elderly became less divers in that elderly increasingly only have vertical contacts (with children), which is related to the strong focus on the nuclear family (Lefebure, Cantillon & Van den Bosch in Cantillon, Van den Bosch & Lefebure, 2007). Also, the support people can expect, has changed towards new patterns of solidarity within families,

more individual care preferences, intimacy at a distance, and support that is less absolute and less unconditional (Machielse, 2016; Machielse, 2015). In an individualised society which is more fragmented and less predictable, there is more insecurity and there seems to be less solidarity, less trust and declining cohesion (van Campen, Vonk & van Tilburg, 2018).

Despite the increase of elderly who live as a couple, elderly with children and the number of children per elderly (which all lead to more informal care possibilities), the process of individualisation and the changing social structures in general influence informal care possibilities in a negative way. Indeed, informal care possibilities are negatively impacted by the increased labour participation of women, the ascertainment that parents and adult children live less often under the same roof, live farther from each other and have less contact with each other. Moreover, divorced fathers can in lesser degree count on informal care from their children, in comparison with divorced mothers (De Koker, Jacobs, Lodewijckx & Vanderleyden in Cantillon et al., 2007). In short, the process of individualisation and the changing social structures have resulted in less informal support for elderly. Therefore, the question is raised if additional (informal) support by family members will still be sufficiently available to guarantee optimal social embeddedness of elderly. *'The integrative function of the family seems to be at risk as a consequence of the trends towards increasing rates of divorce and remarriage after marital breakup, in combination with the forming of complex new forms of stepfamilies'* (Fokkema et al., 2012, p. 204). Moreover, while the family has been the main and most stable source of elderly care since long, it holds the risk that elderly without a family cannot appeal to this type of care.

3.1.4 Intermediate conclusion

The preconditions of 'autonomous acting' make clear that elderly are far from automatically integrated in society. The WHO describes ageing, and states that at the biological level *'ageing is associated with the gradual accumulation of a wide variety of molecular and cellular damage. Over time, this damage leads to a gradual decrease in physiological reserves, an increased risk of many diseases, and a general decline in the capacity of the individual'* (WHO, 2015, p. 25). It is clear that elderly are more likely to be negatively affected in multiple areas of life because getting older goes hand in hand with a deteriorating health and changing social relations (Van Regenmortel, 2017). Therefore, the evolution towards 'ageing in place' contains for example a potential risk because living alone is one of the most important risk factors for loneliness. Due to their increased frailty, the resources of elderly which enable them to 'act autonomously' decline through which they have more difficulties sustaining a supporting informal network, staying connected to the broader society, fulfilling their social needs and re-embedding in a meaningful way. This negatively impacts their quality of life (Machielse, 2016). In this respect, social capital comes to the foreground as a potential source of strength which makes 'autonomous acting' possible and counters social isolation and feelings of loneliness.

3.2 Social capital

The fulfilment of social needs, *'the basic human need for love, acceptance and belonging'* significantly impacts the quality of life of elderly (Ten burggencate et al., 2018, p. 2). The extent in which social needs are met not only affects physical and psychological well-being (because it relates to physical and mental health problems), but also emotional (because it is associated with subjective feelings of loneliness) and social well-being (because it relates to objective social isolation and the possibility to maintain independence longer and to 'age in place') (Ten burggencate et al., 2018). One needs social capital to fulfil social needs, which is just as important a risk factor for decease than more known risk factors such as smoking and obesity (Vandenbroucke, Lebrun, Vermeulen, Declercq, Maggi, Delye, & Gosset, 2012). *'Whereas economic capital is in people's bank account and human capital is inside their heads, social capital inheres in the structure of their relationships. To possess social capital a person must be related to others, and it is those others, and not himself, who are the actual source of his or her advantage'* (Portes, 1998, p. 7).

Social capital refers to resources that can be employed to realise certain goals (van Tilburg, 2005). It consists of bonding and bridging social capital, which both have a structural and cognitive component. Bonding social capital refers to the bonds between individuals and families, and relates to informal participation (Heylen & Mortelmans in Cantillon, Van den Bosch & Lefebure, 2007) in horizontal bonds with people who are in an equal position (van Tilburg, 2005). However, not only is it important that one can appeal to family and friends, but also that people *feel* that they can count on them. Hence, while structural bonding social capital is indicated by contact frequency and the composition of the social network (~ objective), cognitive bonding social capital is indicated by feelings of loneliness, having a confidant and the wish to have more social contacts (~ subjective). Bridging social capital refers to the relation between groups (both horizontal and vertical) and relates to formal, civic participation. Whereas structural bridging social capital is indicated by the membership of organisations, participation in organisations and volunteering, cognitive bridging social capital is indicated by the trust in others (Heylen & Mortelmans in Cantillon et al., 2007). In this respect, less close bonds with far family and acquaintances (horizontal) and participation within organisations (vertical) are related to accessibility to services (for example getting a job through connections) (van Tilburg, 2005). The following table gives an oversight of the factors that could be used to indicate social capital.

Table 3.1 Oversight possible indicators for social capital

Type	Level	Component	Indicator
Bonding	Micro	Structural	Contact frequency Composition network
	Micro	Cognitive	Having a confidant Wishing more contacts Loneliness
Bridging	Macro	Structural	Membership associations Participation associations Volunteering
	Macro	Cognitive	Trust in others

Source Heylen & Mortelmans in Cantillon, Lefebure & Van den Bosch, 2007

Social capital is of paramount importance for elderly who are increasingly confronted with declining possibilities and loss experiences because it is an important source of strength through which elderly can deal with those adversities. Indeed, whereas their losses are mostly biologically determined (functional limitations), the way elderly deal with losses is mostly socio-culturally determined. The societal context can thus compensate biological losses (van Tilburg, 2005). In this respect, social capital forms a source of support and well-being on the individual level, and leads to collective awareness on the societal level. It is positively associated with accessibility to services and forms a protective factor for life events like the decease of a partner, decreased physical abilities, ... (Heylen & Mortelmans in Cantillon et al., 2007). Further, we find that social participation generates social capital on both the individual and societal level, and consequently is a precondition for social capital (Heylen & Mortelmans in Cantillon et al., 2007).

When the social capital of a person is (experienced to be) insufficient, feelings of loneliness and social isolation can arise.

3.3 Loneliness and social isolation

'When the personal network no longer suffices to fulfil social needs of a person, feelings of loneliness, depression and an overall feeling of psychological un-well-being arises' (Machielse, 2016, p. 34).

Loneliness and social isolation are of paramount importance because they significantly affect various other life domains and quality of life in general (Janssen, 2013).[9] The feeling of loneliness is one of the most important indicators for well-being (de Jong Gierveld & van Tilburg, 2008): it goes together with physical and psychological problems such as depression, cognitive decline, higher blood pressure and heart diseases, and lonely elderly use the health care system more, exercise less, forget to take their medication more often, eat less healthy, ... Social isolation is also consistently associated with reduced well-being, health and quality of life, and people who are socially isolated are less self-sufficient and more often dependent on professional forms of care (Machielse, 2015).

The actual relevance of this subject is shown by the prevalence of loneliness among elderly aged 65 or more in Europe, which ranges between 10% (Denmark) and 33.4% (Italy) in 2013. Moreover, research states that there is an increase of loneliness in all observed European countries between 2004 and 2013 (Arsenijevic & Groot, 2018). This could be explained by the ageing population which is associated with disability-related obstacles, longer periods living as widows or widowers, but also by delayed marriage, increased dual-career families, increased single-residence households, reduced fertility rates (Masi, Chen, Haxkley & Cacioppo, 2011), and that elderly nowadays are more willing to acknowledge that they are lonely in comparison with the past (Arsenijevic & Groot, 2018).

3.3.1 Loneliness and social isolation defined

Loneliness can be defined as the unpleasant experience that occurs when a person's network of social relationships is deficient in some important way, either quantitatively or qualitatively (De Jong Gierveld & van Tilburg, 2008, p. 5). This cognitive discrepancy theory for loneliness states that the perceived quality of social relations is a summary of all their aspects and arises from a cognitive process that precedes the arousal of a sense of loneliness (Heylen, 2010). Hence, loneliness is a subjective evaluation of social relations that refers to the difference between the quantity and/or quality of existent social relations and our desired relations (VandenBroucke et al., 2012).[10] Social connectedness as opposed to loneliness (De Jong Gierveld & van Tilburg, 2008), refers to *'a positive subjective evaluation of the extent to which one has meaningful, close, and constructive relationships with other individuals, groups, or society indicated by: (1) feelings of caring about others and feeling cared about by others, such as love, companionship or affection and (2) feeling of belonging to a group or community'* (O'Rourke, Collins & Sidani, 2018). Further, social relations can be placed on a continuum between social isolation and social participation. These are objective indicators that deal with the size, frequency, structure and functioning of social relations. In this respect, social isolation refers to the lack or almost complete absence of relations with other people (De Jong Gierveld & van Tilburg, 2008, p. 5).[11] Thus, while the continuum from loneliness to connectedness refers to a subjective interpretation of social relations, the continuum from social

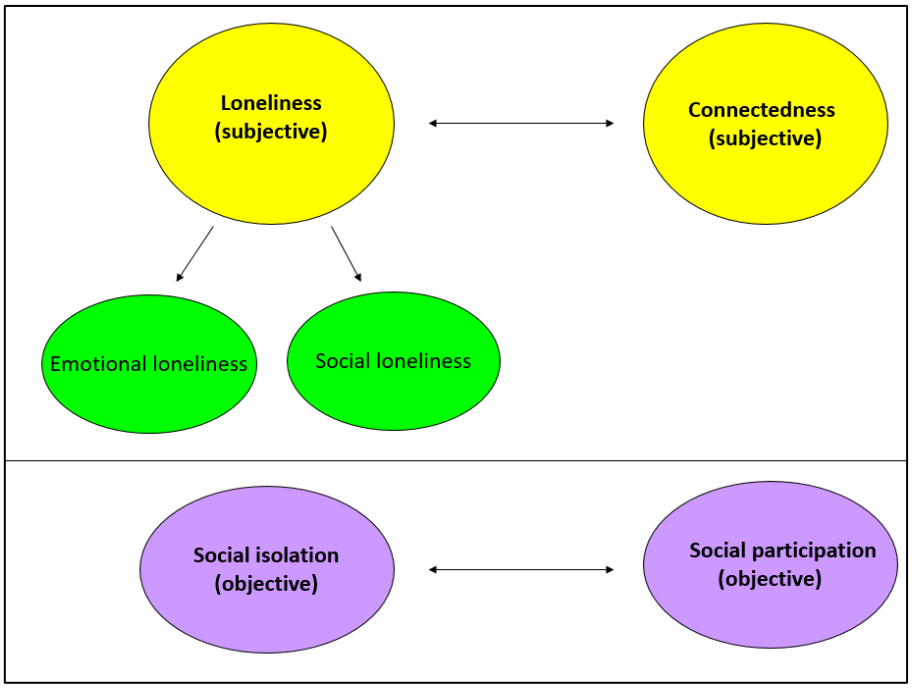
9 In this respect a specific research in the Netherlands finds that the link between loneliness and quality of life is not that straightforward: this link becomes less strong when the association is controlled for by other variables. This implies that solely targeting loneliness might be less fruitful as an approach than when other factors are also taken into account (van Campen, Vonk & van Tilburg, 2018).

10 Two less common theories about loneliness are the evolutionary and existential theory. The evolutionary explanation states that people have the need to belong to a group because it decreases their vulnerability. Therefore, loneliness refers to an unhappy feeling, but also a feeling of insecurity, which serves as a signal in order to let people try to find (qualitative) social contacts. In this respect, alleviating loneliness is not desirable because loneliness leads to people protecting themselves. The existential view states that people stand fundamentally loose from each other, and existential loneliness is said to be the experience of this independence. As a result loneliness is unique for each individual: in the end existential lonely people realize that they are alone in their individuality. This inner experience is said to be necessary for a person to grow, and during this process negative experiences are transformed to positive ones (van Campen, Vonk & van Tilburg, 2018).

11 Measuring social isolation often involves recording levels of social contact, enumerating social participation and quantifying social networks (Gardiner et al., 2018).

isolation to social participation refers to the objective characteristics of social relations. From this follows that while social isolation can be voluntary, loneliness is always involuntary (Dickens, Richards, Greaves & Campbell, 2011).

Figure 3.1 Loneliness and social isolation



It is important to mention that although there is a significant association between the objective characteristics of social networks and the subjective interpretation of those networks (when one is alone, the risk of feeling lonely increases) (Gardiner, Geldenhuys & Gott, 2018), this is not a one-to-one relationship. Indeed, since feelings of loneliness are subjective, they are inherently partly determined by the character of a person, which explains why different persons in similar situations do not experience the same feelings of loneliness (VandenBroucke et al., 2012).

With respect to loneliness we can further distinguish between emotional and social loneliness, which are both strongly linked to certain types of social relations. This distinction is important because it gives insight into the origins of loneliness and thus helps to determine effective intervention strategies (Heylen, 2010).[12] Emotional loneliness refers to the absence of a meaningful, intimate and exclusive relationship such as a partner or a close friend (for example due to the decease of a partner). Those meaningful and supporting social relations make sure people can deal with insecurities, because it is important to be appreciated for who you are despite societal status (Ten burggencate et al., 2018; Machielse, 2016). *'Humans require not simply the presence of others but also the presence of others who value them, whom they can trust, and with whom they can communicate, plan, and work together to survive, prosper, and care for their offspring sufficiently long that they too reproduce'* (Masi et al., 2011, p. 219). Social loneliness refers to the lack of an adequate, broad social network of friends and acquaintances (Ten burggencate et al., 2018; Machielse, 2016), or a lack of feelings of social integration (Heylen, 2010). It is said that social loneliness can be alleviated more easily (through new acquaintances) than emotional loneliness (through the formation of an intimate bond) (Dickens et al., 2011). From this distinction follows that both intimate and peripheral relationships are important, just like a connection with the broader neighbourhood, community and society (Ten burggencate et al., 2018). An

12 Interventions often focus on broadening the social network based on the incorrect assumption that loneliness comes from a limited network (Ten burggencate et al., 2018; Machielse, 2016).

advantage of this conceptualisation is that we can determine specific risk factors and intervention strategies that are related to the resulting four categories: people who are 'not lonely', 'social lonely', 'emotional lonely', and 'social and emotional lonely' (VandenBroucke et al., 2012).

There are two reliable and valid scales that are often used internationally to measure loneliness (within the context of survey research, not diagnosis): the University of California Los Angeles Loneliness Scale (UCLA) that consists out of 20 items, and the scale of De Jong Gierveld that consists out of 11 items. The latter can be used to measure social, emotional and general feelings of loneliness separately. Furthermore, a minimised version of 6 items has been created that is more practical to use in practical research settings. (de Jong Gierveld & van Tilburg, 2008).

A validated self-report measurement scale that gives an indication of social isolation is the Lubben Social network Scale (Gardiner et al., 2018), which consists out of 12 items (long version) or 6 items (short version) (Lubben, Blozik, Gillmann, Lliffe, von Renteln Kruse, Beck & Stuck, 2006).[13]

3.3.2 Social needs and social networks

The feeling of loneliness and social isolation are both determined by (the subjective evaluation of) social networks, the source through which social needs can be fulfilled. Therefore it is important to gain more insight in the defining characteristics of those networks: diversity, the meaning or function, proximity and reciprocity.

First, diversity refers to *'the individual and cultural differences between older individuals in terms of their social needs'* (Ten burggencate et al., 2018, p. 14). Indeed, social needs are subjective and concern individual perceptions and expectations. In this respect, it is clear that the older population is a heterogeneous one that exists of individuals with differences in needs, dependent on the individual's life experiences, culture and personality (Ten burggencate et al., 2018). Within the older generation one can distinguish for example between the young elderly (third life phase) and the old elderly (fourth life phase). While the third life phase is characterised by losses in social roles (due to no longer being productive through labour) and being in good health, the fourth phase is characterised by physical limitations and dependence. The transition from the second to the third phase lies between 55-65 years old, and the transition from the third to the fourth phase lies around the age of 75-80 years old (van Tilburg, 2005; Heylen & Mortelmans in Cantillon et al., 2007).

Second, the meaning (or function) of social relations is an important defining element (Ten burggencate et al., 2018, p. 15). In this respect, *social connectedness* (i.e. the presence of social ties) and *social support* (i.e. the emotional, instrumental, informational or appraisal support) are essential because they contribute to the meaning of life. Connectedness is more emotional and positively associated with health because it *'provides older adults with a mechanism to engage life in meaningful, positive and purposeful ways'* (Ten burggencate et al., 2018, p. 16). Social support on the other hand is more functional, and has an ambiguous relationship with independence: receiving social support can lead to longer independence, but it can also lead to a diminishing sense of independence. In this respect, Machielse distinguishes three support functions of social networks: *'instrumental support (material or practical help, e.g. money, food, clothing, household help, information), emotional or affective support (attention for a person's experiences and feelings) and companionship support (the joint undertaking of social activities, like shopping, going to a movie, going out for coffee')* (Machielse, 2015, pp. 339-340).

Third, proximity is an important characteristic of social relations. This not only refers to geographical proximity of the social network, but also to intimate and peripheral relationships. Both types of relationships create a sense of connectedness, help dealing with grief and loss, and create a feeling of safety and security. While intimate relationships give elderly a feeling of love and belonging, peripheral relationships make them feel connected to society (Ten burggencate et al., 2018). A *'complex net-*

13 More information about these scales can be found in appendices.

work of different types of friendships might be the best protection against loneliness' (Cattan, White, Bond & Learmouth, 2005, p. 60). Based on a systematic review, we find for example that an increase in network support shortly after the death of a partner does not help the person recover from loneliness in the short term, but that participants with a broader social network at the start of the intervention do better in remaining reduced loneliness (Cattan et al., 2005). In this respect, Steverink & Lindenberg (2006) distinguish three functions of social relationships that relate to social need fulfilment: *affection* (love, trust, acceptance, ...), *behavioural confirmation* (doing the right thing and being useful for example via volunteer work) and *status* (respect, being independent). Since the latter two are mostly satisfied by peripheral networks, it seems unlikely that elderly tend to focus only on emotionally and intimate relationships, because their well-being also strongly depends on those peripheral relationships. So although both intimate and peripheral relationships matter, the latter become more difficult to satisfy as a result of a loss of resources and goals (Ten burggencate et al., 2018). In this respect, Putnam distinguishes between closed and open networks. *Closed networks* focus on exclusivity, interaction between people in the inner circle, and having binding social capital. However, only having such a type of network could lead to suffocation and isolation. *Open networks* refer to bridging social capital through which people are directed outwards, are stimulated to surpass social boundaries and enrich themselves with information of external sources and acquaintances in the broader circle. Through those networks connections are formed between societies and groups (Paes in Van Regenmortel, 2010), which shows again that both intimate and peripheral social relations are important.

Fourth, reciprocity within social relations is important. Elderly want to participate and contribute to society because it amplifies the feeling of independence, being meaningful and connectedness, and thus also well-being. Reciprocity *'means not just receiving but also giving support and friendship, helping others and contributing to a community or society'* (Ten burggencate et al., 2018, p. 17). Altruism means *'doing someone a favour without expecting something in return, [and] can be considered a higher level of reciprocity'* (Ten burggencate et al., 2018, p. 18).

To summarise, it is important to acknowledge people's diversity in social relations. Individual preferences and differences should be respected and considered. From this follows that one intervention will not be suitable for all, but that interventions should be tailored around the unique needs of the individual. Secondly, elderly should not only be stimulated to have intimate relationships, but also relationships with peripheral members of their social network, and with people in close proximity (neighbours, ...), social events/clubs, ... Thirdly, social relations should fulfil various functions, more specifically social connectedness and social support, for example through leisure activities and contacts with all layers of society. Fourthly, reciprocity is an important element of social relations that impacts well-being. By drawing on one's own resources through hobbies and volunteer work for example, feelings of connectedness, participation and independence arise.

In this respect, the authors of a systematic review (Ten burggencate et al., 2018) formulate following policy recommendations:

- promote active involvement:
  - involve elderly in interventions;
  - leisure activities, volunteer work;
  - reciprocity.
- show respect:
  - for individual differences;
  - address talents and skills;
  - intergenerational initiatives;
  - focus on independence.
- stimulate social contacts:
  - both close and peripheral relationships;
  - neighbourhood initiatives;

  - facilitate social meeting places.
- share knowledge:
  - satisfying social needs.

With respect to the link between social networks and well-being, the *activity theory* states that when people are more active, productive and connected to society, they experience more autonomy, life satisfaction and well-being (Tornstam in Heylen, 2010; Heylen & Mortelmans in Cantillon et al., 2009), and less loss of functions (van Tilburg, 2005). Hence, inactivity is regarded as problematic. Therefore this theory focusses mostly on the physical and social obstacles that impede social interactions and participation (Tornstam in Heylen, 2010). However, although participation and connectedness of elderly associates positively with quality of life, this 'activity' theory contains the danger of one-sidedly promoting 'active ageing' as a key to successful ageing. Whereas we need to recognise that elderly still have enormous potential, it is also important to acknowledge that old age is accompanied by declining possibilities, declining social participation and increased dependence, and that not each older person is able or willing to participate. A one-sided focus on active ageing in which participation and being active become the norm and in which sickness and dependence are problematised, is not desirable because it results in difficulties for dependent elderly to accept their dependence and in a feeling of not being able to fulfil the norm (Heylen & Mortelmans in Cantillon et al., 2009). As a result, the ideal of 'active ageing' could result in social exclusion of elderly who are no longer able to participate: *'Elevating civic engagement as an ideal for aging may further marginalise those people who, for any number of reasons, are not civically engaged and thus do not reflect that ideal'* (Heylen & Mortelmans in Cantillon et al., 2009). By accepting and acknowledging limitations it is possible to stigmatise elderly in a lesser degree (Heylen & Mortelmans in Cantillon et al., 2009).

3.3.3 Factors associated with loneliness and social participation

Loneliness and social participation are complex phenomenons that are associated with characteristics on the personal, relational and societal level (Fokkema & van Tilburg, 2007). The emergence of loneliness seems to be an undetectable process in which various risk factors arise such as a declining social network, the feeling of less mastery, becoming ill, ... (van Campen et al., 2018).

Personal level

With respect to characteristics on the personal level, we first find that loneliness is related to a lack of social capabilities, self-confidence and coping capabilities (Fokkema & van Tilburg, 2007). Lonely individuals approach social encounters with greater cynicism and interpersonal mistrust, rate others and themselves more negatively, expect others to reject them more easily, have lower feelings of self-worth, blame themselves more often for social failures, are more self-conscious in social situations and adopt behaviours that increase their likelihood of rejection (Masi et al., 2011). Moreover, loneliness is intertwined with self-perceptions of isolation, negligence and abandonment (Vozikaki, Papadaki, Linardakis & Philalithis, 2018), leads to increased feelings of shyness, anxiety and anger, and decreased feelings of social skills, optimism, self-esteem and social support. This implies that loneliness goes hand in hand with a whole pallet of attributes, expectations and perceptions. Also, research indicates that lonely individuals increase feelings of loneliness among those with who they interact (Masi et al., 2011). In accordance with the *cognitive explanation* of loneliness which indicates that loneliness refers to the difference between existent and desired relations (VandenBroucke et al., 2012), research further finds that people adapt their expectations to the actual situation to minimise the felt discrepancy. Older people with poor self-assessed health for example attach less importance to the number of *social* contacts and adjust their standards to their restricted opportunities to meet others (Heylen, 2010). In this respect, coping capabilities are essential to tackle loneliness, namely through taking action (active coping), and adjusting expectations and goals downwards (passive coping). Both

strategies are related to the extent one thinks he or she has mastery, which in its turn is dependent on education, income, health, work, age, dependence on care, ... (van Campen et al., 2018).

Second, loneliness is associated with health problems (Fokkema & van Tilburg, 2007) such as depression (Cattan et al., 2005). *'Living alone in poor health is associated with 10 times higher odds of feeling lonely as compared with living together with someone and having good health'* (Sundström, Fransson, Malmberg & Davey, 2009, p. 274). People with health problems have more difficulties to engage in satisfying personal relationships that can prevent and alleviate loneliness (Fokkema et al., 2012). In this respect, a distinction can be made between physical, cognitive, sensoric and psychological health. Physical health problems lead to ADL limitations and mobility problems, through which it becomes more difficult to maintain social relations. Further, chronic, cognitive, sensoric and psychological health problems can hinder autonomous functioning and lead to dependence on the social network, and consequently result in a lack of reciprocity (van Campen et al., 2018). Therefore, it can be assumed that by addressing health needs of elderly, one promotes the level of social connectedness and alleviate feelings of loneliness (Vozikaki et al., 2018).

Third, loneliness is related to income and wealth (Fokkema & van Tilburg, 2007). Research in various European countries found that the risk of loneliness is higher in the least wealthy groups and lower in the wealthiest groups. People with a lower income or less wealth have less financial resources to participate in society and visit friends and family, and are more likely to have limiting physical and mental health conditions, making social participation more difficult. Also, the wealthiest people participate more in comparison with the least wealthy, which leads the authors to conclude that social participation could help alleviate loneliness among elderly and act as a buffer against the negative effects of socioeconomic disadvantage (Niedzwiedz et al., 2016).

Fourth, gender is associated with loneliness (VandenBroucke et al., 2012). Women more frequently report higher levels of loneliness compared to men (Niedzwiedz et al., 2016), which could be explained by men's unwillingness to admit feeling lonely and that it is socially more accepted for women to express their emotional states (Vozikaki et al., 2018). However, other research suggests that loneliness is more often present among men which could be linked to the finding that women have traditionally spoken bigger and more divers social networks, while men are socialised to be emotionally independent. Furthermore, although women are more often widows and have more health problems, they also have a better connection with their children and receive more support after a separation than men (van Campen et al., 2018).

Fifth, loneliness is strongly related to age (VandenBroucke et al., 2012), which in turn is related to loss experiences (health, partner, friends, ...), a different vision on life with different goals (changing expectations, social networks) (Heylen & Mortelmans in Cantillon et al., 2007), increased health problems (Niedzwiedz et al., 2016), and life-course trajectories like the deterioration of family and social networks due to adult offspring leaving the parental home. Old age can be seen as a period where intimate attachment figures are more often lacking which may result in loneliness (Vozikaki et al., 2018). Further, age is associated with loneliness through the experience of a loss of mastery, more dependence on professional care and a loss of income (van Campen et al., 2018). However, research also indicates that the greater the age, the lower the risk of *social* loneliness, which can be explained by the socio-emotional selectivity theory that states that older elderly attach more importance to the quality of contacts and are more satisfied with their social relationships (Heylen, 2010).

Sixth, research indicates that loneliness is associated with where one lives. Living in a city is associated with more loneliness which can be explained by activities in cities being often directed towards younger people, and by elderly feeling less safe in big cities because their bond with the close environment is weaker (van Campen et al., 2018). Elderly in Brussels have for example a smaller social network than people in Flanders or Wallonia (VandenBroucke et al., 2012). Research also finds that although citizens of Flanders have less social contacts than those of Wallonia, citizens of Wallonia are more often lonely (Heylen & Mortelmans in Cantillon et al., 2007). A study about the Netherlands states that about 50% of the habitants in nursing homes feel lonely, of who 20% severely lonely and

80% moderate lonely. They researchers find that people in nursing homes are less lonely than elderly who live independently if they are older, have a partner, have more mastery over their own life, and when they have more social contacts. Moreover, habitants of nursing homes of 85 years or older experience less loneliness than younger habitants (Van Campen et al., 2018).

Moving is also said to be associated with increased feelings of loneliness (van Campen et al., 2018), just like the level of education and marital state (with higher education and marriage being protective factors against loneliness). With respect to the latter, we find that being a widow is related to loss experiences which can lead to loneliness. Separation works in a similar manner: the social network declines and emotional difficulties emerge (VandenBroucke et al., 2012). However, although having a partner is a protective factor against loneliness, when the partner relationship does not fulfil expectations, feelings of loneliness can arise just like with people without a partner (van Campen et al., 2018). Moreover, although loneliness is associated with divorce, it is not so much the divorce on itself but rather the absence of a partner and the decline of the (possibilities to expand the) own social network, that negatively influence loneliness (Pasteels, Heylen & Mortelmans, 2014). Finally, loneliness is also related to the composition of the household (VandenBroucke et al., 2012) being childless (Vozikaki et al., 2018; Fokkema et al., 2012), and people with a migration background are more likely to experience feelings of loneliness because they do not always speak the language well, have a lower socio-economic status and more health problems (van Campen et al., 2018).

Relational level: the social network

Besides characteristics on the personal level, loneliness is also strongly related to social participation and social network characteristics (Fokkema & van Tilburg, 2007). While social participation is associated to a lower risk of loneliness (Niedzwiedz et al., 2016), being socially isolated is significantly linked to the occurrence of frequent loneliness (Vozikaki et al., 2018).[14] Therefore, loneliness can be countered by participating in social activities and creating a broader social network (Fokkema & van Tilburg, 2007): participation in formal activities like volunteering and attending social clubs is related to reduced loneliness in later life (Niedzwiedz et al., 2016). A nuance in this respect is that the effect of social participation differs according to the type of participation: participation in charity or voluntary work, or sport, social or other clubs is associated stronger with reduced loneliness than for example being active in political and community organisations (Niedzwiedz et al., 2016). In accordance with the *deficit theory* which states that situational factors cause loneliness and people need social contact to avoid loneliness, research finds that *'the number of a respondent's social relationships directly affected their sense of social loneliness, independent of the perceived deficiencies and people's preferences, and had indirect effects through the level of satisfaction with social relationships and the appraisal of the number of good friends'* (Heylen, 2010, p. 1190). This implies that (social) lonely people benefit from an increase in the quantity of their social relations (Heylen, 2010). In this respect, the membership of associations among elderly of 65 years or older was almost as high in 2001 than in 1985, which indicates that there was no decline with respect to bridging social participation of elderly (Heylen & Mortelmans in Cantillon et al., 2007). However, besides the extent of the social network, the diversity and contact frequency are also important protective factors against loneliness (Pasteels et al., 2014). In this respect, research indicates that the diversity of the network of elderly in Belgium declined between 1985 and 2001, just like the contact frequency of bonding social relationships (Heylen & Mortelmans in Cantillon et al., 2007).

With respect to the factors associated with social participation, we find that social participation is related to better (subjective) health, higher age and marital state. Further, men are more likely to socially participate because they are in general characterised by more labour participation and have more easily access to formal organisations (Heylen & Mortelmans in Cantillon et al., 2009). Also, a lower education is associated with a smaller network and a more important part of family in the

14 Being socially isolated was in this research operationalized as 'living unpartnered, having no children and being socially inactive over the course of the previous month' (Vozikaki et al., 2018, p. 622).

network (Heylen & Mortelmans in Cantillon et al., 2007). Further, institutions and role patterns are important because social contacts often start in an institutional context such as work, school, a sport club, voluntary work, ... (van Campen et al., 2018).

Last, we find that social networks and social needs are not static, but change over time (with age). Social networks often expand when people are younger, and decline when they become older (as a result of death, moving, sickness, declining mobility, ...). More specifically, older people tend to have fewer social contacts with members in peripheral circles, while they maintain or even increase their interactions with family and intimate friends (Machielse, 2016). *'[...] older adults tend to select fewer and more meaningful goals and activities [...]. Goals, motivational priorities and preferences also appear to change [...]'* (WHO, 2015, p. 25). While bonding relations with close family and friends become more important with age, bridging relations (with acquaintances, neighbours, ...), participation in organisations and trust in others decline with age, which demonstrates that people in general loose social capital when growing older (van Tilburg, 2005).

Various theories aim to explain the changing social networks and needs when one gets older and gets confronted with declining health (Heylen, 2010, p. 1182). All these theories can be linked either to declining possibilities through which it becomes more difficult to maintain social relations, or to changing needs and desires. First, the *social convoy model* states that these changes are caused by changed social roles due to a loss of job or health related problems which may result in difficulties to retain a reciprocal relationship (Ten burggencate et al., 2018). Next, the *theory of selective optimisation with compensation* assumes that decreasing cognitive and physical capacities force older people to select their contacts and optimise them (Heylen, 2010). The '*socio-emotional selectivity theory*' lays its cause rather in increased selectivity: older people are said to focus more on deep, meaningful relationships instead of frequent and superficial contacts (Ten burggencate et al., 2018), due to their increased awareness of their finitude. Close to this latter, the *disengagement theory* states that people are conscious of approaching death, which raises self-awareness and leads to disengagement from society. So in the process of ageing, elderly experience a decrease in actual and desired social contacts (Heylen, 2010). Next, the *theory of gerotranscendence* is a variant of the disengagement theory and assumes potentially positive aspects of the cognitive changes one experiences during the final years. It refers to *'a shift in metaperspective, from a materialistic and pragmatic view of the world to a more cosmic and transcendent one, normally accompanied by an increase in life satisfaction'* (Tornstam in Heylen, 2010, p. 1182).

Societal level

On the societal level, we find that a number of characteristics on the societal level can explain the cause of the gap between desired and actual relationships: negative stereotyping about elderly, declining solidarity between and within generations, changes in the structure of the population and/or families (Fokkema & van Tilburg, 2007), culture, societal expectations and norms, wealth of a society and new contact possibilities such as the internet (VandenBroucke et al., 2012). Furthermore, old age pension schemes, social security systems and health care systems impact the self-reliance of elderly and offer conditions in which elderly can live in optimal health, quality of life, social integration and social connectedness (Fokkema et al., 2012).

The impact of these characteristics on loneliness is demonstrated by the differences in loneliness between countries in Europe: in 2013 the prevalence of loneliness among elderly aged 65 or more ranged between 10% in Denmark and 33.4% in Italy (25% in Belgium) (Arsenijevic & Groot, 2018).[15] Research finds that adults in southern and central European countries were generally lonelier than their peers in northern and western European countries (Fokkema et al., 2012). This is in contrast to what we would expect based on our simplified views of 'anomie' in northern countries and 'Gemeinschaft' in southern countries: *'Co-residence and culture-bound indicators of intimacy and community, assumed to*

15 These numbers are based on SHARE data which include following countries: the Netherlands, Austria, Belgium, Germany, Denmark, Italy, France, Sweden, Spain and Switzerland) (Arsenijevic & Groot, 2018).

prevent loneliness, are clearly more common in Southern European countries' (Sundström et al., 2009, p. 267). Indeed, since Nordic countries were the first to go through household atomisation and solitary living, we would expect loneliness to be highest in those countries. Since this is not the case, it could be hypothesised that expectations have been adjusted in the northern countries accordingly to the changed actual living arrangements, and that expectations in the South with respect to social interactions are higher (Sundström et al., 2009). According to some research people in southern countries endorse more strongly 'norms of filial obligation' (Fokkema et al., 2012), and express higher expectations with regard to family support for ageing parents and lower expectations for institutionalised care than people in northern countries (Sundström et al., 2009, p. 2689). Research has also shown that cultural heritage determines the manner in which people express and cope with respect to loneliness. Indeed, *'state, regional, and community provisions shape the conditions for individual older adults to participate in the community and to be involved in social activities with kin and nonkin network members and consequently lead to varying country-level outcomes'* (Fokkema et al., 2012, p. 203). The increasing life expectancy, changing characteristics of the family structure and trends in familial support systems vary between countries, through which it can be expected that *'differences in the composition and functioning of the familial system (exchange of instrument support, e.g., as related to coresident living arrangements), the connected cultural values and norms, and the socioeconomic characteristics of countries continue to differently affect the social embeddedness in varying countries of Europe'* (Fokkema et al., 2012, p. 205). In sum, not only characteristics on the personal and relational level, but also contextual and cultural factors explain differences in loneliness between European countries (Sundström et al., 2009). Hence, country-tailored interventions are needed together with generic approaches aimed to enhance social embeddedness (Fokkema et al., 2012).

With respect to social participation, research finds that there is a correlation with the *socio-cultural environment*. First of all, there is more formal social participation in northern European countries than in southern countries. This could be linked to the fact that in northern countries individualistic values and norms are central and thus looser contacts and formal social participation could be more important, whereas in southern countries familial and more traditional values are central and thus informal bonds are presumably a more important form of social participation. Further, the *institutional context* is also a determinant of social participation: northern welfare states for example enhance possibilities to participate socially (by realising more financial means and more leisure time), while southern states (who are more family oriented) support voluntary organisations in a lesser degree. Next, *cultural differences* with respect to what is presumed under 'good old age' and the role of participation are important. Indeed, in countries where formal social participation is deemed more important (Nordic, individualised countries) the relation between social participation and well-being is found to be stronger than in southern (family oriented) countries where less emphasis is laid on social participation. Indeed, elderly who do not participate feel more often socially excluded in northern countries than in family oriented countries. While there is a significant association between social participation and a higher quality of life in north European countries, this correlation is not found in southern countries, which implies that the role of social participation in 'successful ageing' is dependent on the country (Heylen & Mortelmans in Cantillon et al., 2009).

3.3.4 Loneliness and social isolation among Belgian elderly

As we have seen in previous paragraphs, being alone is not the same as being lonely. The cross section between the continuum from lonely to connected, and the continuum from socially isolated to participation results in four categories. First, one can feel lonely while one has a broad social network: *'the lonely'*. Second, people can feel lonely and have a small social network: *'the socially isolated'*. Third, one cannot feel lonely and have a broad social network: *'the socially resistant'* and lastly, one cannot feel lonely and have a small social network: *'the contact-poor'*. In this respect, a representative survey conducted in 2011 with more than 1,500 Belgians of 65 years or older shows that 45% of the elderly

belong to the category 'socially resistant', 23% to the 'lonely', 23% to the 'socially isolated' and 9% to the contact poor.[16] This means almost half of the respondents feel lonely.

When we look into the factors that are associated with loneliness and social exclusion in Belgium, we find that *older elderly* (85 years or older) are more often socially isolated than younger elderly: from the age of 85 the number of friends and acquaintances decline, and women tend to have less friends or acquaintances than men. Further, lonely and socially isolated elderly are not only more common among the older elderly, but also among *women, widows*, elderly with *health problems* and elderly with *financial difficulties*. The latter shows that economic capital plays an important role in loneliness and the social network of elderly. Indeed, the percentage of elderly that belong to the category of the 'socially resistant' is about 26% for elderly with a monthly family income less than 1,000 euro's, and 55% for elderly with a family income of 2 000 euro. Furthermore, the percentage of socially isolated elderly augments to 40% for a low-income group, in comparison with 15% among a high-income group.

The percentage of 'socially resistant' elderly is higher among those who still live at home than those who *live in a nursing home* and who *have less children* and a *less broad social network*. Elderly who live in nursing homes and who would like to have more contact (especially with their grandchildren) are more often socially isolated. Problematic in this respect is that only one out of three elderly who still live in their own home, have talked with somebody about how they would like to live in the future. Furthermore, for about 40% of the elderly the move to a home for elderly was not planned (VandenBroucke et al., 2012).

With respect to *evolutions concerning loneliness*, research is inconclusive: there is no clear increase or decrease in various European countries with respect to the prevalence of loneliness in the period after the Second World War (van Campen et al., 2018). According to a certain research project loneliness has even decreased in Flanders between 1985 and 2001, which may be due to changing expectations of elderly towards more autonomy and other types of relations (Heylen & Mortelmans in Cantillon et al., 2007). Certain authors find that there are no indications that loneliness among elderly in Belgium has increased during the last decades. However, even if the percentages remain the same, in 2020 there will be more than 1 million lonely elderly in Belgium (VandenBroucke et al., 2012). A research in the Netherlands finds that loneliness among elderly in general declined between 1996 and 2016, which implies that the mean elderly is less lonely than 20 years ago. This decline is the strongest for the oldest age group (78-87 years old). According to the authors this is related to changes during the last decades such as the amelioration of social contacts: more elderly now have a partner, they experience more mastery, and their social network is on average bigger and more diverse than 20 years ago (Van Campen et al., 2018). However, other recent research indicates that loneliness among elderly has surely increased both in Belgium (from 11.6% in 2004 to 25% in 2013) and in the Netherlands (from 6.5% in 2004 to 22% in 2013) (Arsenijevic & Groot, 2018). The differing outcomes of these researches could be explained by the different manners in which they measure loneliness.[17] However, various research studies about loneliness in the Netherlands that used the same loneliness scale (De Jong Gierveld) have shown different results: from 31% in 2016 to 48% in 2012. This indicates that loneliness is difficult to signal and measure, which can be related to the acquiring of the respondents, the manner in which the instrument is used (oral, on paper) and other methodological causes (van Campen et al., 2018).

A more recent (online and telephone) survey conducted with 2,122 Belgians between 60 and 85 years old that were not yet in need for help, shows that 23% indicate that they experience a high level of social isolation, and 32% of the respondents experience a low level of social isolation. In this

16 In this respect, social capital was measured by the number of contacts, with who, satisfaction with those contacts, do the elderly have social support and a confidant, do they participate in society. Loneliness was measured based on the scale from de Jong Gierveld (Koning Boudewijnstichting, 2012).

17 In this respect, in the research of Arsenijevic & Groot (2018) loneliness was measured by a one item question: *'How often did you feel lonely during the last 12 months?'* When people responded sometimes or often on a three level Likert scale, they were categorised as feeling lonely (Arsenijevic & Groot, 2018). The research conducted by Van Campen et al. (2018) made use of the loneliness scale of De Jong Gierveld (Van Campen, Vonk & van Tilburg, 2018).

respect, people who live in an apartment are more often socially isolated than people who live in a one-family house (Koning Boudewijnstichting, 2017). With respect to participation in society, about 14% of the respondents themselves are informal caregivers, and another 8% is willing to become it if necessary. Further, about 60% of the respondents (especially those younger than 70 years old) are willing to engage in neighbourhood networks and neighbourhood initiatives with seniors (e.g. doing some shopping for someone else, cooking meals or keeping others company). However, only a few elderly are aware of such initiatives in their own town which results in only 4% of them already being engaged in such activities (Koning Boudewijnstichting, 2017). This willingness to participate to society shows the importance of reciprocity and participation.

With respect to the way people perceive and *experience the ageing process*, we find that this is determined by various societal processes such as negative stereotyping and discrimination, digitalisation and evolving family structures (Van Regenmortel, 2017). With respect to the latter, the number of siblings declines, elderly live less often together with their children, the number of stepfamilies increased in which the roles of a family member is less clear, ... (van Campen et al., 2018). Although there is no such thing as *the* elderly, it is stated that many elderly put emphasis on *growing old in a meaningful way*. They want to keep *living independently* as long as possible and *contribute* to society by volunteering in communal life, participate in political, cultural and sport activities, take care of their grandchildren, ... (Koning Boudewijnstichting, 2017). From a representative survey of the King Baudouin Foundation with more than 2,000 Belgians between 60 and 85 years old (and who are not in need of help), we find 68% of the elderly who participated in the research have a positive to very positive view of ageing. This positive perception is motivated by being able to take things more slowly now, having more time for themselves and their loved ones, being able to do more things they love, their role as a grandparent, etc. However, this implicates that 32% of the respondents consider the ageing process in a negative or very negative way, which even increases to 50% among elderly who are afraid their health problems will further deteriorate or who have the feeling that they receive little social support. This positive/negative stance towards ageing is not only associated with a shrinking social network and health problems, but also with the education level (Koning Boudewijnstichting, 2017).

When we look at the social needs as mentioned by the Belgian elderly themselves, an important source of concern is to be found in the *loss of autonomy* for the Belgian seniors. And when one day they would become in need of help, 72% of the respondents prefer to be cared for by family and 41% by a professional or volunteer with who they do not have a connection. Secondly, we find that all seniors but especially house owners, are very much *attached to their home*. The majority want to spend their old age at home, and there is a high level of willingness to use technological tools and (informal or formal) care in order to make this possible. Despite the wish to age in place, only 26% of the respondents have already taken concrete steps to prepare themselves for their old age, and 37% has not even thought about it (Koning Boudewijnstichting, 2017).

3.4 Old age social exclusion

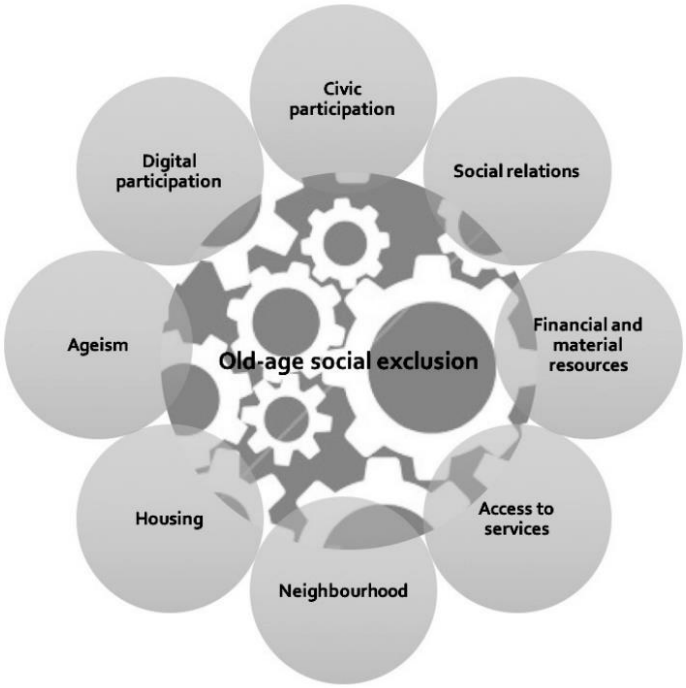
Social exclusion is a broad term and can be conceptualised in many ways. It is more than just poverty which is a term primarily referring to a lack of financial means. Social exclusion is described as the whole of disadvantages within different areas of life such as the lack of access to public services, limited options to participate in society, few social relations and no decent housing (Levitas, Pantazis, Fahmy, Gordon, Lloyd & Patsios, 2007; cited from Van Regenmortel, 2017). Despite the broad conceptualisation of social exclusion, there is a consensus regarding its main characterising traits. Social exclusion is conceived as being dynamic, context dependent (time, place, life phase) and multidimensional (Atkinson, 1998; Marlier & Atkinson, 2010; Room, 1999; Tsakloglou & Papadopoulos, 2002; cited from Van Regenmortel, 2017). The dynamic aspect of social exclusion refers to the possibility people have to move in and out of their status. In addition, social exclusion in Belgium is not necessarily perceived the same way as it is done in other countries or a few years ago. It is a constantly

evolving concept which is dependent on one's phase in life and encompasses several dimensions which can influence each other both in a positive and negative manner (Van Regenmortel, 2017).

Both individual and environmental determinants, as well as life events are significantly associated with social exclusion of elderly. With respect to individual determinants, women, people aged 70 or older, elderly with a lower educational level, tenants, never-married, widowed or divorced people are more likely to be socially excluded. With respect to environmental factors, 'resource poor' municipalities (with higher criminality rates and fewer services), inaccessible neighbourhoods (perceived busy traffic, perceived presence of ethnic minorities) are in a higher degree characterised by social exclusion. Life events (bankruptcy, retirement, divorce and new relationships) also impact social exclusion. Bankruptcy does for example not only lead to financial difficulties, but also to losses of family and friends, shrinking participation and feelings of shame (Van Regenmortel, 2017).

Van Regenmortel (2017) operationalises old age social exclusion as the whole of different types of exclusion on eight life domains: digital and civic participation, social relations, financial and material resources, access to services, the neighbourhood, housing and ageism. Old age social exclusion differs between municipalities and is influenced by both individual (e.g. age, gender, educational level, marital status, etc.) as well as environmental determinants (e.g. criminality rate, wealth of the municipality, etc.). These dimensions are interrelated and can be determinants of each other. Furthermore, psychological and physical health are not considered as dimensions of social exclusion, but rather as determinants (Van Regenmortel, 2017).

Figure 3.2 Old-age social exclusion



Source Van Regenmortel, 2017

Based on her conceptual model, Van Regenmortel distinguishes between four categories of social exclusion, each of which are based on a different combination of the dimensions of old age social exclusion (which is created by a latent class analysis):

1. 'Low risk': those who have a low risk of being socially excluded on the eight domains of old age social exclusion.

2. 'Non-participating financially excluded': those who are financially excluded as well as on the domain of (digital) participation.
3. 'Environmentally excluded': those who are socially excluded in a number of domains (neighbourhood, social relations, housing, access to services and are more likely to be the victim of ageism).
4. 'Severely excluded': those who are socially excluded on all of the eight domains of old age social exclusion (Van Regenmortel, 2017).

Figure 3.3 Categories of social exclusion and their determinants

Non-participating financially excluded	Environmentally excluded	Severly excluded
Individual determinants	**Individual determinants**	**Individual determinants**
Age	Education	Age
Gender	Tenure	Gender
Education	Marital status	Education
Tenure	Length of residence	Tenure
Marital status		Marital status
Length of residence		
Environmental determinants	**Environmental determinants**	**Environmental determinants**
Wealth municipality	Service provision	Criminality rate
Criminality rate	Presence ethnic minorities	Unemployment rate
Unemployment rate		Service provision
Service provision		Busy traffic
Busy traffic		
Presence ethnic minorities		

Source Van Regenmortel, 2017

3.4.1 Social exclusion among elderly in Flanders and Brussels

Based on her research, Van Regenmortel (2017) concludes that 45.7% of the elderly in Flanders and Brussels experience a low risk of old age social exclusion because they have lower probabilities of being excluded from one of the eight dimensions, in comparison to the total population (Van Regenmortel, 2017, p. 138).[18] As a contrast, 16.2% is severely excluded because they have a higher probability of combined exclusion in all dimension (Van Regenmortel, 2017, p. 138). 25.5% belongs to the 'non-participating financially excluded' category, which refers to *'people with a high probability of digital exclusion'* and *'a higher probability of being excluded from civic participation and financial resources compared to the population total'* (Van Regenmortel, 2017, p. 138). Lastly, 12.5% is environmentally excluded: *'a combination of a higher probability of neighbourhood exclusion and exclusion from social relations with a higher probability of experiencing feelings of ageism and exclusion from services and decent housing'* (Van Regenmortel, 2017, p. 138). These categories however, differ strongly between the various communities and their characteristics such as degree of urbanisation (Van Regenmortel, 2017).

When we look at the eight dimensions distinctively, we find that old age social exclusion is the most common with respect to digital participation (64.2%), followed by the neighbourhood (40.1%), social relations (31.1%), civic participation (24.1%), financial resources (23.5%), housing (15.2%) and ageism and access to services (both about 10%). Furthermore, 64% of elderly face exclusion in more than one dimension, and almost 20% in four or more dimensions (Van Regenmortel, 2017).

18 Results are based on data concerning 20 275 elderly spread over 80 municipalities in Flanders and Brussels.

3.4.2 Risk of poverty and social exclusion amongst Belgian elderly

With the Europe 2020 strategy which is about creating more jobs and better lives for European citizens, a lot of attention is given to reducing poverty and social exclusion on the European level. In this respect, measurable targets were put forward: the objective is to reduce the number of Europeans living in poverty by 25%, which comes down to lifting over 20 million people out of poverty (European Commission, 2010). An indicator 'people at risk of poverty and social exclusion' was developed to monitor the progress made, which refers to people who are at risk of poverty, are severely materially deprived and are living in a household with a very low work intensity.

The table below shows that 16.2% of the Belgians aged 65 or older in 2015 were at risk of poverty and social exclusion, which is lower than the average of the total Belgium population (21,1%), and also lower than the average of EU-28 population aged 65 or older (17.4%). However, it is higher than most neighbouring countries like France (9.3%), Luxembourg (8.2%) and the Netherlands (6.1%). In sum, with respect to risk of poverty and social exclusion the population of 65 and older do better than other age groups and than most EU-28 countries, but worse than a number of neighbouring countries.

Table 3.2 People at risk of poverty and social exclusion by age group (2015), in %

	Total population	0-17 years	18-64 years	65 years and older
Belgium	21.1	23.3	21.7	16.2
Germany	20.0	18.5	21.3	17.2
France	17.7	21.2	19.0	9.3
Luxembourg	18.5	23.0	19.2	8.2
The Netherlands	16.4	16.8	19.1	6.1
EU-28	**23.7**	**26.9**	**24.7**	**17.4**

Source European Statistics, 2018

3.4.3 Financial situation of Belgian elderly

Income

From a survey conducted by the National Bank of Belgium in 2014-2015, we find that Belgians aged 65-74 have about 30,500 euro as a median income and Belgians aged 75 or more have about 25,700 euro as a median income, while this amount to 41,200 euro for the total Belgian population regardless of age. Although Belgian elderly have a lower income than the average income in the population, Belgian elderly and Belgians in general clearly have a higher median income than Europeans in general (VandenBroucke et al.).[19]

Financial assets

When we look specifically at the financial assets of elderly in Belgium, a survey conducted by the National Bank of Belgium in 2014-2015 shows that the age group of 65-74 years old have about 29,800 euro in financial assets as the median, and Belgians of 75 years or older have about 25,800 euro in financial assets as the median. For the total Belgian population regardless of age, this amounts to

19 Total gross household income is calculated as the sum of the employee income, self-employment income, income from public pensions, income from private and occupational pensions and income from unemployment benefits (items collected for households members aged 16+) and income from social transfers other than unemployment benefits, regular private transfers (such as alimonies), rental income from real estate property, income from financial investments, income from private business or partnership and regular income from other sources (items collected at the household level). The income reference year varies by country (Household Finance and Consumption Survey, 11 October 2018).

28,500 euro. Hence, concerning financial assets elderly in Belgium do not seem to have less possibilities than other age groups. Also, Belgian elderly and Belgians in general clearly have more financial assets in comparison with Europeans (European Central Bank, 2018).[20]

Assets in the form of housing

A study about the repartition of financial assets (based on the Household Finance and Consumer Survey conducted in 2010) shows that about 80% of the people aged 65 or older in Belgium possess a home, which is more than the 70% of all Belgium households regardless of age (Kuypers & Marx, 2014). From another study we find that the mean net value of the house of homeowners of 65 years and older in Belgium is 272,500 euro in 2014. This is more than the 226,900 euro for all households regardless of age. Furthermore, only 1.3% of the Belgium homeowners of 65 years and older still have to pay off a debt for their home, while amounts to 43.4% of all households regardless of age (Heylen, 2018). From this, we conclude that a big proportion of the population of 65 and older possess a home of a mean value of 272,500 euro that they fully paid off, and consequently that they have considerable financial means in comparison with other age groups.

Risk of poverty

In 2016 about 13.7% of the pensioned population in Belgium is at risk of poverty, which is lower than that of the total population (15.9%). A risk of poverty refers to the situation where a person's available income is lower than that of the poverty threshold, which in 2016 was placed on 1,139 euro per month (according to the most recent EU-SILC survey).

Furthermore, the risk of poverty among the pensioned population in Belgium declined between 2005 and 2016: while about 20% of this population in 2005 was at the risk of poverty, this declined to 13.7% in 2016. More specifically, this risk declined strongly after 2005 and remained relatively stable since 2014, which can be explained by the raise of the minimum pensions of elderly, and the fact that more women have worked and now independently receive a pension that moreover is higher than before. According to prognoses, this risk will continue to decline until the beginning of the 2050s, after which it will remain relatively stable (Hoge Raad van Financiën, 2018).

Not surprisingly, based on a survey of Wikifin.be in 2017, we find that about 50% of elderly in Belgium (65-74 years) are able to save money.[21] In this respect, they do worst of all age groups (together with the age group of 35-44 years old), which can be explained by their declining income (Wikifin.be, 2017).

20 Financial assets include deposits (sight and saving accounts), mutual funds, bonds, shares, money owed to the households, value of voluntary pension plans and whole life insurance policies of household members and other financial assets item - which includes private non-self-employment businesses, assets in managed accounts and other types of financial assets. Medians and deciles are conditional, among households owning any sort of financial asset (Household Finance and Consumption Survey, 11 October 2018).

21 The survey took place in January 2017 and concerned 1002 Belgians aged between 25 and 74 years old.

4 | Interventions to tackle loneliness and social isolation

In this chapter we bring together the core elements of empowerment and loneliness and social isolation, in order to see what we can learn from this with respect to interventions that could counter loneliness and social isolation among elderly.

4.1 Loneliness and social isolation: an empowerment perspective

> *'It is important] not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth. These strengths may be particularly important in helping people navigate the systems and marshal the resources that will enable them to deal with the health issues that often arise in older age'* (WHO, 2015, p. 25).

When we look at the core elements of empowerment, we conclude that this paradigm lends itself well to the subject of 'lonely and socially isolated elderly'. It is useful to understand how elderly can still have mastery on their lives despite their often limited living conditions (Janssen, 2013). In this respect, not only the lives of elderly are characterised by two seemingly contradictory happenings (the focus on independence and increasing frailty), but empowerment itself also seemingly contains a contradiction: on the one hand it focuses on collaboration, support and connectedness, but on the other hand also on influence, strength, and control (Van Regenmortel in Gravesteijn & Aartsma, 2015). In this respect, empowerment states that elderly need to gain the strength to make their own choices, which can be stimulated by learning skills, performing tasks and participating.

First, since empowerment is ethically grounded in values such as solidarity, it tends to *focus on vulnerable groups* such as lonely and the socially isolated elderly. This also concords with the increasing emphasis to realise active citizenship and social inclusion for each individual in society.

Second, the concept of '*relational autonomy'* which states that all individuals are *inter*related, is essential to analyse the situation of elderly because their (increased) dependency on others will often remain for the rest of their lives. In this respect, the presumption is made that each individual can still lead an autonomous life despite certain care needs and dependency. Consequently, empowerment states that the goal of interventions for elderly should not be to realise maximal independence since this is unachievable, but to focus on QOL by stimulating mastery. This concords with the modern vision on health and health care that increasingly lays the emphasis on helping people gaining mastery over the determinants of their quality of life, instead of taking away problems in functioning. In this respect, a balance needs to be found between care and self-reliance for vulnerable elderly in order to remain as independent as possible so they can retain their autonomy and unicity.

Third, empowerment assumes a *shared responsibility* (and circular causality) for social exclusion, and therefore all actors in society should contribute to ameliorating the situation of vulnerable elderly: elderly themselves, the informal social network and professionals. In this respect, the empowerment paradox states that society needs to create 'enabling niches' through which elderly can employ their strengths and empower themselves through a growth process.

Fourth, empowerment supposes a *relational, multi-dimensional picture of society* where individual/psychological factors, social factors and societal structures are inherently interconnected and influence loneliness and social isolation among elderly. And since loneliness and social isolation have complex, multiple forms, various interventions do not prove to be effective because they do not take the unicity of each situation sufficiently in account. Instead of one-size-fits-all measures that often do not work, *holistic and demand oriented* care is appropriate to combat loneliness and social isolation among elderly. Care should be the least intrusive, integrative, comprehensive, coordinated, and tailored around the unique needs of the individual (based on an 'insider perspective').

Lastly, when we look at the core principles of empowering interventions in practice, we find that the *strengths perspective* is essential to combat the dysfunctional balance of giving-and-taking of lonely and socially isolated elderly (~ reciprocity). By a strengths focus unnecessary dependence and integration and participation problems are avoided. Stimulating the strength of elderly is the task of professionals, the social network and environment because people gain strength by connecting them with their family, friends, neighbours and the society in general (Van Regenmortel in Gravesteijn & Aartsma, 2015). To realise this, it is firstly important to work on a *positive self-image* which is strongly determined by the increased dependence and loss in functioning of elderly. This can be done by promoting *reciprocity* through for example grandchildren, hobby's, talents, caring for others, volunteering, ... Further, elderly should be stimulated to ask help which could increase their autonomy and positively influence their unicity and identity formation. This is important because elderly often do not want to be a burdon, through which they refrain themselves from doing certain activities (Janssen, 2010). This strength focus is strongly related to *resilience* which enables people to continue to function well during difficult circumstances and helps them gain mastery. In this respect, both internal and external sources of strength are employed that can be found on the individual (e.g. pride, mastery by practicing skills, ...), interactional (reciprocity, social relations) and contextual domain (accessibility of care, social policy, ...).

Second, the *use of resources* is essential such as moving timely to a suitable home. Third, *learning* and room to experiment (e.g. memory training, physiotherapy, ...) are important in order to let elderly participate. During those moments, it is important that elderly are active actors who have a say and do not simply undergo (Janssen, 2010). Indeed, empowerment states that it is essential that elderly *actively participate in social networks*, because those networks give meaning to their lives and are essential to 'act autonomously' and re-embed in our individualised society. In this respect, the focus of empowerment on strengthening self-respect, reciprocity, self-confidence, self-efficacy, the feeling of belonging and being competent, identity formation, ... stimulates feelings of connectedness and independence and so also increases the possibilities of elderly to 'act autonomously'. Besides participating in society, elderly also need to *participate in the care process* by exerting influence (choice and control) based on information and insight (critical awareness). This means having a say in the analysis of the situation, determining goals, and the choice and intervention type. The relationship between caregiver and elderly should be characterised by partnership, equality, connectedness and reciprocity. Indeed, the caregiver is not the sole expert. By participating elderly can 'give' and maintain reciprocity in the relationship. In this respect, awareness is needed that every form of participation is appreciated and sufficient, and aligned with the possibilities of elderly. Therefore, it can be helpful to start from the prioritisation of elderly (with respect to specific and concrete issues), and consequently also work on other life domains. Furthermore, *a positive attitude* between elderly and caregiver should be central, that stimulates the feeling of belonging, motivates, gives support, amplifies the belief in one's own possibilities, and where respect for each one's individuality is paramount. In this respect, the bond between caregiver and elderly should be characterised by respect, attention, realness, concern, reliability and transparence. The caregiver should be 'present' and real encounters should take place. In addition, an *inclusive* approach means that all subgroups of the lonely and socially isolated elderly should be involved in the care process and should have a voice, and the principle of *'integrality'* states the importance to take into account all the relevant domains of elderly (financial, social, emotional, ...

aspects), but also the past, present and future, and behaviour, emotions and thoughts. Further, *structuration* refers to the creation of collaborative associations that intend to result into a better understanding of loneliness and social isolation among elderly and possible solutions. Structuration implies ordering the complex care for elderly, which in itself can already amount to problem reduction and a different perspective. It means working based on a plan, which leads to more transparency and offers more possibilities for participation. In this respect, it is important to detect problems and possibilities of elderly and their environment on different life domains, together with those elderly. Goals are put forward and priorities are determined jointly, and this both on short and long term. In this respect small goals are also important because they lead to success experiences. However, although working on a structured way entails various advantages, a plan is not a goal on itself: it serves to structure, to show what is done, to demonstrate what works and to give elderly a voice in the care process. Further, *coordinated* working implies that one person manages and coordinates all aspects of a situation because it is possible that multiple actors are involved around one elderly. This is strongly related to case management. Partnership is central and the goal is for all involved actors to realise a collective strategy and coordination of care. Lastly, *proactive* working can combat under protection via outreaching methods. In this respect, society, organisations and professionals actively look for elderly, and move into their environment to better detect their strengths. This is also important with respect to prevention of loneliness and social isolation.

Lastly, empowering organisations are essential in that they offer their professionals possibilities to learn and experiment, and give them space to make powerful connections with other professionals and organisations. Indeed, critical professionals are important that are reflective and try to innovate, ameliorate based on knowledge.

4.2 Practical implications of the empowerment perspective on interventions that target loneliness and social isolation among elderly

The above described core elements of empowerment have implications on the micro, meso and macro level.

On the individual, psychological level care should be aimed at supporting elderly gaining more mastery over the determinants of their quality of life (rather than on problem solving), which can be done by helping them gaining *control* (perceived or real capacity to influence decisions), sharpening *critical awareness* (understanding the working of power structures and the mobilisation of resources) and *participating* (influencing). In this respect, social relations are the central focus of care without neglecting the interrelatedness of social relations with other life domains. First, a holistic, integrated, multi-disciplinary needs assessment that identifies the physical, psychological, functional and social capabilities and difficulties should be made, that starts from the insider perspective. A tailored approach which is based on the individual needs, is needed because numerous elderly are confronted with problems on different life domains. In this respect, outreaching aid and listening to narratives are essential to detect the strengths and possibilities of elderly and to understand the meaning that is given to certain happenings. Making use of experience knowledge stimulates fitting care to specific individual coping strategies, and also implies fostering participation and diminishing dependency (by increasing *reciprocity*) through which empowerment is enabled. In this respect, Gobbens (2017) proposes the use of the Balance model which takes the abilities of frail elderly as the starting point, without neglecting their vulnerabilities. It takes into account both care surplus (measured by external and internal resources such as informal care and self-management skills) and care deficit. In this respect, D-Scope, a Dutch and Belgian research group is working on a frailty balance in which both strengths and weaknesses are included (Gobbens, 2017). Next, professionals need to support elderly in making choices that fit their personal wishes and expectations, in order to ensure they can fully experience their authenticity and identity which is all the more relevant for elderly because values such as respect, self-direction, self-esteem seem to become more relevant as a result of declining

possibilities. In this respect, *empowering techniques* such as structural consultation, collective participation forms and empowering group work are often useful because there elderly can participate and create a positive self-image, learn new skills, using resources, form social networks, gain critical awareness, ...Indeed, through groups where elderly participate socially, find each other, find support and exchange experiences, get to know their own strengths and qualities, elderly can accumulate social capital which augments their QOL (Paes in Van Regenmortel, 2010).

On the organisational level, it is essential to create 'learning and reflexive organisations and caregivers' that create enabling niches in which elderly can empower themselves. In this respect, it is said that collaboration and coordination of services and organisations, for example through the use of case managers who jointly consider appropriate intervention strategies and who coordinate the care around a lonely or socially isolated elderly, is important to ensure that a situation is regarded at from different angles. A link between care and well-being professionals could also be stimulated by social district teams, which are defined by Movisie as *'an interdisciplinary, mobile and pro-active team of professionals from areas such as municipal authorities, the police, community work, housing associations, social services and healthcare, who identify complex problems at district and household level and ensure that at-risk residents (including frail elderly) receive appropriate assistance'* (Gobbens, 2017, p. 26). Such a holistic and person-centred view is important since standardised care packs contain the danger that elderly become too dependent when certain things are done for them while they can still do them their selves. This could lead to under appreciation and a low self-image, and so a lower quality of life of elderly (Janssen, 2010). Furthermore, such collaboration and coordination between various formal and informal actors (self-help organisations, volunteer caregivers, experience experts) is appropriate because it stimulates making use of the least intrusive form of care. Gobbens (2017, p. 25) states that communication, complementarity, effective coordination and continuity of care are key components of pro-active integrated aged care*: 'They are necessary to protect older adults, and to have their informal systems operate properly based on effective self-management so that only integrated formal care and support that is absolutely necessary are provided, based on reciprocity and shared decision-making'*. In order to collaborate and coordinate effectively and efficiently, an understanding of the functioning of other disciplines (and thus formation) is necessary, just like the willingness to open up one's own activities for discussion for example by exchanging information (Gobbens, 2017). *'The essential goal of the collaboration is to arrive at a healthcare and well-being arrangement that puts the frail older adult (or, if this is not possible, their social network) in control. If this does not prove feasible, control must fall to one of the care professionals, taking the client's wishes and the nature of the problem into account'* (Gobbens, 2017, p. 27). However, although this perspective is ubiquitous in recent health and social care literature, until now there is no inconclusive evidence that this will benefit the QOL of elderly. The National Aged Care Program in the Netherlands that tries to stimulate ageing in place by creating an effective informal care network and an organised community care in the form of multidisciplinary first-line care, showed for example little to no effect on ADL's, IADLs, QOL or the usage and costs of care (Gobbens, 2017).

On the community level policy should stimulate the use of the strengths of older people by letting them participate in society, but also the strengths of organisations and communities. In this respect, it is important that communal/shared needs and goals are recognised, and that both the informal and formal interactions within the community are developed into social capital. Furthermore, resources should be combined together (through natural meeting places and neighbourhood initiatives), and collective action should be stimulated by letting individual elderly and groups use their combined strengths to exert influence on decision-making processes. Indeed, experience knowledge should be used with respect to the development of service provision. Not only does this lead to better services, but also a more positive image of ageing because outsiders will learn from this insider perspective.

4.3 Loneliness and social isolation interventions

4.3.1 More research is needed about the effectiveness of interventions

> *'Our systematic review has identified a need for well-conducted studies to improve the evidence base regarding the effectiveness of social interventions for alleviating social isolation'* (Dickens et al., 2011, p. 20).

With respect to the existing knowledge about the effectiveness of interventions that target loneliness and/or social isolation, we find that effort and good intentions are not sufficient to tackle loneliness and social isolation. Indeed, a study of ten interventions that aimed to target loneliness, found that only two were successful (Fokkema & van Tilburg, 2007). From a systematic literature review (Cattan et al., 2005), we find that there is a lack of evidence of the effectiveness of many interventions that target loneliness and social isolation among older people: only one third of the interventions were judged to be effective. Another review that looked into studies about 34 interventions that aimed to alleviate loneliness among elderly found that 12 studied were effective and 15 studies were potentially effective (Cohen-Mansfield, 2015). Also, research indicates for example that the effects of preventive home visits on limited ADLs and IADLs, quality of life, hospitalisation and mortality are inconsistent and minor if present (Gobbens, 2017). Finally, a more recent study states that interventions are rarely proved successful to help elderly meet their social needs (Ten burggencate et al., 2018). As a result, various authors conclude that more research is needed about the characteristics of (effective) interventions (Dickens et al., 2011). A recent review about interventions that aim to reduce social isolation and loneliness said that often the quality of evidence is weak. Based on an analysis of 39 studies the authors conclude that *'there is an urgent need to further develop theoretical understandings of how successful interventions mediate social isolation and loneliness'* (Gardiner et al., 2018, p. 147).

Difficulties with studies about the effectiveness of interventions that target loneliness and social isolation of elderly are *generalisability*, the specific *cultural context*, the ascertainment that *subjects are often self-selected* which could lead to the participation of socially-active lonely rather than resigned lonely or isolated lonely (Cattan et al., 2005). Further, most *interventions are complex* and contain more than one mechanism that aims to reduce loneliness and/or social isolation, through which it is unclear which factors of an intervention contribute. For example: mindfulness interventions are often effective but also mostly given in a group setting through which it remains unclear what the effective element is: mindfulness or the group setting (Gardiner et al., 2018). Another study states that *'all the interventions were delivered in groups, and it was not possible to determine the relative contributions of general group interactions compared with the specific therapeutic intervention'* (Mann, Bone, Lloyd-Evans, Frerichs, Pinfold, Ma, Wang & Johnson, 2017, p. 630). Further, research about the association between ICT and loneliness and social isolation is often *not theoretical based*, making it difficult to provide an explanation for hypothesised associations (Khosravi, Rezvani & Wiewiora, 2016). In this respect, various authors have different theories about which factors are targeted by a specific intervention, meaning inconsistency in the scientific literature with respect to the mechanisms by which the interventions have been conceptualised to target loneliness/social connectedness. As a consequence more research is needed in which the intervention evaluation is based on theory which speaks of the different factors that are targeted by the interventions, and that examines the effects of the interventions on each factor. *'Conceptualisation of the mechanisms by which interventions address loneliness/social connectedness, as opposed to isolation/contact, is needed, responding to calls for theory-based interventions that are problem-specific'* (O'Rourke et al., 2018, p. 2). Further, a recent literature review states that *'inconsistencies in definition and measurement across the 39 studies mean the practice and policy relevance of findings may be limited'* (Gardiner et al., 2018, p. 150). In this respect, the notion of social isolation is for example understood and defined in various ways, and the manner to measure this concept also varies (Gardiner et al., 2018). Cohan-Mansfield (2015) states that the *flawed design* not rarely prevents proper evaluation of efficacy. Further,

Fokkema & van Tilburg pose that intervention types (talking groups, home visits, sensibility campaigns, ...) are often only evaluated by the number of people participating, and the satisfaction of the participants and social workers. Hence, it remains unknown if people become less lonely, and this results in ineffectively using public means and in an incomplete theoretical insight in this subject. Therefore, the authors promote the use of loneliness scales in order to measure the effect of interventions (Fokkema & van Tilburg, 2007). In this respect, it is also stated that more studies using randomised controlled designs are needed (Saito, Kai & Takizawa, 2012): *'Development of clearly defined loneliness interventions, high-quality trials of effectiveness, and identifying which approaches work best for whom is required'* (Mann et al., 2017). Finally, most reviews up until now have focused only on quantitative outcome measures, through which other kinds of evidence fall out of the scope of those studies. Consequently, according to some authors most studies fail to adequately capture depth and breadth of research activity (Gardiner et al., 2018).

In sum, it is clear that when the protective factors against loneliness decrease and the risk factors increase, people become more susceptible to loneliness. However, more knowledge about the complex interplay of these factors is needed because it remains incomplete at the moment. This insight is necessary for creating effective interventions to tackle loneliness (van Campen et al., 2018).

4.3.2 Loneliness interventions

From the scientific literature we can extract a number of recommendations and theories with respect to which characteristics of loneliness interventions are effective.

Improving relations, lowering standards or accepting a discrepancy

According to Fokkema & van Tilburg (2007) there are three ways to combat loneliness. First, it is possible to enhance the existing relations to the level of the desired relations by creating new relationships or by ameliorating existing relations ('network development') (Fokkema & van Tilburg, 2007). This approach is related to the theory of selection, optimisation and compensation, which is useful to help explain how elderly can deal with declining possibilities: it refers to the situation where after loss experiences the remaining sources of strength are activated, optimised and used for the most important domains in life whereby selected goals are realised (van Tilburg, 2005). In this respect, social skill training and psycho-education could be appropriate because they can improve for example conversational ability and reflecting on body language. *'The hypothesis is that such practical advice and information will better equip the individual to form meaningful relationships and have better skills to prioritise and maintain over time'* (Mann et al., 2017, p. 631). When the cause of the loneliness is related to personal characteristics, improving those characteristics and social skills could be a useful strategy (van der Zwet & van de Maat, 2016). And when the cause of the loneliness lays rather in changes in the social network (due to a move, a divorce, ...), other approaches are probably more effective such as partaking in social activities and creating more contacts. Secondly, lonely elderly could try 'lowering standards', which refers to adjusting unrealistic desires concerning social relations. Thirdly, elderly can learn to 'deal with feelings of loneliness' by accepting, relativising, denying or distraction (Fokkema & van Tilburg, 2007). The latter two ways to deal with loneliness are related to the theory of 'the dual process model' which states that it is sometimes essential to adjust goals and expectations. When the losses of social capital are of a certain importance, it may be better to adjust goals that are no longer attainable. In sum, it is stated that when the first strategy (maintaining goals and adjusting oneself) is no longer feasible, the second strategy is used (adjusting goals). This latter strategy is more important for older elderly in the fourth life phase, while the compensation strategy is more used by elderly in the third life phase (van Tilburg, 2005).

Since research clearly points out that lonely people have specific cognitive biases and attributional styles and that loneliness can lead to negative evaluations of other people and a lack of interpersonal trust, it is important to give sufficient attention to changing cognitive conditions. It is hypothesised

that changing the way people think (about themselves in relationships, assumptions about other people, ...) could lead to changed behaviour and so reduce loneliness (Mann et al., 2017, p. 631). In this respect the motivational theory of life-span development is relevant, which distinguishes between primary control capacity (i.e. *'individuals' ability to influence important outcomes in their environment'*) and secondary control capacity (i.e. *'internal, most notably motivational, processes to minimise losses to maintain and expand existing levels of primary control'*) (Janssen et al., 2012, p. 351). Secondary control strategies are used to bring oneself in line with environmental forces, and thus serve primary control striving. During the life course it is said that striving for primary control is a constant and universal motive. With old age, this capacity to strive for primary control declines. Therefore older persons need to activate secondary control strategies, for example by disengaging from goals that are no longer achievable and by selecting realistic goals given the environmental context (by adjusting expectations, values and attributions). As a result *'losses in primary control are not undermining the individuals' motivational resources for primary control striving in general'* (Janssen et al., 2012, p. 351).

Problem-focused and emotion-focused coping strategies

Another way to look at possibilities to cope with loneliness is the distinction between problem-focused and emotion-focused coping strategies. *'Problem-focused coping styles target the causes of stress in practical ways, whereas emotion-focused coping strategies focus on eliminating the negative emotional response to the problem or cause of stress'* (Decks, van den Akker, Buntinx & van Driel, 2018, p. 900).

In this respect the above-mentioned styles to deal with loneliness can also be classified as problem-focused and emotional-focused: by improving relationships people are problem solving, and lowering expectations or learning to deal with feelings of loneliness are related to emotion-focused coping. In this respect, it is said that with increased age, lowering one's expectations is more often suggested as a coping strategy. Moreover, those emotion-focused strategies are more associated with higher levels of loneliness (Decks et al., 2018). Moreover, a systematic review that included 12 studies about the association between loneliness and coping styles, found that there is an association between *problem-solving coping* styles and lower levels of loneliness, and *emotion-focused coping* styles and higher levels of loneliness. Therefore, it is stated that the effectiveness of the coping strategy might be related to the type of loneliness (emotional and social loneliness). Indeed, problem-focused strategies could be more helpful to alleviate social loneliness and emotion-focused strategies could be more effective to tackle emotional loneliness (Decks et al., 2018).

Setting up loneliness interventions

To set up a successful intervention Fokkema and van Tilburg (2007) state that one should start by *investigating the loneliness problem*: to assess the variety and the extent, form and causes of loneliness. A second step is to detect the most important risk groups and select one. Third, theories about loneliness indicate where one could start searching to find a solution. Fourth, with respect to *the choice of the intervention*, it is important to gain an oversight of all interventions and look at which factors work and which do not. Fifth, it is important to assess possible effects and side effects of interventions such as becoming aware of the actual, unpleasant situation, opening up old wounds, feelings of rejection because the social worker becomes more distant during the process, and a relapse after ending the intervention. In this phase, the possibilities to adjust interventions to the specific context and/or target group should also be looked into, just like the possibilities to combine interventions.

Consequently, with respect to the *possibilities to execute* the intervention, it is important to analyse the needs, possibilities and motivation of the participants (Fokkema & van Tilburg, 2007). Indeed, interventions need to take into account the *personal characteristics* of elderly (Machielse, 2015). In this respect, elderly must acknowledge and *be aware of their loneliness* and of the possible interventions to tackle this feeling. Also, they must *want to do something* about the situation and they should *be able to participate* in the intervention. With respect to the latter numerous factors can hinder participation such as physical and mental health problems, financial limitations, a lack of social capacities and low self-esteem

(Fokkema & van Tilburg, 2007). It is also essential that interventions *fit the cause and type of loneliness* because there are individual preferences and differences with respect to social needs and social relations, from which follows that interventions should be tailored around the unique needs of the individual. However, numerous interventions are aimed at tackling loneliness by promoting social participation and active engagement in local communities or expansion of the social network: often these interventions are not effective because these goals are not always feasible nor desired when they do not fit the specific cause and type of loneliness (Machielse, 2015). *'Social networking interventions that are aimed at stimulating social participation and reducing loneliness do not always match the specific ambitions, motivations, and abilities of socially isolated older adults. The wrong type of intervention may even harm the client and make him more reluctant toward new interventions'* (Machielse, 2015, p. 352). Last, the possibilities to execute the intervention depend also on the social workers who execute them and the duration of the interventions (Fokkema & van Tilburg, 2007).

4.3.3 Social isolation interventions

> *'Interventions should fit with the ambitions and strategies of the clients involved, and expresses the possibilities for (re)integration of various types of socially isolated elderly'* (Machielse, 2015, p. 350).

The heterogeneity of the group 'socially isolated elderly'

The ineffectiveness of various interventions that aim to tackle social isolation can partly be explained by them not taking into account the heterogeneity of the group of 'socially isolated elderly'. Therefore Machielse presents a typology that imposes structure in this heterogeneous group and describes the implications of this typology for interventions. With respect to the latter, this typology makes clear that for each type of social isolation *time investment* and *intensity of care* differ strongly, and it becomes clear *which results are possible* and where the limits of care can be found (Machielse, 2011). This typology can serve as a theoretical basis for applying interventions aimed at increasing self-reliance of socially isolated elderly, which is essential since contemporary governments emphasise the importance of independence and self-reliance of their citizens: *'governments aim at fostering mutual involvement between citizens and enabling them to take care of each other as much as possible. Access to social care services becomes less generous and citizens can only count on help from professionals when their own network is insufficient or absent'* (Machielse, 2015, p. 340).

Three defining characteristics: duration, motivation and coping strategy

Machielse distinguishes a number of relevant characteristics that define the type of social isolation. Firstly, there is the persistence (duration) of the social isolation. In this respect, a distinction is made between situational isolation which refers to *'older adults who [recently] entered a situation of isolation after demonstrable negative circumstances or events'* and structural isolation which refers to *'older adults who have been in social isolation for many years already without clear (demonstrable) circumstances or events'* (Machielse, 2015, p. 345). The time a person is socially isolated gives an indication of the degree to which this person has gotten used to it and also of the expected intensity of the help. Indeed, an improvement can be accomplished in a shorter time period for situational isolated elderly than for structural isolated elderly. For the latter often more intensive assistance trajectories are desired, certainly if the isolation affected other life domains. Secondly, the action orientation (motivation) of the socially isolated persons is relevant. Action orientation refers to *'the need and motivation of socially isolated persons to participate in societal contexts. This can involve contact with a partner, family, friends, and neighbours (informal contacts), or participation in an association, volunteer work, or paid work (formal contexts)'* (Machielse, 2015, p. 346). This motivation says something about the ambitions of the older person and expectations with respect to care, and thus offers a perspective on effective interventions. For motivated elderly, interventions are aimed at promoting social participation and increasing the social network. For less motivated elderly,

the emphasis lies on offering support so they can deal with their situation, often by tackling practical problems. Thirdly, the coping strategy to deal with difficult situations is important. Socially isolated people often have a different set of social rules and coping strategies that differ from the rules not-isolated people have, and which are taken on subconsciously and are imbedded in a person. In this respect, poor social competencies tend to lead to passive coping strategies, manifested as emotional denial, avoidance, or withdrawal behaviour, which can even enhance social isolation. When socially isolated people already have dealt with numerous rejections, taking on a different set of social rules contains a risk for them. Consequently, they often repeat their behaviour and avoid social relations where they do not feel certain, which further decreases their social capabilities to participate, and may lead to a negative spiral. Many socially isolated people use passive coping strategies and keep withdrawing even farther from society. Furthermore, those passive strategies are difficult to break through, and will often cause problems in other areas of life, in the form of addiction, depression, debt, or neglected personal hygiene. For people with passive coping strategies it is important to continue to try new behaviour in numerous social settings. Interventions could be directed at solving practical problems, and building a relationship of trust, or simply creating a safe environment (Machielse, 2015).

Eight types of socially isolated elderly

Machielse (2015) states that socially isolated people use both active and passive coping strategies in dealing with negative situations, and that both strategies run through the persistence and action orientation dimension. Consequently, a combination of both dimensions and the coping strategy produces a social isolation typology that consists of eight profiles which are divided into situational and structural isolation.

Table 4.1 Typology of socially isolated individuals

Persistence of the social isolation	Actions aimed at Social Participation	Actions not (clearly) aimed at Social Participation
Situational isolation	Actives	
Active coping strategy	Actives	Secures
Passive coping strategy	Laggers	Dependents
Structural isolation		
Active coping strategy	Compensators	Outsiders
Passive coping strategy	Hopefuls	Survivors

Source Machielse, 2015

With respect to *situational isolation*, we first have the 'Actives'. This refers to elderly who always have had an active social life and want to keep it that way, but because of circumstances are no longer able to do so on their own. They have an active coping strategy and look for help in order to participate in society. In this respect, interventions should be aimed at removing the barriers for participation: e.g. by deploying a volunteer. Secondly, the 'Secures' were never very active, and feel safe in a social network of family and friends. When this network breaks down, they look for manners to feel protected again. Interventions in this respect could be aimed at intensifying existing relationships that may offer this sentiment of protection and safety. Thirdly, the 'Laggers' never had a broad social network nor were they active. A few intensive social contacts sufficed. After the falling away of those important contacts, they need emotional support of a close friendship, but are not able to establish such a contact alone. They passively wait, but without help their situation will not ameliorate. Interventions could be directed towards increasing independence and offering emotional support. Fourthly, the 'Dependents' never built their own social life and continued to stay with their parents

or brothers and/or sisters. When their social network falls apart, they avoid contact with others because it leads to tension and conflicts. This passive coping strategy strengthens their isolation. Interventions could be aimed to increase self-reliance, offering emotional support and seeking a safe environment where they feel safe.

With respect to *structural isolation*, the cause for the negative spiral can no longer be detected: the social isolation was developed early on in life, and their coping strategies have since long been internalised which makes it more difficult to break through. In this respect, fifthly, we have the 'Compensators'. This are people who always had few social contacts but compensated by functional activities such as volunteering. These activities give them meaning and a social context through which their need for company and conversation is met. When these activities fall away, they are isolated and use an active strategy to remain active. In this respect, social workers can offer practical help, but other help is rejected. Sixthly, the 'Outsiders' have never found connection with others and empathically turn away from society. They remain outside society and are very independent practically. Only when they can no longer manage alone and their problems piled up, social service agencies can see their situation. For those social workers it takes a lot of time to build a relationship of trust. Seventhly, the 'Hopeful' have a strong need for social relationships but are not able to engage in supportive relationships. They encounter difficulties when dealing with people and experienced various failed relationships. They find it difficult to reconcile with their situation and continue hoping their situation will improve. Interventions in this respect could be directed towards emotional and psychological support, solving practical problems and assistance with daily functioning. Lastly, the 'Survivors' are people that avoid contact with others, have little social competencies and are not able to engage with others. They have a passive coping strategy and are resigned to their situation. They only deal with surviving and their problems often have strongly accumulated. Interventions should be specialised, such as psychiatric care or addiction therapy.

When we consider this typology we find that structurally isolated elderly are less quickly recognised by care organisations because they have withdrawn from society: to reach those types more outreaching methods seem preferable, just like long-term aid with professional support. Elderly that are characterised by situational isolation are probably helped more with group interventions, activities and short term individual trajectories. Isolation is difficult to counter with respect to structurally isolated elderly because the coping strategies of those people are often stabilising or even enhancing isolation. For them the results of care are often to be found in practical problem solving and prevention of further escalation. Interventions aiming to enhance participation and enlarging the social network are often not realistic for this group, in contrast to elderly who are situationally isolated.

4.3.4 What works and does not work to combat loneliness and social isolation?

> *'There are indications that social isolation interventions may have wide-ranging benefits including structural social support, functional social support, loneliness and mental and physical health'* (Dickens et al., 2011, p. 19).

In this paragraph we describe some characteristics of interventions that may be effective to tackle loneliness and/or social isolation amongst elderly. Since both concepts are multidimensional, related to the lack of social incorporation and often used interchangeably in the literature and practice (Khosravi et al., 2016), we consider loneliness and social isolation together in this paragraph. However, this is not ideal because loneliness and social isolation in fact are two distinct concepts that require different interventions to tackle them. *'The components and activities of interventions designed to target loneliness/social connectedness may differ in important ways from those designed to reduce isolation/increase social contact. Furthermore, how the interventions addressed either the indicators of loneliness/social connectedness or its possible influencing factors is unclear'* (O'Rourke et al., 2018, p. 2). Since it is difficult to determine which

characteristics of interventions are actually effective to combat loneliness and/or social isolation, cautiousness is warranted with respect to the interpretation of research results.

As a result of the growing diversity in interventions that aim to target loneliness and social isolation, a good categorisation is important in order to be able to identify the common characteristics of effective interventions. Nevertheless, in the literature we find various different ways to categorise interventions, based on *intervention type* (activity, support, internet training, home visiting, service provision, ...), *way of delivery* (group, one-to-one, service delivery) (Cattan et al., 2005) or *intended outcomes* (improving social skills, enhancing social support, increasing opportunities for social contact and addressing maladaptive social cognition) (Masi et al., 2011).[22] Gardiner et al. (2018) differentiate based on the purpose, mechanisms of action and intended outcomes: social facilitation interventions, psychological therapies, health and social are provision, animal interventions, befriending interventions and leisure/skill development. Other authors distinguish between individual interventions and community based interventions (Arsenijevic & Groot, 2018), or between direct interventions (changing cognitions, social skills and psychoeducation, supported socialisation) and indirect interventions.

It stands out that most characteristics of effective interventions that tackle loneliness and/or social isolation are very general (van der Zwet & van de Maat, 2016).

Group versus one-to-one interventions

A systematic review (Dickens et al., 2011) found that *group interventions* are more effective in combatting loneliness and social isolation among elderly: while 79% of group-based interventions reported at least one improved participant outcome (with regard to social, mental and physical health), this amounts to 55% of one-to-one interventions. In this respect, some studies found positive effects of group interventions providing *activities* on the creation of friendships, reduced depression, more participant activities, increased social interaction, increased contact with grandchildren and distant friends and improved self-rated health (Dickens et al., 2011). Activity group interventions refer to engaging in an activity of interest in order to promote relationships that are characterised by support, friendship or companionship. This intervention type often aims to target caring, belonging, social support, personal development, social participation and the social network (O'Rourke et al., 2018). Further, group interventions providing *support* also found positive effects on functional health status, action-directed coping, more confidants available, better satisfaction with social support, reduced loneliness, enhanced socialisation and reduced depression (Dickens et al., 2011). Another systematic review (Cattan et al., 2005) found that the effectiveness of group interventions is enhanced by emphasising *intra-personal resources* such as self-esteem, competencies, and social contact outside the group.

However, in contradiction to the above, a literature review of Cohen-Mansfield and Perach (2015) found that group interventions were less often evaluated as effective compared with one-to-one interventions (Gardiner et al., 2018, p. 154). Another study of Hagan et al. (2014) also found that group interventions are not necessarily more effective than one-to-one interventions. The authors assume however that this can be explained by the relative short duration of the studied group intervention studies. They presume that long term group work is beneficial because of its informal aspects: *'What worked was not the coercion of a group of strangers to tackle commonly held concerns but rather it was the building of relationships, through social activities, that generated self-esteem, mutual respect and confidence that led to action'* (Hagan, Manktelow, Taylor & Mallet, 2014, p. 689). They do mention to be attentive of possible negative consequences of group work with all lonely individuals because of the tendency of negativity to be self-reinforcing (Hagan et al., 2014). Hence, until this day there is no conclusive evidence about which interventions (group or one-to-one) are the most effective, due to the often contradictory research findings. Consequently, effective interventions are not restricted to those

22 Since improving social skills and maladaptive social cognition are more related to the quality of social relations, it addresses loneliness more directly than enhancing social support or increasing opportunities for social interaction which are presumed to address social isolation more than loneliness (Masi, Chan, Haxkley & Cacioppo, 2011).

offered in group settings (Gardiner et al., 2018). Thus, some group interventions will have no effect while one-to-one interventions do. The effectiveness of the intervention type is therefore probably related to the type of loneliness (van der Zwet & van de Maat, 2016).

One-to-one support is one of the most frequently provided activities to alleviate loneliness among elderly (Cattan et al., 2005; O'Rourke et al., 2018), and often refers to a scheduled contact between a participant with another individual such as family member, friend or volunteer in order to strengthen the social network, social support, caring, belonging and technology use (O'Rourke et al., 2018). Nevertheless, the effectiveness of those interventions (such as befriending or home-visiting schemes) in order to remedy social isolation and loneliness remains unclear, despite that older people appreciate them. In this respect, it is stated that one-to-one interventions have more effectiveness *when the volunteer belongs to the same generation*, have common interests, and share a common culture and social background as the older care receiver, which can be explained by the importance of *reciprocity* in the social relation (Cattan et al., 2005). Other authors presume that innovative interventions that promote solitary activities can offer solutions for those hard to reach groups such as housebound older adults, (Gardiner et al., 2018).

Peer support programs as a type of group intervention

> *'Peer support programs are based on the premise that shared experience is a valuable resource that assists individuals to adjust to, and cope effectively with, stressful events... Peer support is based on the premise that mutual sharing of information is beneficial for participants... Facilitators may be professionals, trained volunteers or committed community members'* (Lok in Van Regenmortel, 2010, p. 179).

The prevalence of loneliness among persons with severe mental illness is about twice that of the general population. In the mental health sector, a well-known type of group interventions are peer support programs (Masi et al., 2011).[23] Support groups are said to be the primary method for *social skills training* and are found to be the primary strategy for *strengthening social support* among people with mental illnesses. Moreover, *deficits in social cognition* could be addressed via self-help groups that try to enhance thinking from negative and fearful to positive and self-supportive (Masi et al., 2011). In doing so, they relate to both problem-focused and emotional-focused coping strategies.

Peer support programs can be described as *'groups based on contact with peers where no professional guidance is present'*. Another description of peer support programs by the 'Flemish Meeting Point Self-help' are *'voluntary, more or less structured collaborations of people whose activities are directed towards controlling and concurring disorders and physical or social problems they are affected by personally or as acquaintances. Self-help groups do not strive to make a profit. Their goal is ameliorating the personal life circumstances of people and often also a change of their social and political environment. [...] The group is a mean to remedy the extern (social and societal) and intern (personal, mental) isolation'* (Lok in Van Regenmortel, 2010, p. 176). Peer support programs have from 10 to 20 participants, and are characterised by an easy accessibility, intensity, long duration and are voluntary by nature. In general peer support programs have homogeneity with respect to experience (through which people understand each other better), and heterogeneity with respect to social class, culture, political or religious convictions. Peer support programs stimulate empowerment because they teach participants that they themselves are master and architect of their own lives by *sharing concrete experiences* and *learning new skills*.

In peer support programs experience and learning from difficult circumstances (coping strategies) which lead to critical awareness, changing attitudes and new skills is essential, together with a strengths perspective. Indeed, experience and reflection are cyclical: reflection is stimulated by experiences and perspectives of others on a situation. Via peer support programs people listen to each

23 In the 1970s the self-help movement has embraced empowerment (Castro, Van Regenmortel, Vanhaecht, Sermeus & Van Hecke, 2016).

other, support each other, analyse together, and learn from each other's experiences through which they regain mastery over their own lives. As a result more self-awareness and insight arises, knowledge about problems and treatments, rest and self-confidence, acceptation of problems, being able to better deal with problems, and gaining more perspective in life and friendships. Such peer support groups can be considered as 'enabling niches' that are characterised by holism, social contact, learning new skills, feeling socially appreciated and safe, and where people develop a sense of self-value. In this respect, *reciprocity* (the 'helper-therapy principle') is essential, namely that helping has a bigger advantage than being helped because it entails a positive self-image, higher prestige and status which results in a positive identity. In support programs, people are therefore *inter*dependent and not dependent which is a big surplus compared to regular care. Those programs offer emotional support, company, friends, useful activities, practical support and possibilities for development, which enhances both social survival and psychological well-being. Through the social contact a new social network arises and social isolation is avoided, and psychological well-being is improved because participants help each other through their own experiences which counters feelings of loneliness.

However, possible negative consequences also exist such as overburdening with problems of others and for example loss experiences when a participant dies or leaves. Moreover, the effects of peer support programs are difficult to measure, especially effects on well-being and psychosocial functioning are less known. Hence, more research about these effects seems necessary (Lok in Van Regenmortel, 2010). And lastly, these programs are mostly known in the sector of mental health care, are less knows with respect to elderly.

Mastery

Schoenmakers states that an effective method to alleviate loneliness is stimulating mastery of elderly, which refers to the extent in which one regards his own life chances as under his own control (in Janssen, 2013, p. 20). Indeed, relatively little elderly are said to consider to enlarge or ameliorate their social network, because often they are not convinced that this will work for them. Therefore it is important to raise awareness concerning the possibilities to enlarge or ameliorate their network (van der Zwet & van de Maat, 2016).

Duration

In the previous part we have seen that some authors argue that a longer duration of group-based interventions is important in order that the participants can build informal networks (Hagan et al., 2014). In this respect, Cohen-Mansfield (2015) states that the association between duration and effects of interventions is a complex relationship which is interrelated with population characteristics, study design and setting, follow-up periods and maintenance support: *'It is clear that long duration or long session length is not a necessary ingredient for efficacy, yet in all cases the untangling of this complex picture will probably require much more research or different approaches to the study of loneliness interventions'* (Cohen-Mansfield, 2015, pp. 120-122).

Theoretical basis

According to a systematic review (Dickens et al., 2011) the development of interventions within the context of a theoretical basis is a common characteristic of effective interventions: while 87% of the interventions that were theoretical based had beneficial effects on the social, mental and physical domain, this declined to 59% of interventions with no evident theoretical foundation (Dickens et al., 2011). In this respect, it is stated that more research is needed to test the divergent theories of why interventions work, in order to understand the interventions mechanisms (O'Rourke et al., 2018).

Participation, activities and support

Participatory interventions are found to be more effective than non-participatory interventions: 80% of participatory interventions had beneficial effects compared to 44% of non-participatory interventions (Dickens et al., 2011). This was confirmed by a literature review that states that interventions involving *productive, active engagement* are found to be more effective than passive activity interventions (Gardiner et al., 2018). Indeed, when elderly are involved with the development and execution of activities, this augments effectiveness (van der Zwet & van de Maat, 2016). According to a systematic review 86% of interventions providing *activities* and 80% of those providing *support* had beneficial effects, while this declines to 60% for home visiting and 25% for internet training interventions (Dickens et al., 2011). Other authors also found that programs which enable elderly to participate in planning, developing and delivering activities are more likely to be effective, and that most effective interventions often have some kind of *educational or training* support input and focus on specific groups of older people (Cattan et al., 2005). This was also put forward by Cohen-Mansfield (2015) who states that educational programs (that focus on social network maintenance and enhancement) are often effective in both group and one-to-one interventions, and that various studies involving shared activities are rated effective (Cohen-Mansfield, 2015, pp. 120-122).

Technologies

Although there is growing attention for technology among academics and practitioners, studies that show the effectiveness of ICT interventions remain scant (Khosravi et al., 2016).

Some authors find that those technologies are overall effective to alleviate loneliness in both one-to-one and group formats (Cohen-Mansfield, 2015), which was confirmed by a literature review (Hagan et al., 2014) that found that especially new technologies are effective to reduce loneliness among elderly. A meta-analysis of Choi, Kong and Jung (2013) showed that computer and internet-based interventions significantly reduce loneliness among elderly: it helps them to communicate with family, to find news and practical information (Choi, Kong and Jung in van der Zwet & van de Maat, 2016). A systematic review on the effect of ICT on social isolation among elderly shows that ICT use in general consistently influences social support, social connectedness, and social isolation positively. *'ICT was found to alleviate the elderly's social isolation through four mechanisms: connecting to the outside world, gaining social support, engaging in activities of interests, and boosting self-confidence'* (Chen & Schulz, 2016, p. 2). However, the authors also stated that the effect on loneliness was inconclusive, that the positive effect of ICT use on social connectedness and social support appeared to be only short term, and that the results for self-esteem and control over one's life were consistent but generally non-significant (Chen & Schulz, 2016).

From another systematic literature review of empirical studies (Khosravi et al., 2016) we find that certain technologies can be used to reduce social isolation and loneliness amongst elderly. *General ICT* creates more ways of communication and makes sure seniors can communicate with family and friends. A number of studies that investigated this, showed a significant reduction in loneliness. The effectiveness of *social network sites* is inconclusive, and thus more research is needed. *Robots* such as pet robots or conversational agents could help in realising a sense of social presence and communication, companionship through social interaction, and enabling seniors to connect with family members and friends. Numerous studies in this respect show a decrease in social isolation and loneliness. *Video game interventions* could have a positive effect on cognitive and physical stimulation and leads to better social interaction and less loneliness. *A software specifically created for elderly* to support them with respect to social connectivity, memory and leisure activities, also shows promising effects. Further, ICT that is used to evaluate the health status by monitoring, communication and support show a decrease in loneliness. Lastly, the use of a 3D virtual environment seems to alleviate loneliness as well. In sum, ICT seems to have a possibly alleviating effect on loneliness and social isolation among elderly: *'in general, some technologies used to alleviate social isolation and loneliness among seniors have a positive impact on seniors' lives and wellbeing. Possible explanations for studies that show no effect include the methodological quality, poorly*

developed interventions and lack of proper theoretical basis' (Khosravi et al., 2016, p. 601). Thus, more research seems necessary to profound our understanding of the different forms of ICT interventions, with respect to different forms of loneliness and social isolation and personal characteristics.

Various types of interventions

A review (Gardiner et al., 2018) that studied almost 40 studies (with various methods) concerning interventions that aim to tackle social isolation and loneliness found that most *social facilitation interventions,* interventions who have as a primary purpose facilitating social interventions with peers or others who may be lonely, showed some success in reducing social isolation or loneliness. They were often characterised by reciprocity, mutual benefit to all participants and group-based activities. Factors that seem to support the success of those interventions are a supportive environment, a sense of companionship, keeping occupied and creating a sense of belonging. Further, *psychological therapies* have the most robust evidence to tackle loneliness and social isolation according to this review. Therapies such as humour therapy, mindfulness, stress reduction, reminiscence group therapy significantly reduce loneliness and have positive effects on other outcome measures such as life satisfaction. Most of these therapies involve group-based activities (Gardiner et al., 2018). In this respect, a review states that correcting maladaptive social cognition works best to reduce loneliness, in comparison with interventions that address social support, social skills and opportunities for social intervention (Masi et al., 2011). Next, *animal-based interventions* refer to canine or feline animal interventions. Some studies suggest that having a pet could serve as a coping mechanism, possibly by providing social support and companionship. This form of therapy is most effective in an individual setting (Gardiner et al., 2018). However, other research finds no inconclusive evidence that animal-based interventions are effective to alleviate loneliness. A systematic review stated that various studies about this theme were not conducted properly (van der Zwet & van de Maat, 2016). Lastly, *befriending interventions* are a form of social facilitation with the aim of formulating new friendships. They are often one-to-one interventions that involve volunteers. The difference with social facilitation interventions is that the main aim is to support the lonely individual, rather than to promote a mutually beneficial relationship. These interventions are not seldom characterised by problems regarding volunteer recruitment, local rather than national control of projects, and promotions and publicity issues (Gardiner et al., 2018).

Adaptability to a local context and community development

Also, various qualitative studies state that the *adaptability to a local context* is important, particularly if they are implemented by national organisations. Further, a *community development approach* is appropriate which refers to involving service users in the design and implementation of interventions (Gardiner et al., 2018).

The use of volunteers

Increasingly, governments of many European welfare states emphasise informal care to meet the needs of elderly with complex problems and who are socially isolated. They scale back their formal care provision and encourage citizens to fill in this gap by volunteering. In sum, people increasingly need to handle their problems on their own, possible with the help of their informal network. In this respect volunteering organisations play a significant role in supporting those elderly. Indeed, many interventions are carried out by volunteers through 'mentor projects', *'where a trained volunteer (the 'mentor') is paired with someone in a vulnerable situation, one-to-one, for a longer period of time'* (Machielse & Bos, 2018, p. 71).

In this respect, a program evaluation study concludes that *'programs aimed at preventing social isolation are effective when they utilise existing community resources [i.e. volunteers], are tailor-made based on the specific needs of the individual, and target people who can share similar experiences'* (Saito et al., 2012, p. 539). However, another evaluation study of an intervention that aims to make elderly more self-reliant by stimulating

social activities and social contacts, makes clear that interventions based on volunteers have various limitations, certainly with respect to isolated and lonely elderly.

Isolated and lonely elderly often need personal attention and emotional support, and this for a longer period of time. In this respect, it is essential that the volunteers are willing to create a long lasting bond with the older care receivers (Machielse & Bos, 2018). Moreover, those elderly need a relation-based approach where the relation with the client is the starting point of the care, and not the specific form of aid. Within such a relationship, the caregiver/volunteer finds out what is possible and desirable for the client. As a result, professionals are often reserved with respect to using volunteers because those latter needs to possess various qualities which is not given: creating a bond and contact, and aligning to the world of the client, having empathy, detecting problems, faithfulness and perseverance. Moreover, professionals need to be able to trust the volunteers, and have sufficient time to form them, exchange experiences and give feedback (Machielse & Runia, 2013). In this respect, the contact with volunteers is often difficult and characterised by tightening and pushing off because volunteers cannot or do not want to fulfil the expectations of the care receivers. Also, the contact with the volunteer which is mostly restricted in time, often cannot be ended timely. In this respect, it is said that the relationship between elderly and volunteer is better when the reciprocal expectations of elderly and volunteers are aligned. From this follows that accurate decisions with respect to the fit of elderly and volunteers should to be made, taking into account the good relational abilities of the volunteer, but also the willingness to participate of elderly themselves (Machielse & Bos, 2018). In this respect, volunteer coordinators are desirable because they concentrate knowledge about clients, volunteers and professionals (Machielse & Runia, 2013).

4.4 Social exclusion interventions

Based on her PhD dissertation Van Regenmortel (2017) formulates a number of policy recommendations with regard to interventions that aim to tackle social exclusion among elderly. First, since the elderly population is a heterogeneous group and social exclusion is a complex, multi-dimensional concept, one-size-fits-all measures do not work. Indeed, care should be integrative, comprehensive, coordinated, and individualised (Van Regenmortel, 2017). In this respect, a holistic view is essential, just like collaboration in a coordinated and integrated policy approach where case managers are used and multi-disciplinary needs assessments are performed. *'Important is that these policies and interventions acknowledge both the diversity of the older population and the variation in categories of old-age social exclusion and the multidimensionality of old age social exclusion [...]'* (Van Regenmortel, 2017, p. 147). Further, Van Regenmortel states that it is important to start targeting social exclusion through prevention in earlier life stages, since some life events have lifelong influences (Van Regenmortel, 2017). Indeed, until today most policy is very reactive in nature, demonstrated by the relatively small budget on prevention (Gobbens, 2017, p. 25). In this respect, professionals can initiate preventive interventions concerning the concrete lifestyle of elderly because various studies have shown that a healthy lifestyle works preventive for social exclusion. And since the lifestyle of generations differ, the policy recommendation is formulated to create generation-specific policy (Gobbens, 2017). Next, it is important that the target group itself has a say in policy creation, seen the importance of subjective environmental determinants for old age social exclusion: *'By including people in deprived situations in policymaking, not only more insights are gained in these perceptions, but it also strengthens their position and inclusion, consequently, enhancing their power [...]'* (Van Regenmortel, 2017, p. 147). Furthermore, lifelong learning programs are said to enhance social inclusion because they lead to growth in different domains: *'Mainly competences on the individual level, such as increasing mastery, stronger identity and feeling more secure foster their social inclusion'* (Van Regenmortel, 2017, p. 149). Also, the improvement of the financial and material situation of elderly through welfare rights can enhance their quality of life. Finally, environmental factors should be tackled such as criminality rates and municipalities' accessibility. Strengthening service provision at the

local level is essential because older adults tend to age in place, and therefore need to rely on resources available in the local community (Van Regenmortel, 2017).

4.5 Conclusion

This chapter points out that empowerment is a useful framework for dealing with loneliness and social isolation among elderly because it emphasises that elderly who are increasingly confronted with problems on various life domains (psychological, physical, social) can still have mastery over their own situation and the environment. Therefore, it is essential that all actors support elderly gaining control and awareness so that they can participate, and gain a sense of mastery. This will have a positive effect on the determinants of their quality of life such as physical, material, social and emotional well-being, and also on feelings of loneliness and social isolation.

With respect to interventions that aim to alleviate loneliness and social isolation, research (cautiously) indicates that certain characteristics are more often effective than others. First, both group and one-to-one interventions can be effective. Group interventions that provide activities or support are more effective, and also those who emphasise intra-personal resources (self-esteem, coping strategies). It is important to learn from difficult experiences through reflection of a group on a situation, because this leads to more awareness, changing attitudes, (coping) skills and a sense of mastery. Moreover, it is presumed that group interventions have more positive effects on the long term because of its informal aspects (building a social network, having more contacts). A possible negative side effect of group-based interventions is that negativity can be self-reinforcing when multiple persons with a negative attitude are brought together. With respect to one-to-one interventions, we find that they are more effective when the volunteer or social worker share values, culture and background, belong to the same generation and have common interests (~ reciprocity). Third, theoretically based interventions are more effective, just like interventions in which the elderly actively participate, support is given or an educational or training is offered. Fifth, technology (computer and internet based, robots, ...) can have positive effects on loneliness and social isolation because it helps elderly to communicate, find news and practical information, realise a sense of social presence and companionship through social interaction, and it is related to cognitive and physical stimulation. Finally, facilitating social interventions with peers or other lonely elderly can be effective, just like psychological therapies (humour therapy, mindfulness, stress reduction, reminiscence group therapy) and having pets, which is related to social support and companionship.

However, with respect to loneliness and social isolation interventions, it is essential to keep in mind that there is no such thing as *the* elderly: the older population is a heterogeneous one. Furthermore, also feelings of loneliness and social isolation come in multiple forms (e.g. the distinction between emotional and social loneliness, the typology of socially isolated elderly of Machielse), that may each need a different intervention strategy. As a result, one-size-fits-all measures do not exist and intervention strategies must be tailored around the specific situation of the elderly. Intervention strategies should take on a holistic perspective in which not only the specific characteristics of the loneliness and/or social isolation problem (causes, duration, variation, severity, ...) are taken into account, but also the personal characteristics of the elderly (subjective perceptions and needs, coping strategies, motivation, psychological and physical health) and their context (social support, financial situation, ...). Subsequently, based on all this information, an appropriate intervention strategy can be chosen: enhancing social relations, lowering expectations or accepting a discrepancy between the actual and desired situation.

- PART 2 PRACTICES FROM AN EMPOWERMENT PERSPECTIVE -

5 | Inspiring programs

In this chapter we investigate eight programs that aim to contribute to the quality of life of elderly and other vulnerable groups. While it is the specific goal of some programs to alleviate loneliness and/or social isolation among elderly, for other programs this goal is less straightforward. These programs are active in Brussels, and are partners of be.Source which makes it relevant to investigate them since they subscribe to its mission.

We first describe the eight programs extensively to gain a good understanding of their functioning. In the second paragraph we analyse those programs with respect to the general empowerment principles and the empowerment flower. In doing so, we verify if these programs find these principles relevant for their practices, and how they apply them.

5.1 Programs

In this paragraph we describe eight programs that try to improve the quality of life of elderly: their history and goals, the target group, the service and its working mechanisms, and its evaluation and effectiveness.

5.1.1 Atoll vzw[24]

History and goals

> Atoll est un lieu d'accueil qui soutient le maintien des aînés à domicile et qui s'inscrit dans une alternative préventive à l'hébergement en maison de repos.

Atoll is a day centre where lonely and socially isolated elderly who live at home, can spend the day. It was created around the millennium based on the ascertainment that there was a growing need of support in the home environment, and the awareness that the social role and function of elderly needs to be safeguarded.

The goal of Atoll is to support elderly to remain in their homes as long as desired (and possible), and can thus be seen as preventive of going to nursing homes.

Target Group

The target group of Atoll consists of vulnerable elderly of 60 years or older who live in their own home, and who are affected by loneliness and/or social isolation.

In this respect, age is not a criterion of exclusion: lonely and socially isolated persons younger than 60 years old can in some cases also be accepted. Further, exceptions can temporarily be made with regard to living in their own homes: when an elderly needs support entering (or leaving) a nursing home, he can sometimes still go to Atoll to ensure a smooth transition. Last, the professionals of Atoll do not explicitly enquire about the loneliness and/or social isolation of the elderly: this becomes clear during the various informal encounters and activities.

24 The description of Atoll is based on a conversation with Martine Deprez on the 15th of January 2019, and on the website of Atoll (http://www.atoll.be/) which was consulted on the 14th of January 2019.

Most of the elderly at Atoll are vulnerable and characterised by a loss of autonomy (related to mobility problems, difficulties making choices, expressing their opinion and desires, and defending themselves), and do not dare to undertake activities on their own. A lot of them have psychological problems such as anxiety or memory troubles. Nevertheless, a prerequisite to enrol at Atoll is that the elderly are sufficiently valid and able to participate to activities, go to the toilet, eat, ... on their own. It would be too time intensive if the professionals of Atoll needed to help them with this. Further, the behaviour of the elderly may not disturb the group. When their behaviour becomes disturbing after a while (e.g. as a result of severe dementia or depression), the professionals of Atoll search a solution with the elderly (and eventually their family). With respect to the financial situation of the elderly, a social mix is established. This is said to be more enriching, and safeguards a financially stable organisation. While about 40% of the elderly have financial issues and may pay a reduced day price, 60% pays the full day price.[25]

The service and its working mechanisms

Atoll has two locations in Brussels and is open from Monday to Friday (from 9 am - 5 pm). It welcomes about 15 to 17 elderly each day and offers an open space where they can live, participate to activities and meet people between and within generations and cultures. The elderly can also make use of a carpooling service to pick them up at their home in the morning and drop them off at the end of the day (which costs 10 euros a day). From this it is clear that Atoll offers structure which is important since a lot of the elderly have memory troubles. A typical day at Atoll has following structure:

- 9 am: Welcome;
- 10.30 am: Activities;
- 12 am: Meal and free time;
- 2 pm: Activities;
- 3.30 pm: Snack;
- 5 pm: End.

The activities which are organised by an animator of Atoll, volunteers and/or external animators aim to stimulate the resources of elderly, make use of their strengths, and increase their participation and social connectedness. They focus on different aspects such as communication, relaxation, distraction and occupation, learning to use resources, physical and cognitive exercises:

- socio-cultural and recreational activities: organising parties, parlour games, artistic projects, gardening, doing groceries and cooking together, listening to music together, singing, ...
- communicational and cognitive activities: learning new technologies such as emailing, discussion groups, following actuality, information, writing, body, art, philosophy where life questions are discussed, learning English, ...
- physical wellbeing: swimming, exercises, Tai Chi, ...
- intergenerational activities: helping children from primary school with their homework on Wednesday afternoon
- relaxing around a meal and celebrating anniversaries, taking care of themselves (manicure, aesthetic care), ...
- excursions, holidays, going to the cinema, collaborating with the local library, going to conferences, theatre, ...

Atoll does not make specific publicity to find seniors. The seniors are in general referred to Atoll by social services of hospitals, revalidation centres, mental health services, centres that offer care at home, 'Soins Chez Soi', medical centres, pharmacies, ...

25 More information about this day price is given in the following parts.

Atoll asks 25 euros a day from all beneficiaries in order to remain financially stable. This must be paid in advance, which results in less absences and more involvement of the elderly. However, when the elderly do not have sufficient financial means, a lower day price can be set (thanks to the financial support of be.Source). In that case, the social workers from Atoll use their network to create a social file for the seniors, which is among other things based on their revenue. When a lower day price is allowed, the seniors only have to pay 11 euros a day (instead of 25 euros), and 2 euros a day for the carpooling (instead of 10 euros). In that case they must sign a convention in which they state that they will ask the Public Centres for Social Welfare (PCSW) to intervene financially (which is often granted when the elderly only have the minimum pension but is not considered when the seniors are homeowners).

With respect to the working philosophy, first, a person-centred working approach is hold onto. Despite the structure offered during the day, each senior decides for himself at what rhythm he participates to activities, and no individual objectives are imposed on them. However, when the seniors indicate that they want to realise certain goals, they are of course supported. A second characteristic of the working philosophy is the familiar, informal sphere. Atoll is a friendly, warm, colourful and cosy location where people feel at home and secure, and where an ambience of kindness is central. In this respect, the professionals of Atoll greet each elderly in a personalised manner, and all seniors are given a social role (making coffee, cleaning the table, telling jokes, having a special laugh, ...) which improves their self-esteem and general strength. Indeed, the working of Atoll is based on reciprocity between the service and the elderly. This familiar and confidential sphere is also expressed when seniors move from their own home to a nursing home: in that case it can be allowed that they remain going to Atoll one day a week, so the relationship and the structure they received from Atoll is phased out in a smooth manner. Further, the so-called 'lady of the house' ads to the familiar character of Atoll: she is in charge of the living space and is present during informal moments: she sets coffee, talks to the elderly, sets the table, welcomes everybody, makes a walk with them, ... Third, the relationship between the professionals and elderly must be authentic by really listening to their remarks, talking and debating, having respect and having a relationship based on equality. However, professionals must also be able to take emotional distance and make firm decisions. Fourth, the working philosophy of Atoll is holistic. Indeed, the seniors are encouraged to contact specific services that might be able to support them: occupational therapists, social services, services that deliver care at home, psycho-medical services, 'Soins Chez Soi', ... The social assistants of Atoll can help the seniors who need support (e.g. by joining them). The holistic character of the working philosophy is also indicated by the activities which are complementary to each another and are all-encompassing. Moreover, the activities are centred on the daily life of the elderly and thus useful when they are in their own home: learning to communicate and defend themselves verbally, expressing an opinion, making jam at Atoll and taking it home afterwards, ... And although these activities and the general working of Atoll are not explicitly theory based, implicitly they are because they are based on various conversations with experts and the reading of (scientific) literature during the years.

With respect to policy influencing, representatives of Atoll take part in a number of committees to formulate policy recommendations, and sometimes have contact with representatives of the administration and cabinets in order to give their opinion about legislation.

Evaluation & effects

With respect to the evaluation of Atoll, the professionals sometimes hold meetings to evaluate, learn and reflect on the working of the service (for example in the context of an annual report). The seniors themselves are mostly heard on a day-to-day basis through informal contacts where they can state their concerns about for example activities, animators, ... Such discussions with the seniors are also explicitly and proactively opened on specific occasions: when there are problems in the group, when

seniors leave Atoll, after a collective holiday, ... Although statistics are less meaningful given the relatively small amount of beneficiaries at Atoll, the professionals of Atoll do gather certain statistics of their working.

With respect to the effects, it is said that the seniors are very thankful for the services they receive from Atoll. This is indicated by the fact that elderly (who stayed at least three months at Atoll) on average continue to go to Atoll for about two years. Moreover, the reasons why seniors stop going to Atoll, are rarely related to them not willing to go, but rather to sickness, death, hospitalisation, and a move to a nursing home. Further, both professionals and elderly indicate that the seniors often 'do better', and the families also state that the seniors often change during their time at Atoll: they are more relaxed, active, social, have more interests, a tense face relaxes, they talk better and laugh more, are more mobile, take better care of themselves (more hygienic, go more often to the hair dresser) and their self-image improves. Further, the accessibility of care increases because Atoll encourages and supports seniors to contact specific services that could help them (Soins Chez Soi, Belgian Red Cross, ...). Nevertheless, participation outside of Atoll remains very difficult for most participants. From this, we find that many of the mentioned effects are difficult to measure and are mainly based on observations of the involved actors.

5.1.2 Bras dessus Bras dessous[26]

History and goals

> 'Bras dessus Bras dessous aspire à un monde plus citoyen où la société garde les personnes âgées actives en leur donnant les moyens de s'y engager et de s'y épanouir. [...] le project vise à diminuer l'isolement des aînés et leur donner la possibilité de retrouver une place dans la société en créant un réseau de voisinage solidaire'.

Bras Dessus Bras Dessous (BdBd) was created in 2015, and started from the observation of citizens that the elderly in their neighbourhood were seen less and less in the streets. Based on conversations with elderly in their neighbourhood, they found that various factors made that they do not go out: loneliness, general emptiness surrounding them, no meaning or sense to go out, fear of going out, mobility problems, ... Next, based on conversations with professionals of about 30 organisations who are active in the neighbourhood (family help, PCSW, social services of the municipality, medical houses, ...), they also found that professionals often don't have time to drink a coffee or have a chat with the elderly they visit. It is clear that all these factors impact the possibilities of elderly to remain in their own home in a qualitative way. A second observation was that a lot of (younger) people would like to engage more and strengthen the social and intergenerational bond with people in their neighbourhood. As a result, BdBd aims to combine both by creating bonds between lonely and/or socially isolated people and their neighbours in a specific neighbourhood.

BdBd aims to support lonely and/or socially isolated elderly to remain in their own home as long as possible and desired, by stimulating participation and creating intergenerational bonds by bringing neighbours together. More specifically, it is a local initiative which is based on solidarity, where two neighbours regularly undertake an activity together that they would like to share with each other (and which is free of charge). In doing so, BdBd aims to strengthen the network of elderly, improve their health and give more meaning to life.

26 The description of Bras Dessus Bras Dessous is based on a conversation with Céline Remy on the 23 January 2019, on the Annual Report 2017, and on the website of Bras Dessus Bras Dessous (https://www.brasdessusbrasdessous.be/) which was consulted on the 7 February 2019.

Target Group

Within the target group we distinguish between beneficiaries and visitors. At the moment there are about 85 beneficiaries and 115 visitors. However, this distinction is not that straightforward: some beneficiaries can become visitors after a while, and vice-versa (visitors can become beneficiaries).

The beneficiaries must be 60 years or older, live at home, and express a feeling of loneliness or social isolation. In practice, they are between 60 and 97 years old, and the biggest part of them is between 70-89 years old. They all feel lonely and about 50% has no people around them on who they can count (family, friends, ...). A lot of the beneficiaries never go out alone: while about 30% are not able to go out alone, numerous elderly do not want to go out. Further, about 60% of the beneficiaries are accompanied by other professional organisations such as family help, respiratory physical therapy, household support, ... With respect to their financial situation, most beneficiaries only have a small pension (about the revenue of the PCSW or a little more). However, since the financial situation is not a criterion of exclusion, there are also house owners who feel lonely among the beneficiaries.

The visitors are between 20 and 70 years old (in 2017), and the biggest part of them are between 30-49 years old. The fact that a lot of visitors are relatively young is presumably related to the flexibility with respect to the engagements of the visitors (this is explained in a following paragraph). Further, only a very small proportion is 60 years or older.

The service and its working mechanisms

BdBd holds onto a very proactive and outreaching method to look for 'beneficiaries' who feel lonely. In first instance they contacted various professional confidants of elderly in the neighbourhood (doctors, medical houses, social workers of PCSW, family support, Soins Chez Soi, ...), but also small shops (pharmacies, butchers, ...). They informed those actors about the program and handed out flyers and posters. In this respect, it is important that people see those flyers and posters in various places because it takes time before certain beneficiaries dare to take contact or simply realise that they are in fact lonely and need help. After being informed, beneficiaries contact BdBd (in some cases the beneficiaries contact BdBd together with their confidant). Further, BdBd was also physically present in the neighbourhood during five days with a caravan to inform people about loneliness and social isolation and to convince them to make contact with their neighbours. In this respect, it was important to stay several days so neighbours could gaining trust and take time to get to know the program. BdBd also informs the public through information channels (Bruzz, BX1, ...). The 'visitors' were sought through the same channels in the neighbourhood (bakery, small stores, ...), but also through word-of-mouth publicity and publicity in schools, on Facebook, ... The amount of beneficiaries and the amount of visitors grew at about the same rate.

BdBd maintains a person-centred working philosophy: everything starts with the wishes and needs of the beneficiaries. So when an elderly takes contact and expresses a feeling of loneliness or social isolation, BdBd meets that person to understand his personal needs, wishes and desires. Moreover, BdBd makes a file for each beneficiary which contains information about their confidants, which activities they would like to undertake (learning a language, going to the theatre, playing games, going to the cinema, simply being together, going out for a walk, ...), their availability, ... During this conversation BdBd also gives information about which organisations can help the beneficiaries with specific needs BdBd cannot fulfil, in order to work complementary to other organisations. BdBd also has an intake with candidate 'visitors' to gain insight in their wishes, motivations, availability, ... The only engagement which is demanded from visitors is that they sign a convention of voluntary work (which is above all a moral engagement) and that they show a proof of good conduct. BdBd is very flexible with respect to engagements, hours, activities, ... This flexibility makes possible to include more individuals in this program (such as single parent households who only have little time to spare), and may explain why there are more visitors than beneficiaries at the moment.

Next, BdBd matches one beneficiary with one to three visitors. In this respect, their individual preferences (availability, interests, ...) are taken into account to offer a personalised response. The

desire to meet each other and to share an activity is essential for the relationship because it enhances reciprocity (e.g. helping with practical chores or administration). Furthermore, it is very important that participants are clear about their expectations and engagements.

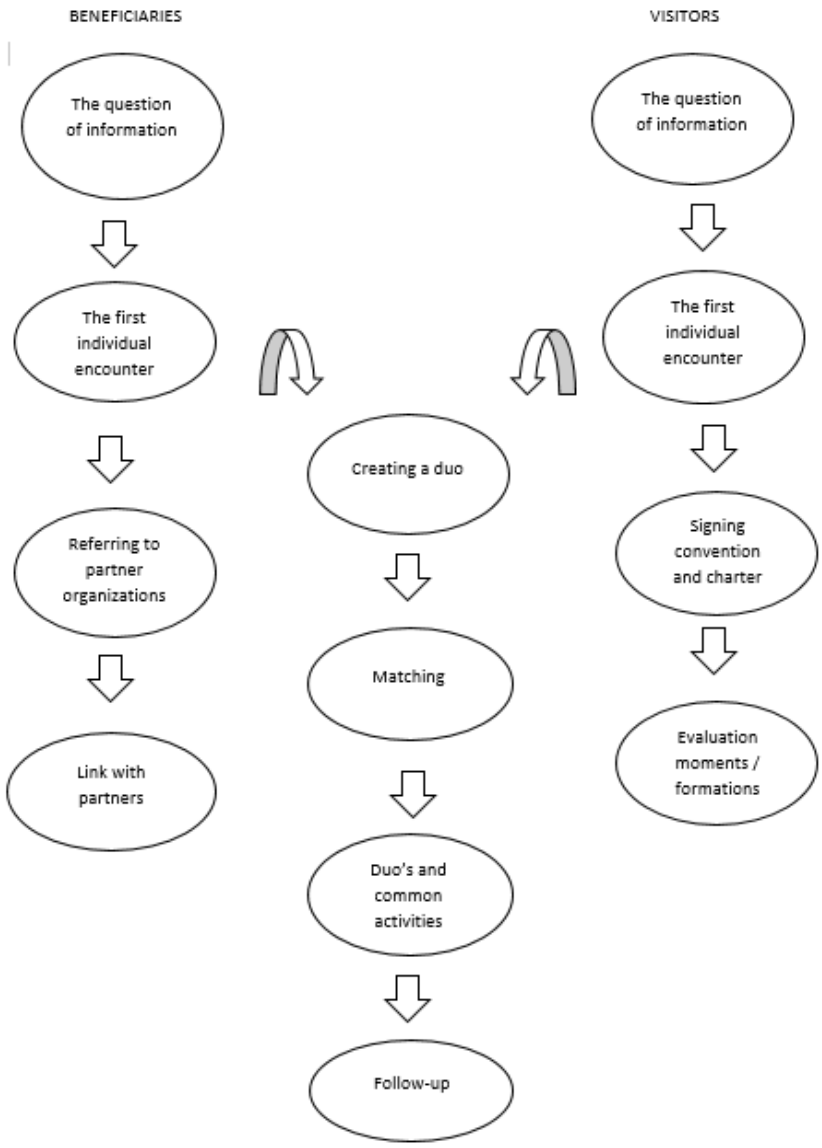
Once a match between two neighbours is made, they meet each other (together with the professional from BdBd) at home, in a bar, a cultural centre, ... The same day or a few days later, both parties indicate to BdBd if they are okay with the other person. If this is the case, they meet each other maximally once a week to undertake an activity together. After the first week, BdBd takes contact with both parties to find out if they met each other again, and how it went. This happens again one or two weeks after that. From that moment, if everything went well, BdBd verifies on an irregular basis if the encounters go well (once every month or every two months). BdBd also sporadically meets for example social workers that referred certain beneficiaries to BdBd, to evaluate their situation.

Every two months the visitors are invited to a meeting where they can share their experiences and where external speakers are sometimes invited to speak about relevant themes. During those meetings BdBd also informs the visitors about the program (cost, numbers, activities, ...). Further, BdBd is planning to organise a number of formations visitors can follow, to learn to deal with certain situations (talking about death, ...).

In order to enhance communication between all actors who surround a beneficiary, BdBd uses the ICT tool 'Famidesk'. Through this tool, all involved actors (beneficiary, visitors, their doctors, children, nurse, ...) can communicate with each other and send messages to all participants around a beneficiary, or simply to one person in specific. By doing so, they can for example make sure two people do not visit the beneficiary on the same day, in order to spread their contacts. Since older beneficiaries not always have access to internet, they often do not use this application. Moreover, their accord for the use of this application is not specifically asked.

From the above, it is clear that BdBd follows a certain structure with both beneficiaries and visitors, which is shown in the Figure 5.1.

Figure 5.1 Structure of Bras dessus Bras dessous



Source Annual Report 2017

There are no specific objectives formulated with respect to the encounters between beneficiaries and visitors. The overall goal is to create a social bond between people. Hence, the program does not really concern volunteering, but is rather a local, informal initiative where neighbours get to know each other, which enhances a dynamic in the community. The fact that there is no money involved adds to the creation of real connections between neighbours.

BdBd also organises 'Soup workshops' once a week where all neighbours can get to know each other in an informal manner while eating soup. Sometimes the elderly are joined by their younger neighbours, other times they come alone. During these 'Soup workshops' (for which BdBd works together with a food store in the neighbourhood), local actors are also invited to talk to the beneficiaries about their specific projects. A number of Muslim women of the neighbourhood were for example invited to discuss their cultures, differences, ... which resulted in a number of them entering the program. BdBd also organises other initiatives: an annual meal, going to the sea for a day and intergenerational activities such as going to the cinema with younger neighbours or helping children

with their homework. But although these group activities have an added value, they are not the 'core business' of BdBd because a lot of socially isolated elderly do not want to participate in group activities, or even state that they do not want to be around other 'old people'.

Last, BdBd informs politicians by inviting them to the 'Ateliers de soup'. This is important because BdBd does not receive structural aid, and must seek new subventions every year. Therefore BdBd also wants to better measure the social impact of their program (via quantitative indicators) to prove its effectiveness and to find more resources.

Evaluation and effects

In order to evaluate their working, BdBd organises meetings with the visitors where they discuss what goes well and what does not. In January 2018, the beneficiaries were also invited to talk about their perspectives on the current and future program. This ad-hoc analysis was necessary because the growth of the program imposed certain questions about its future. Although the beneficiaries are further not structurally implicated in the process of BdBd, informally they are often asked about their perspectives. During these encounters, the beneficiaries can clarify their needs and wishes, which for example led to the creation of the 'Soup workshops'.

With respect to the effects for the beneficiaries, BdBd states that beneficiaries use less medication, go less often to the doctor and use less respiratory physical therapy. Moreover, they are said to be happier and their self-image and mental health presumably improves. Some elderly go out again (after being literally indoors during multiple years), put on make-up again, better take care of themselves, ... Further, certain pairs start calling each other on their own and again took contact with their children, which indicates that they start socialising again on their own. Also, the beneficiaries can stay longer in their own homes. Other positive indicators are that some beneficiaries became visitors after a while, and that about 80% to 90% of the pairs never stopped their visits. With respect to the effects on (often lonely) visitors, the program increases their social life by going out more, and makes them feel better by helping others and giving meaning to their lives, which in turn improves their health. Various visitors like to participate to the 'Soup workshops' and the meetings to get to know their neighbours.

5.1.3 Compagnons Dépanneurs vzw - Senior in action[27]

History and goals

> 'Compagnons Dépanneurs a pour objet d'intervenir sur le plan matériel auprès des déshérités, ainsi que des homes et organisations quelconques qui sont dans la difficulté et qui, par manque de moyens financiers, ne peuvent vivre dans la norme [...] et d'encourager les bonnes volontés latentes des jeunes et moins jeunes et de les réunir dans un effort bénévole qui épanouira tant les aidants, que les aidés'

Compagnons Dépanneurs (CD) was created in the 1970s and is acknowledged as an organisation in the social economy sector that supports the insertion of people through housing. CD is active in eight different sections in Belgium and consists of 19 salaried workers and 264 volunteers in total, of which 6 salaried workers and 143 volunteers in Brussels. The 'Senior-in-Action' program was created in 2013 in Brussels (with subventions received from be.Source). Although this program has the objective to specifically help seniors in need by appealing to older volunteers, in practice non-seniors are also accepted.

27 The description of Compagnons Dépanneurs is based on a conversation with Cécile Nyssen & Didier Vanderton (on 17 January 2019), the annual report of 2017, and on the website of Compagnons Dépanneurs (http://compagnonsdepanneurs.be/) which was consulted on 16 January 2019.

The first objective of CD is to stimulate people living healthy and decently, by letting volunteers perform small works in their rented homes. A second objective is to valorise the volunteering of the often socially isolated seniors, who can remain socially integrated through their volunteering.

Target Group

Les Compagnons Dépanneurs visent toutes les personnes en difficulté, quel que soient leur âge, leur sexe, leur religion, leur nationalité, leur culture, leur appartenance politique, leur situation familiale ou sociale. Le seul critère qui intervient est celui des revenus: les personnes bénéficiant du revenue d'intégration accordé par le CPAS ou ayant une revenue de même valeur (pension, mutuelle, ...) peuvent bénéficier de l'aide de l'association.

The beneficiaries are people who are characterised by a financially precarious situation, which is the only criterion taken into account. It concerns people who do not own a home and who receive the minimum income of integration from the PCSW (or an income of the same amount through a pension, unemployment, ...). In practice, the target group consists of people who often feel lonely: although they take contact with CD for practical works, this demand often conceals a need for social contact to break through the loneliness.

The volunteers who perform the works for the beneficiaries need certain technical competences, but also sufficient empathy, social intelligence and motivation. The only engagement asked of them, is that they perform the works that were agreed upon. Since the works are performed during weekdays and working hours, the volunteers seldom have a professional occupation: they are often (pre-)pensioned, unemployed, people who live from a mutual insurance, ... They are between 15 and 90 years old: about 50% of the volunteers are 55 years or older, which means that 50% are younger. Moreover, each month certain schools send a few youngsters to help painting or with other works related to 'social work'.

The service and its working mechanisms

Sometimes CD is asked for help by the beneficiaries themselves, but more often this is done through the PCSW, social services of hospitals, mutual insurances, nursing homes, other associations such as Atoll, word-a-mouth publicity, ... In this respect, we find that it remains difficult to find hard-to-reach groups who aren't known by official institutions. And when CD is not able to perform certain works, the beneficiaries are referred to organisations who might be able to help them.

Although the working hours are free of charge, the beneficiaries must pay a specific amount depending on the work which covers material, insurances, transport, vehicle, ... CD performs following works:

- painting (by salaried workers);
- plumbing, electricity, small reparations of various sorts such as repairing a leak, setting up a dressing room, repairing the doorbell, ... (by volunteers);
- storage of furniture and clothing (of primary need) that was donated and subsequently sold to beneficiaries at a low price;
- collecting the furniture which is donated and delivering it to the beneficiaries who buy it;
- helping when people are moving (with the possibility to rent a van, and make use of a driver).

CD looks for volunteers through various information channels such as journals, the platform of volunteering and television. When a volunteer presents himself, CD will enquire about his motivation, capacities, ... during a first conversation.

Each work at the home of a beneficiary will be done by two volunteers, of which often one has more knowledge and/or skills through which the other one can learn. While the volunteers perform

the works, they talk to the beneficiaries who often have various practical questions. When the volunteers do not have an answer, they talk it over during lunch at CD and afterwards inform the beneficiaries. While doing the works, it is essential that the volunteers are polite and do not insult or hurt the beneficiaries (e.g. saying their home is dirty). In general, the relationship between volunteers and beneficiaries is very positive: volunteers often stay to chat with the beneficiaries who welcome this social contact, and sometimes beneficiaries even give chocolates to the volunteers out of gratitude. However, sporadically there are problems and then the beneficiaries complain for example that the work is not done properly.

The successful functioning of CD is determined by the spirit of the organisation which is characterised by conviviality, generosity and solidarity. In this respect, after having performed a work volunteers and professionals often have a meal together at noon. This social contact motivates them. Further, CD sporadically organises formations (about technical aspects, poverty, first aid, ...), an annual meal, twice a year a team reunion with professionals and/or volunteers, and a teambuilding activity which also contributes to the team spirit.

Last, although policy influencing is not an explicit objective, CD participates to various discussion groups to express their opinion about certain subjects.

Evaluation and effects

Various quantitative information is gathered for the annual report, such as the number of volunteers, the different types of works that were done, the hours worked by both professionals and volunteers, the number of beneficiaries, ... In this respect, it is important to bear in mind that both the time spend and the level of difficulty of a work strongly depend on the specific situation. Furthermore, it is very difficult to measure the overall aim which is social in character. Further, there are no explicit evaluations undertaken (e.g. in the form of a written or telephone survey) with the beneficiaries and/or volunteers about the working of CD.

With respect to the first objective, namely improving homes by doing works, there is no explicit evaluation to verify if the works are performed well. Nevertheless, CD sporadically receives a telephone call or letter in which beneficiaries express their gratitude and beneficiaries not seldom appeal to CD again which is an indication that the previous works were well performed. Further, the volunteers talk during lunch about their works and how they went, and thus informally exchange information. They also fill out a form with information about how the service went, how much time it took, ... According to CD the beneficiaries are helped in a material way which leads to more happiness.

According to CD, the second objective, valorising the work of the volunteers, is also realised. Although alleviating loneliness and social isolation are no explicit goals, this is presumably indirectly realised (because volunteers have more social contacts), just like other positive effects of volunteering on the health of the volunteers.

5.1.4 BuurtPensioen[28]

History and goals

In 2013 the 'BuurtPensioen' was created in Brussels, based on the belief that people could be strengthened by creating more social bonds and connections. The 'BuurtPensioen' is a local network of neighbours who support each other in their daily lives, according to their own possibilities. In this respect, reciprocity and solidarity are of paramount importance because they give people a place in

28 The description of the 'BuurtPensioen' is based on a conversation with Charlotte Hanssens (on 25 January 2019), and on the Cahier 'het BuurtPensioen groeit' (4 January 2018) by Charlotte Hanssens & Stefaan Vermeulen – Kenniscentrum WWZ.

society and give meaning to life. By helping each other and simply being together, people start to take initiatives which results in a dynamic social network that alleviates social isolation.

The goal of the 'BuurtPensioen' is to alleviate social isolation and loneliness, by helping each other and making each other more resilient.

Target Group

Although everybody is welcome to participate to the 'BuurtPensioen', the focus lies on elderly and depending on the needs of a municipality also on other groups (people with a handicap, single parents, ...). In practice, most participants feel lonely and are vulnerable on various life domains. It often concerns older people, one parent households, people with a handicap, migrants, ...

The 'BuurtPensioen' which consists of various networks in Brussels, expanded the last few years: in 2017 there were about 200 participants with a mean age of 70.

The service and its working mechanisms

To realise a network of the 'BuurtPensioen', the professional works together with a local partner (such as a social restaurant, a cultural centre,) to promote the program and to look for participants. This is important because those partners know the neighbourhood and have the trust needed to stimulate neighbours to participate. Moreover, they often let the 'BuurtPensioen' use their infrastructure. Further, the professional also makes publicity for the program by contacting all relevant actors in the neighbourhood such as small shops, PCSW, ... During this time intensive process of starting a network, the professional also searches volunteers who can coordinate the network. Working with volunteers is found (in France by *'Les Petits Frères des Pauvres'* where the program got its inspiration from) to be more effective, self-regulatory and more dynamic. When networks are coordinated by a paid professional, participants are said to take on a more dependent stance based on the idea that the professional will take care of all problems. Therefore, the 'BuurtPensioen' employs only a few professionals who support volunteer-coordinators who themselves coordinate the networks. At the start, the professionals set up and coordinate an antenna until they find (preferably two or three) volunteer-coordinators who can take over.

Once a number of neighbours present themselves, the volunteer-coordinator (or professional) takes the time to meet them individually to understand their motivations, desires, wishes, ... In this respect the participants also state which support they need or can offer. Often it concerns small, practical support with things which pose big problems for the elderly but that can often be easily solved: holding each other company, letting a dog out for a walk, giving each other a lift, playing a game, helping with administration, accompanying each other to an appointment, doing groceries together, ... During this conversation the professional also explains the working of the program, the do's and don'ts, that nothing is guaranteed, ... Since trust and security are essential in a network, these conversations are important to verify the intentions of the participants. The only engagements asked of the participants is that they are honest, go to the meetings and do not gossip about other participants. In this respect, the participants also need to sign a volunteering contract and show proof of good conduct. And when the 'BuurtPensioen' is not able to help participants, they refer them to other organisations that might be able to help them.

Next, the volunteer-coordinator aligns offer and demand, based on the individual preferences of the participants. In this respect, they use 'time banking': each time a participant offers help, the volunteer-coordinator should register this in hours (not in money because all tasks are considered equal) which can be used by those participants to ask for help themselves. However, in about half of the cases the support is not registered because the participants do not necessarily want something in return for their support. But since this registration is important (for follow-up, insurances, showing the impact of the program), the 'BuurtPensioen' wants to create an application to make this registration easier. And after each encounter, the volunteer-coordinator verifies if all went well for both parties.

Further, the volunteer-coordinator also organises monthly meeting moments in a cultural or social centre in the neighbourhood where all participants can come together and drink something. During those meetings, the agenda is discussed and participants talk about last months' exchanges: what they did, what went well and what did not go well, if the matches were good, new demands and propositions, ... About 10 to 40 people participate to those meetings which also serve as an inspiration for others with respect to activities that can be undertaken: this is important because various members do not know what to do about their loneliness. These monthly meetings stimulate the desire to participate and creates trust within the whole network.

Once an antenna has about 30 participants, it starts to live: people get to know each other and support is often offered more spontaneously. While people in the beginning get into contact with each other via the volunteer-coordinator, after a while a bond is created, numbers are exchanged and people contact themselves. A young lady for example contacted two other persons on her own, who now all go to the theatre together. In doing so, the strict boundaries become vague sometimes: is going to the theatre together still support? This clearly illustrates how the 'BuurtPensioen' starts from support and slowly creates a real social network and social cohesion in the neighbourhood. Nevertheless, the neighbourhood support always remains important because the participants still like to meet other people.

The volunteer-coordinators are very engaged and motivated and have a principal role in a network: they are the first contact persons, do the matching and administration, and are the face of the antenna. They enrol new participants (intake conversation, noting information in excel, signing documents (volunteering contract, proof of good conduct, ...), follow up participants (content, time banking), permanence (tasks, trust, cosiness) and organise monthly meetings (goals, agenda, approach). Further, they organise the communication of goals and instruments both intern and extern (newsletter, flyers, ...), maintain and create relations with local partners and create a bond with the participants (listening, setting limits, ...). In this respect, all volunteer-coordinators receive a formation trajectory when they start. Furthermore, volunteer-coordinators (and participants) can sometimes follow courses about specific themes (e.g. 'how to deal with depression'). And about three or four times a year, all volunteer-coordinators of the different networks are brought together to exchange experiences, talk about the functioning of their antenna, learn how to motivate elderly to participate, ... The same is done with respect to the local partners who are also brought together once or twice a year to talk about the program. Last, the beneficiaries are also implicated during a meeting once a year to evaluate the 'BuurtPensioen'.

The 'BuurtPensioen' is different from various online initiatives where they simply align offer and demand because they offer a personal touch: appealing to motivated local partners who help finding participants, taking the time to listen to and motivate participants and volunteer-coordinators, having physical contacts with the participants, ... This personal touch is all the more important because the target group consists of vulnerable elderly who often need to gain trust and confidence before willing to participate and be implicated in the program. Therefore, slowly working to create social cohesion is more important than simply aligning offer and demand. This personal touch also contributes to reciprocity, which is essential for the participants who are often very dependent on others. By taking the time to listen to participants, it becomes clear what they can offer (even when they say they do not have anything to offer). Moreover, thanks to this reciprocity, people more easily ask for help themselves.

Evaluation and effects

To evaluate the working of the 'BuurtPensioen', no strong evaluation methods are applied: the evaluation is mainly based on observations of the involved actors. Nevertheless, the 'BuurtPensioen' states that the participants form new relations, and participate and engage more to society which tackles their social isolation and alleviates their loneliness. By participating and helping each other, they

become happier, feel more valuable, gain self-confidence and self-esteem, and their health presumably also improves. Further, they learn new skills through the courses that are given (e.g. 'setting limits when helping others'), and the accessibility of care is presumably improved by referring participants within their network.

5.1.5 Belgian Red Cross[29]

History and goals

In 2008 the Belgian Red Cross created a specific program that appeals to volunteers who are willing to regularly visit elderly who express a feeling of loneliness during one or two hours, and this both at their home or in a nursing home.

The overall goal of the program is to alleviate loneliness and social isolation, and to make elderly feel better.[30]

Target Group

The target group consists of vulnerable elderly who feel lonely (but are not necessarily socially isolated). If the senior says he is lonely, the Red Cross trusts this to be true. And although age is not a criterion of exclusion, priority is given to elderly. Not surprisingly, most of the beneficiaries are 80 years or older, and the group of beneficiaries of 90 years or older increases.

Most volunteers are 50 years or older (and must be at least 18 years old), but younger people increasingly also want to volunteer. In general, they are very motived to help the beneficiaries and are sensitive with respect to old age exclusion. At the moment there are about 150 volunteers active in Brussels.

The service and its working mechanisms

At the start of the program in 2008, the Red Cross mainly focused on alleviating loneliness through individual visits. However, based on a lecture of scientific literature which is said to state that the social network is essential to combat loneliness, the Red Cross since recently tries to shift the focus: besides the individual visits, they now also increasingly stimulate elderly to strengthen their network. In this respect, the volunteer is a facilitator to broaden the network by accompanying elderly to associations, going to the cinema, visit friends and family, participating to social activities in the nursing home, ... In this respect, the Red Cross also has the idea to organise collective visiting moments in nursing homes where residents and their visitors can come together and have the opportunity to get to know each other better as neighbours. Not only is this shift presumably more efficient, it also makes it possible to appeal to volunteers who only want to do group activities.

Two professionals of the Red Cross organise this specific program in Brussels. They are responsible for the publicity and communication, the relations with other partner organisations, recruiting volunteers and beneficiaries, supporting volunteer-coordinators, supervene the functioning of teams and regions, ...

The Red Cross searches volunteers through different communication channels: 'Platform of the volunteers', collective information sessions of the Red Cross, information sessions in municipalities, publicity in nursing homes, ... With respect to beneficiaries who live in nursing homes, the Red Cross has protocols with eight nursing homes in Brussels: the personnel of those nursing homes detect the lonely and socially isolated elderly that are subsequently visited by volunteers. Elderly who still live in their own home are often referred to the Belgian Red Cross by social workers from the PCSW, the

29 The description of the specific program of the Belgian Red Cross is based on a conversation with Catherine Souchon (on 15 January 2019) and on the website of the Red Cross (https://www.croix-rouge.be and https://www.rodekruis.be/), which was consulted on 21 November 2018.

30 In what follows, we speak of 'Belgian Red Cross' only to refer to this specific program.

municipality, medical houses, ... or by their family. Sporadically they take contact with the Belgian Red Cross themselves. In this respect, it remains difficult to reach hard-to-reach elderly who do not come into contact with those services.

When a volunteer presents himself, the professional of the Red Cross has a conversation about his availability (time and geographically), motivation, which activities he wants to do, ... Although no long term engagements are demanded of the volunteers (the Red Cross works with what the volunteers are willing to offer), it must be worth the effort to organise the visits. This means that the volunteer must regularly make a visit and must be clear about his engagements: if they are only available for a few months, they need to clearly state this. In general, the professional tries to assign two volunteers to one elderly so the visits are not abruptly interrupted when one volunteer falls out.

Next, the professional matches a volunteer and beneficiary (based on their individual preferences) and joins them during the first visit where they present themselves. In general, volunteers simply spend time with the elderly during the visits: play a game (cards, scrabble), drink coffee and talk, offer a little service, ... The volunteers do not offer practical support (doing groceries, medical aid, cleaning, ...), but can do certain tasks *together* with the elderly. After the first few visits, the volunteer reports to the professional how the visits went. Only if they did not go well, the professional calls the beneficiaries to gain insight in their perspectives on the visits. In this respect, the professional of the Red Cross admits that it would be better if the beneficiaries would systematically be contacted after the first few visits, but that the lack of means makes this impossible.

Volunteering is not always easy because volunteers need to deal with a lot of repetition and difficult conversations (e.g. about mourning and suicide). Therefore, they need to be balanced and motivated to help, have respect for the beneficiary, not judge them, and accept them how they are. The latter is essential since the program starts from the needs of the elderly themselves, which forms the basis for a good relationship. Although volunteers on the one hand learn 'to volunteer' in practice by experience, formation is also important. In this respect, each starting volunteer gets an introduction of about 3 hours, and the Red Cross sporadically organises meetings with the volunteers during which they receive a course about a specific theme (e.g. 'suicide', 'loneliness', 'cognitive problems'). Furthermore, volunteers sporadically come together to share experiences, talk about what works and does not, and how to deal with difficult situations. These meetings are important because they lead to social cohesion among the volunteers. Regrettably, financial constraints and the lack of adequate meeting rooms in certain municipalities make it impossible to organise such meetings for all volunteers on a yearly basis. The Belgian Red Cross neither organises meetings with the beneficiaries to share experiences and evaluate the program.

Last, although the goal of this program is not to explicitly influence policy by pleading for specific measures, sometimes meetings are attended with council members who can facilitate certain actions (e.g. publicity through journals of the municipalities, ...).

Evaluation and effects

The Belgian Red Cross undertook a telephone survey in 2018 among its volunteers and beneficiaries to evaluate the program. Although the survey with the volunteers did not deliver a lot of new insights, the survey with the elderly showed that about 80% of them are content with the visits and the volunteers, and that a lot of elderly want to participate more to collective activities. Based on that survey it is said that the beneficiaries are more content and have a higher wellbeing which is indicated by them better taking care of themselves (putting on make-up), going out again, saying in a lesser degree that they want to commit suicide, ... However, there is no detailed information available about the effects of the visits (e.g. if elderly feel better afterwards isn't measured in any way). In this respect, the criteria to measure the effects of the visits could be ameliorated.

5.1.6 Soins Chez Soi vzw[31]

History and goals

In 1984, Soins Chez Soi (SCS) was created on the initiative of a few doctors who observed that their patients often had problems on various domains (social, psychological, housing, financial, ...), but that they did not have enough time to deal with those problems. Therefore they engaged a social worker who could attend to those needs. Over the decades, this idea further developed into SCS becoming a centre of coordination of care and services at home that coordinates all the different actors around an individual patient. This is necessary because the lack of connections between different sectors impedes care delivery. In sum, SCS creates a well-balanced plan of care and services together with the beneficiary, which starts with the needs of the beneficiary who is characterised by a loss of autonomy.

The overall objective of SCS is to support people remaining at home, avoiding a hospitalisation or institutionalisation (in nursing homes), or leaving a hospital. At the moment the SCS consists of 12 salaried professionals who engage numerous independent professionals of various professions (nurses, ...). Each year about 25,000 services are delivered for 10,000 patient.

Target Group

All people who are characterised by a loss of autonomy and who live in one of the 19 municipalities of Brussels can make use of the services of SCS. Further, there are no criteria of exclusion.

In general, the target group consists of older persons (between 70-90 years old), families with temporary difficulties, persons who need support after a hospitalisation, persons who want to avoid going to a nursing home and persons with a handicap. There are a little bit more women than men. Further, the target group is often lonely and socially isolated which is related to reduced mobility, physical problems (falling, difficulties walking, ...), not feeling safe in their neighbourhood, not having good moral, feeling tired, lacking energy, and financial difficulties.

The service and its working mechanisms

Beneficiaries are often referred to SCS by doctors, family members, professionals in hospitals, ... and sometimes take contact themselves. Hospitals for example often call SCS when a patient must leave the hospital, but needs support in their home situation. Once SCS is called, they take over and handle the whole situation.

In general the beneficiaries need specific care (nurse, respiratory physical therapy, pedicures, podiatry, psychologists for informal caretakers, ...) or services (social accompaniment, household support, meal delivery, ...). In this respect, SCS first analyses the demand carefully. Hereby SCS holds onto a holistic vision whereby not only attention is directed towards the physical health, but also to psychological and social wellbeing, for example by supporting beneficiaries with respect to housing, mistreatment, access to care, ... Subsequently, SCS contacts its network of independent professionals who will attend to the care needed.

However, when the coordinators of SCS are presented with a difficult case (e.g. people with alcohol dependency or psychiatric problems who have difficulties talking about their situation over the phone), specific social workers of SCS will take over and handle the case. Those social workers will make a home visit to clarify the real needs of the beneficiary and propose solutions, and eventually also involve other actors (the partner, family, psychologist, doctor, nurse, ...) in this process. In this respect, the social worker ensures that all actors are on board and regard problem and solution in the same way, in order to create a relationship based on confidence. This home visit ultimately results in a personalised and well-balanced plan of care and/or services. If possible, SCS organises the care and services in a desired way: when it concerns a lonely or socially isolated beneficiary, they try to spread

31 The description of Soins Chez Soi is based on a conversation with Catherine Ballant (on 21 January 2019).

the care over different days so the beneficiary sees somebody every day. Also, SCS tries to find a 'strong' nurse when a heavy beneficiary needs a nurse, when a Muslim woman wants female caretakers they will try to realise this, or they will take into account the language of the caregiver. This personalised service is made possible through the knowledge of SCS about the working hours of the professionals, in which municipalities they are active, what their specialisation is exactly, ... Subsequently, the care plan is send to the beneficiary, the other actors who were present at the meeting, and to the doctor of the beneficiary (because he is a confidant and often better placed to monitor the wellbeing of the beneficiary). Next, SCS sets this plan in place and sporadically evaluates it by calling the beneficiary and asking if certain services or care could be improved. In sum, SCS offers a very personalised service that starts with the real needs of the person, by each time offering and adding a new service, sometimes cancelling a service who is no longer needed, ...

With respect to the cost, the beneficiaries do not need to pay anything for the coordination offered by the coordinators or social workers of SCS, and thus only need to pay for the care and services. In this respect, the independent professionals (with who SCS has a convention) follow the nomenclature of the Health Insurance. And when it concerns for example services like a hairdresser, a price is agreed upon before organising the service.

A first advantage is that SCS holds onto a person-centred working approach by taking the time when analysing the needs of the beneficiary. This is necessary to detect the real needs which are not always expressed during the first encounters, and sometimes only become apparent after a while (e.g. loneliness). This approach clearly distinguishes SCS from websites where offer and demand is aligned in a very general manner which can lead to mistakes which may cost more in the end. This person-centred approach is also indicated by the personal file SCS has on all its beneficiaries. Thanks to this file, beneficiaries can ask for the same nurse that already helped them a few years earlier and with who they had a good connection (or the contrary avoiding a certain professional). This file also allows SCS to detect that a beneficiary who complains about a nurse, has already made use of five different nurses (which could be an indication that it is not the nurses but the beneficiary who poses a problem). Through this personal file SCS can also verify if care was in fact delivered, when a senior with dementia for example says that a professional did not show up.

Another advantage of SCS is their social network and knowledge of the care organisations in Brussels. When a beneficiary has for example no money to pay for health care, they contact the PCSW to see if it is possible to obtain a 'health card' so that person nevertheless can get the care he needs. Or when a social house which is organised by the PCSW of a municipality is not healthy, they contact the PCSW to solve this problem. Furthermore, SCS for example stimulates lonely or socially isolated beneficiaries to create social bonds and expand their social network by having their meals in a social restaurant in the neighbourhood, by making contact with their neighbours, by making use of services of Atoll, the Belgian Red Cross, ... Further, SCS is very aware of which services are active, how they work and if they deliver quality or not. When SCS receives complaints about a professional for example, they will verify if they are justified (by contacting both parties), and if so discuss this with the professional and encourage him to do better (by giving him a warning).

SCS evaluates about 10% of the cases systematically and always investigates complaints. Although there are no structural meetings with beneficiaries to evaluate the process, everything is done with the accord of the beneficiaries and thus all steps are always informally evaluated. SCS also organises courses (to learn about certain subjects) and meetings with people from the same profession to share experiences and learn. Further, SCS has a newsletter, a New Year drink, and some other possibilities where actors can meet each other.

Within the realm of SCS, a new program was created in 2016 (with funds from be.Source). This program has as a goal to return 'dignity' to seniors who do not take care of themselves. The target group consists of people of 55 years or older with limited financial means, who often have a lack of self-confidence, courage and energy, and who are often disconnected from society. When the coordinators from SCS receive indications that beneficiaries of SCS can barely pay their medication or

meals, are not hygienic, ... they can propose them to make use of this specific program. In this respect, the beneficiaries can not only make use of the coordination of care and services by SCS for free, but can also use certain services for free such as podiatry, hairdresser, cleaning the home, ... By stimulating those beneficiaries to take care of themselves, it is hoped that their self-confidence, feeling of control and independence improves and that they start taking care of themselves again. In this respect, SCS also stimulates beneficiaries to create social bonds by appealing to Atoll, the Belgian Red Cross, Taxistop, Bras Dessus Bras Dessous, ... However, since the goal is not to support those people on a long term basis (through free services), this support is phased out after a while, which gives other people also the possibility to make use of this service. In this respect, it is said that while the beneficiaries are in general happy with this program and some of them are stimulated to take their lives back into their own hands, for others this remains very difficult.

Last, although the goal of this program is not explicitly to influence policy, SCS does meet policy-makers, is active in work groups, collaborates with other associations, ... to give its opinion on policy.

Evaluation and effects

Although the effects of the program are not evaluated with the beneficiaries in a structural manner, this is done informally on a day-to-day basis. In this respect, it is said that various social costs are avoided (nursing homes, hospitalisation, ...) by supporting people to remain in their own homes and neighbourhood, where they receive more visits and have a more balanced social life. Furthermore, there are presumably also positive effects on people's health because the beneficiaries are strengthened by remaining master of their choices.

5.1.7 Mobitwin[32]

History and goals

In 1975 Taxistop was created: this organisation strives to do 'more with less' by using resources that are not fully made use of (e.g. through car sharing). Taxistop tries to impact society by ameliorating the environment, lowering costs, improving health, ... and wants to make its services accessible to as much people as possible.

Within the framework of Taxistop, the first bureaus of Mobitwin were developed in 1982, based on the idea that time is sometimes underutilised and could be spend differently to help fellow citizens. On the one hand there is a considerable demand for social transportation (for family visits, doing groceries, going to the doctor, ...) by (often older) people with mobility problems who are unable to use public transportation and who cannot afford a taxi. On the other hand, numerous people have a car and time to spare through which they could help those people with mobility problems. Based on this observation, the locally situated bureaus of Mobitwin align offer and demand with respect to volunteer-drivers who are willing to accompany people with mobility problems to their destination and back.

The goal of Mobitwin is to tackle social isolation among both volunteer-drivers and their members by making the members mobile again and so creating more social participation. In doing so, they aim to realise a mobile society which is based on solidarity.

Target Group

Members of Mobitwin must have mobility problems and a low revenue. In this respect, the bureaus of Mobitwin trust their members to in fact have mobility problems, which works well because people are not keen on demonstrating their vulnerabilities. With respect to the revenue, the income may

32 The description of this progam is based on a conversation with Sandrine Vokaer (on 11 January 2019), the website of Mobitwin (https://www.mindermobielencentrale.be) which was consulted on 10 January 2019, and on the publication 'Mindermobielencentrale Post' (number 100 July/August/September).

maximally be two times the income of the PCSW. Volunteer-drivers must have a car, be available a few hours each week, and reachable through telephone. Nevertheless, volunteers determine themselves when they are available and if they are willing to do a specific trajectory. Although the majority of both members and volunteer-drivers consists of elderly, younger individuals also apply more and more. Both members and volunteers are mostly persons who do not work because of retirement, unemployment or invalidity.

72% of the municipalities in Flanders have a bureau of Mobitwin, and in Belgium there are about 35,000 members and 2,900 volunteer-drivers.

The service and its working mechanisms

To start a bureau of Mobitwin, Taxistop generally contacts a specific municipality, a PCSW or another organisation with the question if they are willing to organise a centre in their region. If this is the case, that organisation engages a coordinator (or volunteer-coordinator) who will manage that centre: looking for members and volunteer-drivers, aligning offer and demand, motivating all actors, ... That organisation also pays 80 euros each year to Taxistop so it can use its services: the software for the administration and matching, the formation of the coordinator for using that software, the insurances for volunteer-drivers and members (members are insured for damaging the car), working materials such as driver cards, kilometre books, membership cards, and a helpdesk which is reachable during office hours.

The coordinator uses various local communication channels to look for members and volunteer-drivers: local papers of municipalities, 'the volunteering platform', bridge clubs, libraries, social workers of the PCSW or services that offer care at home. In practice, members are also often informed about Mobitwin by their children, and once a centre gets going people inform each other through word-of-mouth publicity. Since younger people increasingly volunteer, Mobitwin will open their communication channels to better reach that group as well. The importance of this collaboration with local actors to make publicity is very important: this is indicated by the difficulties Taxistop has with starting a bureau of Mobitwin themselves in various municipalities in Brussels (where it is Taxistop and not another organisation such as a PCSW who manages a centre), because they do not have access to those local communication channels.

Once there are sufficient participants (volunteer-drivers and members), the coordinator starts to organise trajectories on a day-to-day basis. In this respect, he takes into account the specific wishes (time, distance, activities, ...) volunteer-drivers expressed during their intake. In this respect, it is however important that the volunteer-drivers realise that they not simply realise a trajectory, but rather offer an accompaniment by helping beneficiaries going into a building, buying shoes, getting in and out of the car, doing groceries, ... Nevertheless, this is depend on the needs and motivation of both parties to engage in such an accompaniment. The members must pay 10 euros each year for their membership and need to inform the coordinator of their desired trajectory at least 48 hours in advance (via telephone, internet, a call-centre). And at the end of each trajectory they pay about 30 cents for each kilometre to the volunteer-driver.

After the first trajectory, the coordinator (in theory) contacts both volunteer-driver and member to evaluate the trajectory. Such a proactive method is needed because members not easily complain about the service (out of fear of losing it). Through this evaluation, problems can be detected (e.g. abuse from volunteer-drivers, members who are not respectful, ...) and confidence is established among all actors, which is of paramount importance. In this respect, members sometimes ask for the same volunteer with who they have a good contact and in who they have confidence.

With respect to the evaluation of the service in general, both members and volunteer-drivers are mostly heard through informal contacts with the coordinator of a centre. Their involvement could be amplified by installing more structural evaluation moments. The coordinators sometimes give informal feedback to Taxistop about the working of their centre. Further, Taxistop also organises a

yearly meeting with the coordinators of a few centres to evaluate Mobitwin: they share experiences, discuss the software, ...

The most important factor for success of Mobitwin are the competences of the coordinators. In essence their job is managing and motivating participants (e.g. by organising a yearly drink or meal). Moreover, since the target group often consists of lonely elderly who sometimes simply want to talk to somebody, it is important that the coordinators have empathy, are able to listen, are friendly, and have a good contact with the members. On the other hand, coordinators must also be able to take emotional distance and work goal oriented. In this respect, Taxistop is always available to support the coordinators, explains them how to manage a central, and once a year organises a formation about a specific subject (e.g. 'working with volunteers') for the coordinators of all the centres. This is important because the coordinators are often not explicitly formed with respect to people management.

Last, Taxistop and Mobitwin try to influence policy and policymakers by demonstrating that their services work. They promote their services for example during election time (when politicians often can use new ideas) in the form of a memorandum in which they show the added value of Mobitwin. Taxistop also sometimes asks for meetings with the cabinet of ministers in charge to inform them about possible problems concerning (new) legislation.

Evaluation and effects

Taxistop states that it is the task of the municipalities (or other organisations) who manage the centres, to evaluate Mobitwin. Taxistop cannot organise such evaluation moments where members and volunteer-drivers are brought together, because afterwards they need to work closely together with (the coordinators of) those centres. Hence, when a specific centre does not work well, Taxistop cannot do a lot but accept this.

According to Taxistop, the objectives are realised. The effectiveness and quality of Mobitwin is indicated by the number of members, drives and volunteer-drivers. At this moment, more than 230 centrals are active in Belgium (217 in Flanders, and 17 in Brussels and Wallonia) with almost 40,000 members and 3,000 volunteer-drivers.

Further, thanks to Mobitwin both members and volunteer-drivers come into contact with each other which improves their social life, sometimes even results in friendships, and leads to more social cohesion. Through their improved mobility, the members can undertake more activities which enhances their social life, independency and social integration. Indeed, they indicate that they feel more integrated in society and that they can maintain their social network more easily. Furthermore, the social moment with the volunteer-driver is often important for lonely members and can serve as a door to the world, and therefore is said to result in more positive wellbeing. In this respect, the members are very grateful for the services rendered. Last, by helping others and giving something back to society, the volunteer-drivers feel valuable and needed which is said to have a positive effect on their self-image and wellbeing.

5.1.8 De Munt/La Monnaie – 'A Bridge between Two Worlds'[33]

History and goals

The program 'A Bridge between Two Worlds' is part of the Belgian opera house 'De Munt/La Monnaie' (DM). It was created in 1999 for underprivileged and vulnerable groups in order to make the performances of DM accessible to them. The program also focused on activities for (im)migrants

33 The description of De Munt and its program 'A Bridge between Two Worlds' is based on a conversation with Mirjam Zomersztajn (31 January 2019).

who were learning a language, who could actively come into contact with our culture by singing in a choir. In later stages this expanded to nursing homes and other organisations such as prisons.

The goal of the current program is to make culture accessible for people who are characterised by poverty by letting them sing in a choir, by making the performances of DM accessible (concerts, recitals, opera, dance, ...), or by giving them a guided visit in DM. All these activities are free of charge for the groups and funded by private and public maecenas. The image of 'the bridge' refers to the two sides of a bridge: it is not only important that underprivileged groups go to DM (despite their financial difficulties), but also that DM (employees, musicians, soloists) has contact with the people. It is enriching for both parties. In what follows we focus on the role of the choirs.

Target Group

While be.Source supports this program mainly with respect to elderly, 'A Bridge between Two Worlds' is broader and includes all people who are characterised by poverty: seniors, migrants, prisoners, people who depend on the PCSW, people with psychiatric problems, ... But although everybody with financial problems is allowed to participate to the choirs (e.g. there are no auditions), it is essential that they are able to integrate in a collective activity by respecting the rules. So, in a choir of a nursing home, it could pose a problem when an unaccompanied participant has a severe disorientation through which he cannot concentrate and is disturbing the group. But as long as participants can function more or less in-group, they are welcomed. For participants with a severe disorientation it is better to have someone taking care of them during the choir (ergotherapist, educator, volunteer, ...).

The service and its working mechanisms

The program 'A Bridge between Two Worlds' consists of 18 choirs where 15 to 50 persons come together to sing on a weekly basis. In this respect, the program works closely together with various organisations in the social sector (such as social restaurants, neighbourhood centres of the PCSW, day care centres, the PCSW, ...) which make publicity for the choirs among their members. Four choirs are organised in prisons (and consist of prisoners), and 11 choirs take place in nursing homes of the PCSW (and consist of its senior residents). That the nursing homes are organised by the PCSW makes that its residents are more touched by poverty, which is much less the case of residents of private nursing homes. These choirs which are all led by a choir leader (engaged by DM) take place in the institutions themselves. Further, although the program 'A Bridge between Two Worlds' mainly works with the members of social organisations, individuals can also participate if they proof that they are characterised by poverty (through an attest from the PCSW or IGO). Individuals can participate in one of the three choirs that take place in the building of DM. Further, there are a few intergenerational projects at DM or at nursing homes together with a class of primary school children, babies from a kindergarten or children with a mental handicap. In what follows we focus mainly on the choirs to which elderly participate (in nursing homes or in DM).

The choir leaders build the choirs organically (which takes time) by listening to the participants, taking into account what songs or type of music they want to sing, ... Every choir starts with a body and vocal warming up. The participants sometimes propose specific songs they would like to sing. However, the choirs are very different from professional choirs due to the specific target group: although the choir leader has his own program and wants the participants to improve their singing, it is impossible to put concrete goals forwards (e.g. 'the number of songs to learn in a year'). Indeed, this strongly depends on the possibilities of the participants who are often characterised by various (physical, mental, ...) problems. Hence, the goal of the choirs is simply letting the participants partake to this collective activity, getting pleasure by singing all together, stimulate their memory, stimulate their body, work on their abilities, learning and singing talents, increase their singing potential, increase contacts between the residents of the nursing home through a collective activity, and finally

making culture more accessible. Further, the choir leaders also need to make sure to include all participants (starting by 'the most vulnerable'), and need to deal with various problems: when people do not get along in a choir, people who have an inappropriate behaviour due to dementia, when people are in a very bad state, when people decease, when people do not agree on which songs to sing, ... Therefore, the choir leader needs to work closely with the team of the nursing home. The presence of one or several members of the team during the choir is very important. Moreover, it's important that the choir leader talks a few minutes before and after each choir with the personnel of the nursing homes to inform each another when a specific person is very bad, needs special attention, needs to leave earlier, ... In this respect, the responsible of the program 'A Bridge between Two Worlds' is also often present during the choirs to support the choir leaders. She also talks to the personal of the nursing homes (nurses, people responsible of animation, ergotherapists, ...) which is important to continuously motivate them to help out with respect to the choirs: motivating their residents to participate and searching them before the choir and bringing them back to their rooms afterwards. In this respect, in total about 10 volunteers of DM offer their help during the choirs by looking for residents in their rooms, turning pages, assisting participants. It is said that the choir leaders should not take care of this (more practical) support, but should focus on the artistic project.

On certain occasions the choirs also perform in their respective nursing homes (at Christmas, ...), and once a year all the choirs of the program (except the choirs of the prisons) perform for each other in DM. Although this event is difficult to organise (because a lot of the participants are in wheel chairs, ...), it makes them feel very useful. In this respect the elderly of one specific choir took the initiative to create a committee in their nursing home in order to make a costume and necklace and bowtie for this event. In doing so, this program became a project of the whole nursing home in which elderly participated (by making themselves the necklace and bowties) and took initiatives, which gives them perspectives.

By actively participating to the choirs, the participants warm up their body and voice by singing. Moreover, the choirs are said to be dynamic and have a very good ambience through which the participants like to participate. In this respect, the relationship between the choir leader and elderly is said to be positive because the choir leaders work with their talents, what they can still do, and do not focus on what they can't do. This empowering working approach makes the participants feel useful and active. In a specific choir of a nursing home there are for example mainly participants with dementia who have difficulties learning new songs. Nevertheless, a lot of the participants still know a lot of lyrics from when they were younger and sing with a lot of pleasure, which makes this a very dynamic choir. The participants are happy and full of energy, laugh a lot and when they leave the choir they often continue to sing. Furthermore, participants who are not able to learn new songs (e.g. due to memory troubles), can still participate by not singing all songs, only singing the refrain or by simply moving their lips without making a sound. This focus on strengths is essential because it allows the participants who often think about their diverse problems (physical, psychological, housing, debt, alcohol, ...) to forget those problems for a moment. Further, since a lot of participants are lonely and socially isolated, simply going to the choir and meeting other people is good for their social integration, and gives them energy.

Good choir leaders are essential for this program: they need to be social, have a good contact with the participants, strong social dimension, be diplomatic, ... Although they have experience to lead choirs, they seldom have experience with this specific target group. Therefore, starting choir leaders always visit, observe and eventually participate to other choirs, and talk to other choir leaders to gain more insight into this specific format. Further, a few times a year the choir leaders are brought together to discuss the program, share experiences and learn from each other, under the supervision of a psychologist. And although it is often difficult to bring them all together at the same moment, they know each other well and at times work together. Indeed, with respect to the yearly performance of all the choirs in DM, they sometimes work together because it is not always feasible to let one choir perform alone (e.g. when most participants suffer from dementia).

Last, the general director and intendant of DM mentions the existence of the social program whenever possible (press conference, interviews, public speeches, meeting with policymakers, ...), and informs the public about the importance of DM and its project 'A Bridge between Two Worlds'. The social corporate responsibility dimension of DM is a conviction: the opera house is an inclusive and open space of creation for all generations and communities.

a) Evaluation and effects

Each year the program is evaluated with the direction of the nursing homes and the choir leaders, and the participants are also brought together by the choir leader once a year to discuss the program. Further, the evaluation of the program with the participants is also done continuously and informally during the year. The success of this program is indicated by the expansion of the program over the last 20 years.

The program is said to have various positive effects besides enhancing access to culture. By letting elderly actively participate they gain a better self-image, the memory is trained (by learning new songs) and perspectives are widened. Moreover, the physical posture of participants becomes better and they often leave in a livelier manner than in which they arrived: they laugh more, sit differently, ... Further, the choirs offer structure to the lives of elderly who often do not even know which day or which season they are. Last, simply participating to the choir and meeting other people is said to be positive for lonely and socially isolated elderly.

5.2 Empowerment principles analysed in practice

In this paragraph we analyse the eight programs with respect to the general empowerment principles and the empowerment flower. Hereby we focus mainly on the individual level, namely the extent to which these programs support empowerment among their participants (as 'empowering organisations'). In doing so, we investigate whether the empowerment principles are deemed relevant, and how these programs apply these principles in practice.

5.2.1 General theoretical framework of empowerment

With respect to the general empowerment principles, we first find that the eight programs aim to realise more social inclusion and full citizenship of their participants by supporting them to gain mastery over their life. They do this by stimulating their feeling of control (e.g. letting beneficiaries of SCS being master of their own care plan), critical awareness (e.g. the activities organised by Atoll to acquire skills, and to learn to detect and use resources) and participation (e.g. in the choirs of 'a Bridge between Two Worlds' or when beneficiaries are asked to evaluate the programs). Second, we find that various programs (e.g. BdBd, CD, 'BuurtPensioen', ...) are ethically grounded: they explicitly state that they are based on values such as solidarity, equity and respect. Third, the eight programs focus on (often older) individuals who are confronted with vulnerabilities on various life domains such as lonely and/or socially isolated elderly (e.g. Belgian Red Cross), people who are (temporarily) incapable of taking care of themselves (e.g. SCS) and people who are confronted with poverty (e.g. 'a Bridge between Two Worlds'). Fourth, all programs (implicitly) recognise the shared responsibility of both individual and society with respect to mechanisms of exclusion. Simply by appealing to the strengths and possibilities of beneficiaries, the programs imply that the individual has agency and therefore is (at least) partly responsible. And by their focus on vulnerable groups (e.g. by letting beneficiaries with financial difficulties pay less for a service) they acknowledge and try to break through structural inequalities. An example of this is also given by the program of SCS where the beneficiaries receive certain services for free (to tackle structural inequalities), but only during a certain period (to accentuate the individual role and to give others also the opportunity to use this service). Fifth, both process and result are important for most programs. For example, the process of

expanding access to resources is realised by most programs (e.g. the activities organised by Atoll, increased mobility by Mobitwin), and this is said to result in certain effects (e.g. more resilience, more participation). Sixth, the programs acknowledge the empowerment paradox. SCS creates for example an *'enabling niche'* by supporting their beneficiaries (with all their needs), but lets them decide for themselves which care or services they want (by giving them a very active role in the whole process). Seventh, most programs agree with the concept of 'relational autonomy' in that they acknowledge that dependency goes hand in hand with control and mastery, since people are *inter*dependent. Indeed, the goal is not to realise autonomy, but rather that persons again make conscious choices about their own lives. BdBd states for example that it does not matter if their participants realise certain objectives (e.g. going out again): more important is that they decide again what they want to do and so acquire a feeling of control and a positive self-image.

5.2.2 Principles of the empowerment flower

In this paragraph we describe if and how the eight programs include the twofoldness 'strength and connection' and the other principles of the empowerment flower: positive attitude, participation, inclusiveness, integrality, structure, coordination and proactive. These principles could be used to evaluate programs that intend empowerment.

5.2.2.1 Strength and connection

Most programs make use of the strengths of their volunteers/participants/beneficiaries by focusing on the positive aspects of their lives: their interests, needs and motivations, and on what they can still do. In doing so, *'the power of giving'* comes into play which makes people feel useful and valuable, stimulates the belief in their own abilities and gives them a place in society, which ultimately results in positive identity formation. Furthermore, when people 'give', they also dare to ask for help more easily which enforces their resilience. The latter is also enhanced through the programs improving the accessibility of care by referring beneficiaries to other organisations. Various examples can be given.

First, most programs let the participants decide themselves to what extent they participate to the program or how they want to fill it out (e.g. the activities organised by Atoll, activities undertaken by participants of BdBd, the care plan of beneficiaries of SCS). In doing so, the feeling of control of the participants enhances. Second, various programs hold onto a person-centred approach through which they take the time to find out what the real needs and wishes are of the beneficiaries, and what they can offer themselves (e.g. SCS makes home visits to create a well-balanced personalised care plan). Important in this respect is that the programs (e.g. 'BuurtPensioen') let people participate according to their own possibilities. BdBd states for example that realising concrete goals is not an objective, but rather that elderly again acquire a feeling of control by deciding themselves what they want to do. The program 'a Bridge between Two Worlds' clearly makes use of strengths by letting participants with memory troubles participate by only singing the refrain or simply moving their lips without making a sound. Third, most programs actively stimulate reciprocity. CD makes use of the strengths of their volunteers by appealing to their skills (and by letting them learn new skills), and the main principle of Taxistop is to use resources that are not fully made use of (e.g. of volunteer-drivers). However, it seems that the strengths of the beneficiaries of CD and the Belgian Red Cross are made use of in a lesser degree: the beneficiaries of CD are rather helped in a one-directional (mostly material) way, and those of the Belgian Red Cross appear to 'give' little during the visits whereby they often simply spend time together with the volunteer. Fourth, some programs try to enhance positive identity formation more directly. Atoll for example gives all their participants a social role (making coffee, telling jokes, ...) and organises cognitive activities that enhance the use of resources and skills, and which improves their self-esteem. The program 'a Bridge between Two Worlds' also enhances positive identity formation by letting the choirs perform each year for each other which enforces

pride about oneself. Last, the specific program of SCS aims to improve self-confidence, the feeling of control and one's pride by supporting participants to better take care of themselves.

Besides strength, the programs stimulate connectedness of the participants with their surroundings directly by realising encounters with other individuals (e.g. 'BuurtPensioen', BdBd, the Belgian Red Cross) or in-group settings (e.g. Atoll, 'a Bridge between Two Worlds'). At CD connectedness is above all stimulated among the volunteers (through the meals they have together, ...), more than among the beneficiaries (their contact is mainly limited to the time the volunteers spend in their homes to do certain works). Further, connectedness is also enhanced indirectly by increasing the mobility of the participants (e.g. Mobitwin), or simply by supporting beneficiaries remaining in their homes (Atoll, SCS). Moreover, some projects try to create a real social bond between people. Every month the 'BuurtPensioen' brings people together who help each other out and who take initiatives spontaneously, which results in a dynamic social network in the neighbourhood. Indeed, this program was created based on the belief that people are strengthened by more connections.

5.2.2.2 Positive attitude

A positive relationship based on respect and trust between all participants is of paramount importance because people need to trust each other and feel in security around each other, whether in a group setting or in pairs. In this respect, the personal priorities and needs of the participants are central. Therefore, sufficient empathy and social intelligence of professionals and volunteers are important plus points. Further, it is said that on the one hand the relationship between professionals and participants (e.g. Atoll, DM, Mobitwin, ...) should be authentic, based on respect, empathy and equity. On the other hand, professionals should also take sufficient emotional distance in order to be able to make firm decisions and work goal-oriented.

When the programs concern activities done in pairs (e.g. 'BuurtPensioen', BdBd, the Belgian Red Cross, Mobitwin, ...), a good matching increases the chance of a positive relationship. Therefore, most programs hold onto a person-centred working approach: the professionals take the time to gain insight into the motivations, wishes, needs, engagements, preferences, ... of the participants. In this respect, it is essential that all actors are clear about their engagements and expectations. Furthermore, after a first encounter between two participants, the professionals often take contact with them to verify if all went well. In this respect however, little engagements are asked of the volunteer-visitors of the Belgian Red Cross, which might make it more difficult to create a relationship with the beneficiaries which is based on trust and confidence. Moreover, it is said those volunteer-visitors sometimes see mainly the problems of the beneficiaries, through which respect and equity are not always present. And although a positive relationship is always important, for some services such as CD and Mobitwin this seems less central to their working in comparison with other programs (their 'core business' are rather the services rendered).

A positive relationship between participants and a good ambience are also essential in-group settings (e.g. BdBd, CD). Atoll tries to stimulate this by creating a familiar, informal and confidential sphere via the decoration of the rooms, having 'a lady of the house' present, greeting participants in a personalised way, ... The program 'a Bridge between Two Worlds' also emphasise the importance of a good ambiance in the choir which makes people energetic, have a good time and laugh. Furthermore, a positive relationship between the choir leader and participants is important, which is enabled by a diplomatic and social choir leader, and a relatively small choir which makes it possible to know all participants by name and greet them in a personalised manner. Further, an ambience of conviviality and solidarity is said motivate the volunteers of CD, and trust and respect are said to be essential for BdBd to create real social cohesion. Last, the 'BuurtPensioen' tries to create a good ambience by giving people the opportunity to get to know each other (during the monthly meetings) and intake conversations: this results in people starting to trust each other and feeling in security among each other. By thanking persons personally (when they did something) positive identity formation is enhanced. Moreover, such a personal touch creates trust and confidence through which people dare

to participate, and which results in a positive dynamic of more spontaneous and informal encounters, which ultimately leads to a real social network.

5.2.2.3 Participation

First, all programs stimulate participation of their participants in society by enhancing their connectedness (which we already discussed in a previous paragraph).

Second, the programs also stimulate participation within their respective programs by letting participants exert influence based on information and insight. A good example of this is the working of SCS: the beneficiary has the right of self-determination, and always remains 'master' of the care plan. While the coordinators of SCS support the beneficiary along the way, it is the latter who makes the decisions and determines all actions. In this respect, it is clear that the power relationship between beneficiary and coordinators is one of mutual respect and equity. In this respect, various programs (BdBd, 'BuurtPensioen', the Belgian Red Cross, Mobitwin, DM, CD, ...) ask the participants after a first encounter if the matching was good, so they can informally influence the process. However, the beneficiaries of the Belgian Red Cross are not asked if the matching was good: this evaluation is only based on the perspective of the volunteer-visitor. Hence, the beneficiaries of the Belgian Red Cross could be more systematically implicated in this process. Further, the program 'a Bridge between Two Worlds' also lets the participants influence their working: choirs leaders for example always implicate participants by asking them what they think of certain songs and letting them propose certain songs they would like to sing. Moreover, some elderly of a choir started a committee to create a costume for their performance, which shows their implication (participation, taking initiatives, ...) in the whole process. Further, the participants are often implicated in the decision making process by asking them about their perspectives on the general working of the programs, which clearly stimulates empowerment. Such an evaluation by the beneficiaries is not always done in a structural manner, but is often done on a day-to-day or ad-hoc basis. This participation in the decision-making is important: in BdBd this already resulted in the organisation of the 'Soup workshops', a Christmas meal, a collective holiday, ...

5.2.2.4 Inclusiveness

The programs are inclusive in that they specifically focus on individuals who are confronted with vulnerabilities on various life domains. However, to make the organisation of their program feasible, they nevertheless often formulate specific requirements: the behaviour of the participants of Atoll and 'a Bridge between Two Worlds' may for example not disturb for the whole group, and Atoll asks that participants are sufficiently valid so they can partake to activities, eat, ... on their own. Further, various programs are inclusive by creating maximal opportunities for vulnerable groups to participate: they for example offer lower prices to financially vulnerable persons or offer their services for free (e.g. Atoll, the program of SCS). And Atoll is for example implemented in neighbourhoods with a lot of elderly, in order to have more chance of detecting hard-to-reach elderly. Further, members of Mobitwin can contact Mobitwin through various information channels such as telephone and internet to give as much people as possible the possibility to make use of their service. Also, SCS offers the possibility to hold meetings in for example a hospital when a beneficiary is hospitalised. Last, about all programs emphasise that participants can participate according to their own possibilities (e.g. participants of the choirs of 'a Bridge between Two Worlds' who only sing the refrain). In this respect, the choir leaders always try to include the most vulnerable members of the choir to enhance their participation. However, although the programs try to include all participants, in some settings, inclusiveness is difficult to realise when somebody does not fit in, has a difficult character, is depressed, ... These limits who are related to a group setting should also be recognised.

5.2.2.5 Integrality

Most programs work in an integral and holistic manner because they try to take into account various life domains of their participants. First, this is indicated by most programs taking the time to listen and really understand the real needs on various life domains. Second, if they themselves cannot support the participants, they refer them to other organisations who can. Third, a few programs try themselves to work on an integral manner: Atoll offers for example a wide variety of activities which are all-encompassing and complementary to one another, and which focus on various life domains. In this respect, SCS creates a personal file and a care plan for each beneficiary to realise a holistic work approach. However, some programs do not strive to realise such a holistic work approach. The beneficiaries of both Mobitwin and CD are mostly helped by the services rendered (trajectory and material help). Further, 'a Bridge between Two Worlds' explicitly states that they do not aim to work 'integral': the choir leader only focuses on the artistic project, and is not there as a psychologist or social worker to solve specific problems.

5.2.2.6 Structure

Most programs organise various 'evaluative moments' which result in knowledge expansion (an increased understanding of their services and subjects), development of capacities, ... Indeed, such 'evaluative moments' with professionals, volunteers and participants are not only meant to simply get to know each other, but rather to learn and reflect about the functioning of the program. However, it is said that the lack of rooms in certain municipalities makes it impossible to organise such meetings for all volunteers of the Belgian Red Cross on a yearly basis. In the same respect, various programs also organise courses about certain themes for their professionals and volunteers, and make use of various 'tools' to ameliorate the functioning of their program: Famidesk, time banking, and the software, insurances, working materials and help desk of Mobitwin). A good example of such a 'tool' is the care plan of SCS, which helps to align all involved actors and clarify the different roles. This methodical manner clearly results in more transparency for all actors.

5.2.2.7 Coordination

First, the programs try to align all involved actors by taking the time to listen and understand their real needs and wishes, by being clear about engagements and expectations, by clarifying the different roles (e.g. through the care plan of SCS), ... This is necessary to realise a good program, a good matching and a positive attitude. Further, most organisations work together with numerous other organisations to search participants, but also refer their participants to their network when necessary. Moreover, some programs work together with other organisations to organise specific activities (e.g. Atoll). Last, the eight programs form a network within the HUB of be.Source: there they share experiences and learn from each other. Moreover, once a year they invite all the volunteers of the eight programs for a drink, where they can meet each other and get to know the other programs. In doing so, they valorise their effort.

5.2.2.8 Proactive

First, most organisations work in a limited proactive manner to search participants: in general, they simply make publicity and appeal to other organisations in this respect. However, in this respect BdBd holds onto a very proactive and outreaching working method by being present in a certain neighbourhood with a caravan during a few days, and by making publicity in local shops with flyers and posters. By staying several days in the same neighbourhood with the caravan, they gained confidence and trust, which is needed to reach more hard-to-reach groups.

Second, with respect to the day-to-day working, a lot of programs try to detect the real needs and wishes of the participants by taking the time to listen to them, contacting them to evaluate encounters, trajectories, ... and in some instances home visits are done to gain more understanding of their situation (e.g. SCS). However, some programs such as 'a Bridge between Two Worlds' explicitly tries to

avoid being proactive: they concentrate on the artistic project, and try to not enter into the lives of their participants.

5.3 Conclusion

Based on the description of the eight programs that all aim to contribute to the quality of life of elderly (and other groups), we find that the general theoretical framework of empowerment is deemed important. Indeed, these programs want to realise more social inclusion and full citizenship by supporting vulnerable groups, are often ethically grounded (based on values such as solidarity), acknowledge the shared responsibility of both individual and society with respect to mechanisms of exclusion, the empowerment paradox, the importance of both the process and the results, and the concept of 'relational autonomy'.

Further, the twofoldness 'strength and connection' is central to the working of most programs. Indeed, various programs make use of the strengths of participants by emphasising their right of self-determination and by focusing on what they can still do. In this respect, they take the time to find out what participants can offer. In doing so, 'the power of giving' comes into play which stimulates positive identity formation and incites people to ask for help themselves. This all contributes to people's resilience and feeling of control. However, certain programs do not explicitly make use of the strengths of their beneficiaries (CD, the Belgian Red Cross and Mobitwin): they rather focus on rendering them a valuable service, and are more one-directional in this respect. Nevertheless, indirectly their beneficiaries are of course also strengthened through the service. The programs also stimulate the connection of the participants with their surroundings in a direct manner by realising encounters with other individuals or in group settings, or by rendering a service which gives people more possibilities to engage socially (e.g. increasing their mobility or dignity).

With respect to the empowerment flower, we first find that a positive relationship among the participants (based on respect and trust) is essential, whether in a group setting or in pairs. Indeed, in order to realise a good match (between pairs) or a good ambience (in a group), it is important to take the time to detect the real needs and wishes of the participants, to be clear about expectations and engagements, and to realise a confidential ambience (through the setting, decoration, ...). Therefore, empathy and social intelligence are important characteristics of both professionals and volunteers. And while the relationship between professionals and participants should be authentic, based on respect, empathy and equality, professionals should also be able to take emotional distance and make firm decisions. Second, all programs try to stimulate participation by implicating their participants and letting them exert influence. In this respect, participants decide themselves to what extent they participate and are always implicated during the process. Further, the participants are often informally asked what they think of the program on a day-to-day basis, and are sometimes also implicated in the decision making process by their participation in evaluative moments. However, the implication of the beneficiaries of the Belgian Red Cross could be enhanced by asking them how a first encounter with a visitor went. Third, all the programs try to realise inclusiveness by focusing on vulnerable individuals and creating maximal opportunities for them to participate (e.g. lower prices, various information channels to take contact, giving all participants a social role, home visits, letting people participate according to their own possibilities). Fourth, various programs work in an integral and holistic manner by taking into account the various life domains of their participants. They do this by taking the time to listen and detect the real needs and wishes, referring participants to other organisations, offering all-encompassing and complementary activities which focus on various life domains and using a personalised care plan. However, some programs (Mobitwin, CD and 'a Bridge between Two Worlds') do not strive to work in an integral and holistic manner. For them the services or activities are essential: 'a Bridge between Two Worlds' states for example that the choir leaders focus on the artistic project, and try not to enter into other life domains. Fifth, most programs offer some sort of structure through which knowledge is expanded and capacities are developed. This is

done by 'evaluative moments' with professionals, volunteers and/or beneficiaries, courses about certain themes, and various tools (e.g. software, help-desk, insurances, a care plan of SCS). Sixth, coordination and collaboration are also important: the programs work together with other organisations to search participants, organise activities, make publicity, ... Further, they ensure that all actors are aligned and go in the same direction (via a care plan, intakes, evaluations, ...). Last, although most programs work only limitedly in a proactive manner to search participants, some programs have a very outreaching and proactive working method. BdBd is for example present in a neighbourhood with a caravan during a few days to make publicity, talk to people and come into contact with hard-to-reach groups. With respect to the day-to-day working, various programs hold onto a proactive working approach by realising home visits, detecting real needs (by taking the time to listen to participants), contacting participants to evaluate first encounters, ... However, some programs such as 'a Bridge between Two Worlds' explicitly try to avoid a proactive and 'intrusive' working method: they concentrate on their activity and try not to enter into the personal lives of the participants.

Last, we find that the effects of the investigated programs on loneliness and social isolation are not measured by 'hard' indicators or through a systematic data collection. The evaluations are mainly based on the personal observations of the involved actors, through which it is unknown what the working mechanisms are exactly. Therefore, it could be interesting to gain more insight into the effects of these programs on loneliness and social isolation, and into their working mechanisms. Such information could support policy influencing (which is already done by various programs). Despite this, the eight programs clearly respond to the increasing emphasis on 'aging in place', de-institutionalisation and demand-oriented care. They all observed certain problems in practice and formulated a personal response to them through their specific program. From this, again it becomes clear that one-size-fits-all interventions to alleviate loneliness and social isolation among elderly do not exist: various interventions are needed to tackle these complex phenomenons. Nevertheless, 'silver' empowerment could be a common reference point and objective for these eight programs.

6 | Silver Empowerment, loneliness and social isolation of elderly. A shared responsibility

This first research report 'Silver Empowerment. Loneliness and social isolation among elderly. An empowerment perspective' of the HIVA - KU Leuven and be.Source Chair 'Empowerment of Underprivileged Elderly' shows that both loneliness and social isolation remain extremely relevant subjects in contemporary society. In 2013 about 25% of the elderly in Belgium of 65 years or more were confronted with feelings of loneliness. In Europe, the prevalence of loneliness among elderly aged 65 or more ranges between 10% and 33% in 2013, and is said to increase in all observed countries between 2004 and 2013. This subject is of paramount importance because both loneliness and social isolation significantly affect various life domains (physical, psychological, emotional, social) and quality of life in general. Its importance is further amplified by demographical trends (such as ageing and the increase of the number of older elderly) and the process of individualisation which has led to more elderly living alone and who can count in a lesser degree on informal support. Therefore, it is essential to raise awareness among policymakers with respect to the relevance of this subject, in order to elicit change. In this respect, 'Silver Empowerment' comes to the foreground as a useful paradigm.

6.1 The importance of Silver Empowerment

Silver Empowerment is a fruitful framework for organisations that want to stimulate empowerment among lonely and socially isolated elderly. Indeed, it leans itself perfectly to the care sector that is increasingly characterised by demand-oriented care, de-institutionalisation, 'ageing in place', quality of life, a multi-dimensional and holistic vision on health, ... Moreover, it corresponds with a specific goal of the chair 'Empowerment of Underprivileged Elderly' which is to stimulate a positive image of elderly in society by emphasising their strengths and talents, without neglecting their vulnerabilities. In this respect, Silver Empowerment focuses on the strengthening process of elderly in our society and shows that vulnerability and mastery can go hand in hand. Furthermore, it underlines the importance of (intergenerational) solidarity between different generations in order to stimulate empowerment among elderly.

6.2 The gap between science and practice

The analysis of the scientific literature indicates that various intervention types can be effective to alleviate loneliness and/or social isolation (e.g. both group and one-to-one interventions, psychological therapies, ...), and that certain characteristics of interventions are positively related to their effectiveness (e.g. being theory-based, directed towards activities, reciprocity, ...). Nevertheless, more research is needed about the working mechanisms of interventions that aim to alleviate loneliness and/or social isolation in a specific context. Indeed, effort and good intentions are not sufficient to tackle loneliness and social isolation.

Despite the need for more detailed knowledge, it is clear that it is essential to first gain insight into the type and origins of the problem and into the personal characteristics of the elderly, in order to tailor an intervention around the specific needs of the elderly. First, the problem must be defined (causes, duration, variation, severity, ...): are people lonely or socially isolated? Are people socially lonely or emotionally lonely? While loneliness is subjective and refers to 'the unpleasant feeling that

occurs when a person's social network is found to be deficient either quantitatively or qualitatively', social isolation is objective and refers to 'the lack or almost complete absence of relations with other people'. Further, a distinction needs to be made between emotional loneliness (i.e. 'the absence of a meaningful, intimate and exclusive relationship') and social loneliness ('the lack of an adequate, broad social network'). Second, it is important to gain insight into the personal characteristics of the elderly (subjective perceptions and needs, coping strategies, motivations, psychological and physical health) and their context (social support, financial situation, ...). Indeed, since both problems and elderly come in various forms, one-size-fits-all interventions do not exist: interventions need to be tailored around the specific needs of the elderly.

6.3 Inspiring empowering practices: enabling niches

The analysis of eight programs that are subventioned by be.Source and that try to improve the QOL of elderly shows that empowerment is a useful framework for organisations that want to tackle loneliness and/or social isolation because it emphasises that elderly who are increasingly confronted with problems on various life domains can still have mastery over their own situation and their environment. Various principles of the general theoretical framework of empowerment and the empowerment flower were detected as effective factors in this respect. First, making use of the strengths of elderly is essential because by focusing on what they can still do, reciprocity and 'the power of giving' comes into play, which stimulates positive identity formation and increases peoples' resilience and feeling of control. The focus on strengths also results in more connectedness with the surroundings of elderly which has a positive effect on wellbeing. Next, a positive relationship (based on respect, trust and a feeling of security) among the participants, professionals and volunteers is an important principle that enhances the feeling of control and mastery. Moreover, it is important to stimulate participation of the elderly (both in the care process and in society in general), inclusiveness (by realising maximal opportunities to participate), a holistic and integral working method (by taking into account the various life domains of the elderly), structure (to realise more transparency and participation), coordination and collaboration (to align all actors), and a proactive and outreaching working method (to combat under protection). With respect to the latter, it is important that elderly recognise their vulnerability (e.g. loneliness and/or social isolation) and accept support in order to be able to search and find solutions (e.g. psychological therapy). This will ultimately lead to more mastery and resilience. In sum, it is essential that organisations create 'enabling niches' where people feel safe and secure, and where they can respect and trust each other. This leads to a feeling of belonging and control which ultimately results in more strength and mastery.

6.4 What next?

Despite the importance of the empowerment framework for organisations that want to alleviate loneliness and social isolation, more (evaluation) research is necessary to gain more insight into the working mechanisms of various interventions. At the moment, problems often occur concerning the generalisability of research results, inconsistencies of definitions, ... Moreover, the effects of interventions on loneliness and/or social isolation are often not measured by systematic data collection through which it is unknown if the interventions have an effect on loneliness and/or social isolation, and if so what the working mechanisms are. In this respect, more insight could for example be gathered into the building stones of resilience: what makes lonely and/or socially isolated people more or less resilient? Further, more knowledge could for example be gathered about useful manners to stimulate intergenerational solidarity. Based on such insights, interventions could be improved and made more effective to alleviate loneliness and/or social isolation, in order to ultimately realise Silver Empowerment.

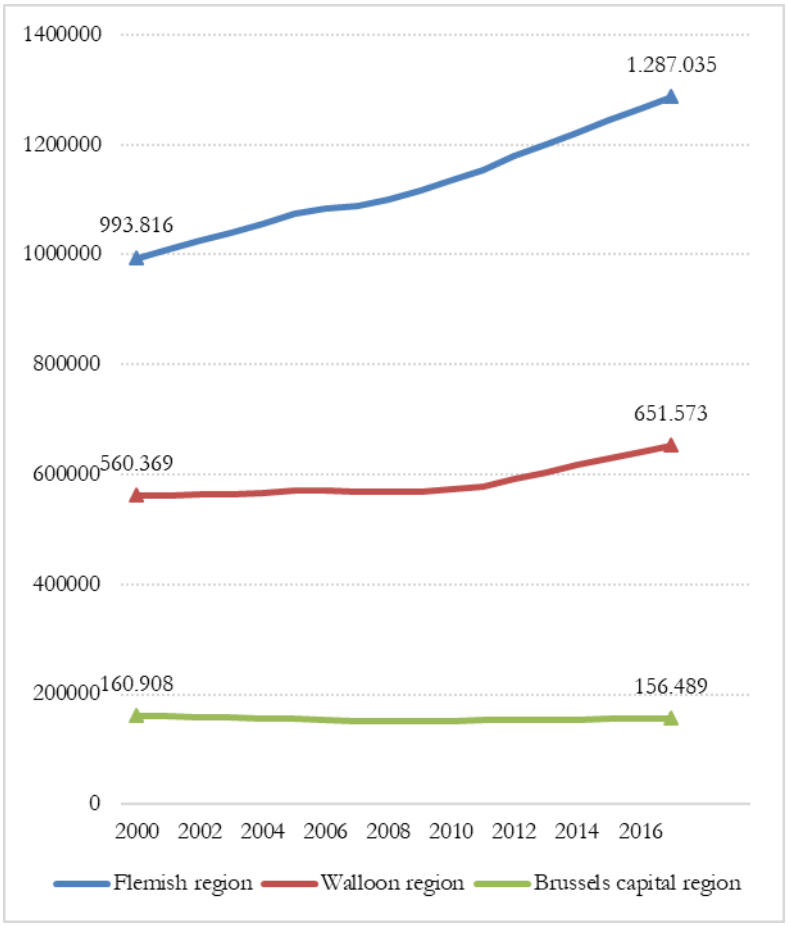
- APPENDICES -

appendix 1 Demographic situation in Belgium

a1.1 Ageing in Belgium

On 1 January 2017, Belgium counted 11,322,088 inhabitants. The majority of them (57.6%) is living in Flanders, 31.9% in Wallonia and a smaller portion in the Brussels capital region (10.5%). The Belgian population is ageing increasingly (Statistics Belgium, 2017), which is shown by the figure below that gives an historical overview of the evolution of those aged 65 or over since 2000.

Figure a1.1 Evolution of ageing in Belgium by region (> 64 years; 2000-2017)



Source Statistics Belgium

As can be seen in the figure above, the number of people of 65 years old or older follows an upward evolution in both Flanders and Wallonia. In 2000, Flanders counted slightly less than 1,000,000 persons who were 65 years old or older (993.816). By 2017, they were already with 1,287,035. This is an increase by 30% over the last 17 years. In the Brussels capital region, the share of the 65 years old and over has remained more or less stable in the same period. In total in Belgium there are 2,095,097 people of 65 years or older in 2017.

Belgium is characterised by an unequal division of age groups. The Brussels capital region is clearly a younger region compared to the other two regions. A larger amount of youngsters live in the Brussels capital region (23% is younger than 18 years) and a lesser proportion of those 65 years or older (13.1%). The opposite trend is noticeable in Flanders, where there are less youngsters (19.4%) and more elderly (19.8%). The ageing trend is also the most pronounced in Flanders. For all age groups, the Walloon region comes the closest to the national indicators (Statistics Belgium, 2017). The following table gives an overview of the proportion of the different age groups by region on 1 January 2017.

Table a1.1 Division of age groups by region (1 January 2017)

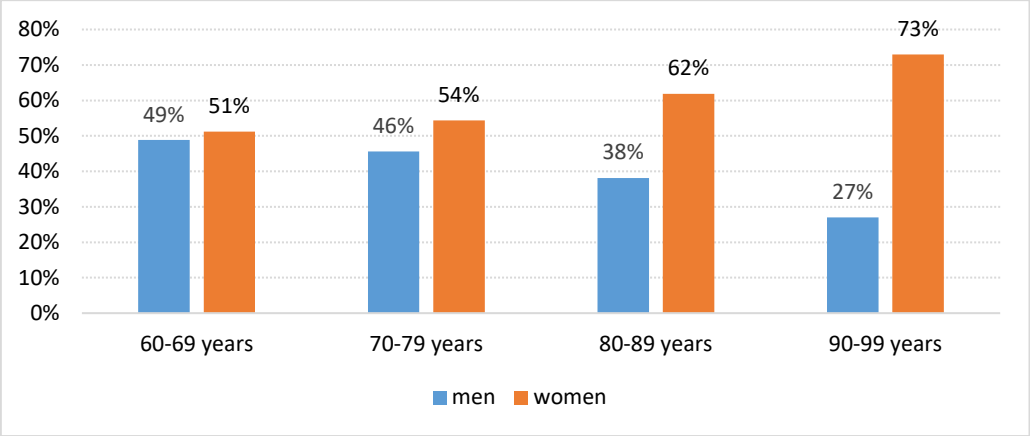
	0-17 years	%	18-64 years	%	65 years and older	%
Flanders region	1,264,376	19.4	3,964,600	60.8	1,287,035	19.8
Walloon region	756,566	20.9	2,206,334	61.1	651,573	18
Brussels capital region	273,697	23	761,418	63.9	156,489	13.1
Belgium	**2,294,639**	**20.3**	**6,932,352**	61.2	**2,095,097**	18.5

Source Statistics Belgium, 2017

Differences in the ageing structure of the population have widened during the last years (Statistics Belgium, 2017). In addition, there are many differences between municipalities. The proportion of elderly in a number of coastal communities is much higher (more than 30%) compared to the national share of 18.5%. A similar observation can be made for several communities in Wallonia (e.g. Chaudfontaine, Spa, Bouillon, etc.). These communities count more than 20% of people who are aged 65 years or over. In Brussels, only a fraction of the older population (10%) lives close to the capital city centre. The further away from the capital city and more to the south (e.g. Watermaal-Bosvoorde, Sint-Pieters Woluwe, Ukkel), the higher the share of the older population gets. Again it exceeds the overall national proportion (Statistics Belgium, 2017).

The older people get, the more important the prevalence of women over men becomes. Due to a higher mortality rate of men at all ages and the fact that women have a higher live expectancy rate, there are more older women than men. The consequence is an imbalance between genders as age proceeds. Whereas the share of both men and women is almost equal at the age group of 60-69 years, the gap becomes bigger when looking at older age groups. There are more than twice as much women than men among the group of 80-89 year olds. Within the group of 90-99 year olds, there are more than three times as much women than there are men (Statistics Belgium, 2017). The following figure shows this trend.

Figure a1.2 Age by gender (2017)

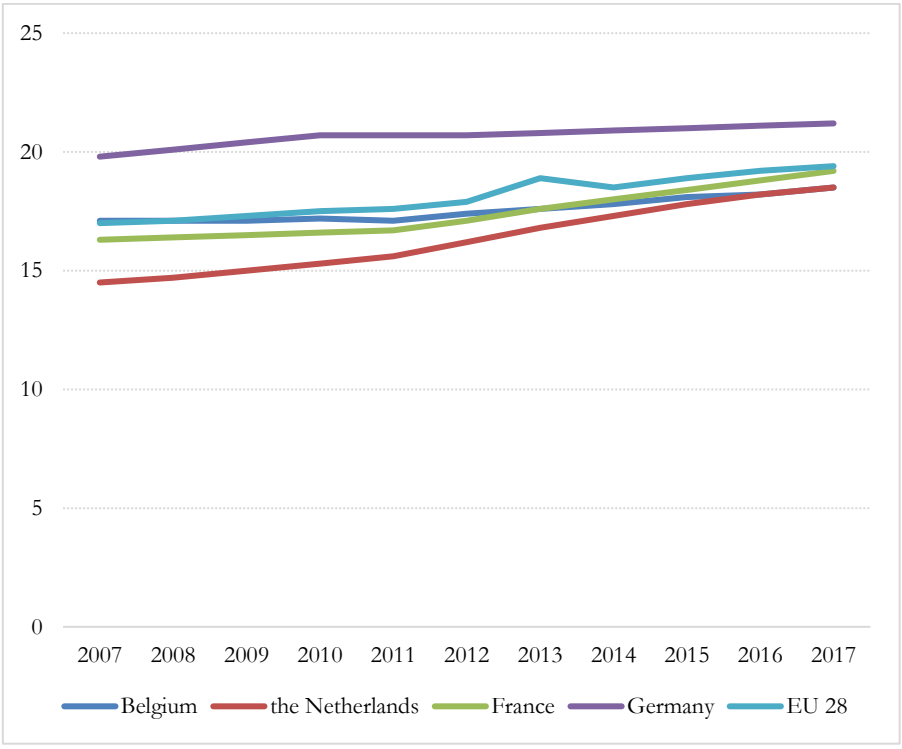


Source Statistics Belgium

a1.2 Ageing in Europe

Looking at the figure below, one can see a positive ageing trend in Belgium and its neighbouring countries, as well as for the EU-28 as a whole. In 2017, Belgium and the Netherlands had the same share of people aged 65 years or older (18.5%). This share is lower than the EU-28 share of 19.4%. Compared to Belgium, France and Germany count a higher share of elderly (respectively 19.2% and 21.2%) (Eurostat).

Figure a1.3 Evolution of ageing in Europe as a percentage of the total population (> 64 years; 2007-2017)



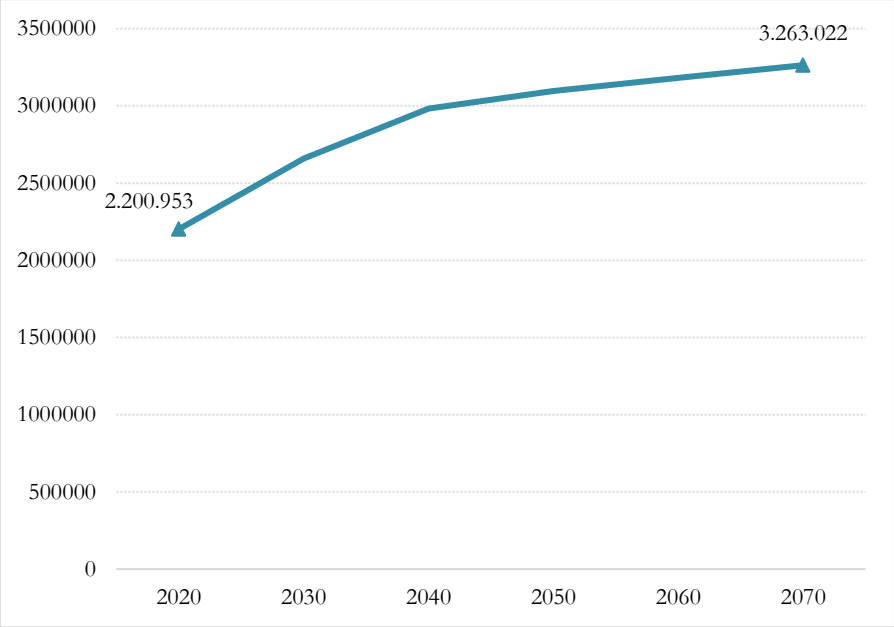
Source Eurostat

a1.3 Demographic prognoses

Demographic ageing is a worldwide phenomenon. The OECD has determined that there are 900 million people worldwide who are older than 60 years. By 2050, their number will have increased to 2.4 billion (Love, 2015).

In Belgium, the demographic prognosis shows an increase in the total population from 11,495,773 in 2020 to 13,429,071 in 2070 (+17%). The proportion of those 65 years or older also increases. Moreover, it almost doubles from 2,200,953 elderly in 2020 to 3,263,022 in 2070. This is a percentage difference of 48%. In 2070, it is predicted that 25% of the total population will be 65 years or older. Belgium will continue to age, but from 2040 onwards, the gradual phase out of the baby boom effect will have a more or less stabilising effect on the ageing trend (Statistics Belgium). The demographic prognosis of the age group 64 years and older is visually shown in the following figure.

Figure a1.4 Demographic prognosis of the population aged 65 or older (2020-2070)



Source Statistics Belgium

In 2016, the average life expectancy of women was 83.7 years and of men 78.8 years (Statistics Belgium, 2017). The table below illustrates the evolution in life expectancy.

Table a1.2 Evolution in life expectancy by gender (1996-2016)

	1996	2006	2016
Men	73.9	76.5	78.8
Women	80.5	82.2	83.7

Source Statistics Belgium, 2017

Life expectancy is estimated to continue to increase for both genders. In 2070, it is expected that men will live up to 88 years. The future life expectancy for women is estimated to be 89.6 years (Federal Planning Bureau, 2018).

Research on the evolution of a healthy life expectancy in Flanders for the period 1997 to 2004 indicates that it is to be expected that within the group of elderly, the 'younger' age group (65 to 84 years old) will have more healthy life years in the future, while the oldest elderly women will be

confronted with an expansion in their unhealthy life years. Social status is of influence on the expected number of healthy life years. 70-year-old persons with few financial resources and a low educational level have 60% more chance to be less healthy. A person of the same age with more financial means and who is higher educated, will only have 30% chance to be unhealthy (Cabinet of Flemish Minister of Wellbeing, Public Health and Family, 2010).

appendix 2 Measurement Scales

a2.1 De Jong-Gierveld loneliness scale

The long version of the De Jong-Gierveld loneliness scale consists of following items (in Dutch):

1. Er is altijd wel iemand in mijn omgeving bij wie ik met mijn dagelijkse probleempjes terecht kan.
2. Ik mis een echt goede vriend of vriendin.
3. Ik ervaar een leegte om me heen.
4. Er zijn genoeg mensen op wie ik in geval van narigheid kan terugvallen.
5. Ik mis gezelligheid om me heen.
6. Ik vind mijn kring van kennissen te beperkt.
7. Ik heb veel mensen op wie ik volledig kan vertrouwen.
8. Er zijn voldoende mensen met wie ik me nauw verbonden voel.
9. Ik mis mensen om me heen.
10. Vaak voel ik me in de steek gelaten.
11. Wanneer ik daar behoefte aan heb, kan ik altijd bij mijn vrienden terecht.

The short version consists of following items:

1. Ik ervaar een leegte om me heen.
2. Er zijn genoeg mensen op wie ik in geval van narigheid kan terugvallen.
3. Ik heb veel mensen op wie ik volledig kan vertrouwen.
4. Er zijn voldoende mensen met wie ik me nauw verbonden voel.
5. Ik mis mensen om me heen.
6. Vaak voel ik me in de steek gelaten.

(de Jong Gierveld & van Tilburg, 2008).

a2.2 The University of California Los Angeles Loneliness Scale (UCLA)

The UCLA loneliness scale consists of 20 questions:

1. How often do you feel that you are 'in tune' with the people around you?
2. How often do you feel that you lack companionship?
3. How often do you feel that there is no one you can turn to?
4. How often do you feel alone?
5. How often do you feel part of a group of friends?
6. How often do you feel that you have a lot in common with the people around you?
7. How often do you feel that you are no longer close to anyone?
8. How often do you feel that your interests and ideas are not shared by those around you?
9. How often do you feel outgoing and friendly?
10. How often do you feel close to people?
11. How often do you feel left out?
12. How often do you feel that your relationships with others are not meaningful?
13. How often do you feel that no one really knows you well?
14. How often do you feel isolated from others?
15. How often do you fee1 you can find companionship when you want it?
16. How often do you feel that there are people who really understand you?

17. How often do you feel shy?
18. How often do you feel that people are around you but not with you?
19. How often do you feel that there are people you can talk to?
20. How often do you feel that there are people you can turn to?
    (Russel, 1996).

a2.3 The Lubben social network scale

The short version of the Lubben social network scale consists of following questions:

1. How many relatives do you see or hear from at least once a month?
2. How many relatives do you feel close to such that you could call on them for help?
3. How many relatives do you feel at ease with that you can talk about private matters?
4. How many of your friends do you see or hear from at least once a month?
5. How many of your friends do you feel close to such that you could call on them for help?
6. How many of your friends do you feel at ease with that you can talk about private matters?
   (Lubben, Blozik, Gillmann, Lliffe, von Renteln Kruse, Beck & Stuck (2006).

a2.4 Tilburg Frailty Indicator

The Tilburg Frailty Indicator consists of two parts. The first part concerning the determinants of frailty contains following questions:

1. Which sex are you?
2. What is your age?
3. What is your marital status?
4. In which country were you born?
5. What is the highest level of education you have completed?
6. Which category indicates your net monthly household income?
7. Overall, how healthy would you say your lifestyle is?
8. Do you have two or more diseases and/or chronic disorders?
9. Have you experienced one or more of the following events during the past year?
   - The death of a loved one
   - A serious illness yourself
   - A serious illness in a loved one
   - A divorce or ending of an important intimate relationship
   - A traffic accident
   - A crime
10. Are you satisfied with you home living environment?
11. The second part contains following questions concerning components of frailty:
12. Do you feel physically healthy?
13. Have you lost a lot of weight recently without wishing to do so?
    Do you experience problems in your daily life due to:
14. ... difficulty in walking?
15. ... difficulty maintaining your balance?
16. ... poor hearing?
17. ... poor vision?
18. ... lack of strength in your hands?
19. ... psychological tiredness?
20. Do you have problems with your memory?
21. Have you felt down during the last month?
22. Have you felt nervous or anxious during the last month?

23. Are you able to cope with problems well?
24. Do you live alone?
25. Do you sometimes miss having people around you?
26. Do you receive enough support from other people?

(Gobbens, van Assen, Luijkx, Wijnen-Sponselee & Schols, 2010).

a2.5 World Health Organization – Quality of Life

The WHO quality of life scale is used to measure quality of life, and should be answered with the last two weeks in mind.

1. Do you worry about your pain or discomfort?
2. How difficult is it for you to handle any pain or discomfort?
3. To what extent do you feel that (physical) pain prevents you from doing what you need to do?
4. How easily do you get tired?
5. How much are you bothered by fatigue?
6. Do you have any difficulties with sleeping?
7. How much do any sleep problems worry you?
8. How much do you enjoy life?
9. How positive do you feel about the future?
10. How much do you experience positive feelings in your life?
11. How well are you able to concentrate?
12. How much do you value yourself?
13. How much confidence do you have in yourself?
14. Do you feel inhibited by your looks?
15. Is there any part of your appearance which makes you feel uncomfortable?
16. How worried do you feel?
17. How much do any feelings of sadness or depression interfere with your everyday functioning?
18. How much do any feelings of depression bother you?
19. To what extent do you have difficulty in performing your routine activities?
20. How much are you bothered by any limitations in performing everyday living activities?
21. How much do you need any medication to function in your daily life?
22. How much do you need any medical treatment to function in your daily life?
23. To what extent does your quality of life depend on the use of medical substances or medical aids?
24. How alone do you feel in your life?
25. How well are your sexual needs fulfilled?
26. Are you bothered by any difficulties in your sex life
27. How safe do you feel in your daily life?
28. Do you feel you are living in a safe and secure environment?
29. How much do you worry about your safety and security?
30. How comfortable is the place where you live?
31. How much do you like it where you live?
32. Do you have financial difficulties?
33. How much do you worry about money?
34. How easily are you able to get good medical care?
35. How much do you enjoy your free time?
36. How healthy is your physical environment?
37. How concerned are you with the noise in the area you live in?
38. To what extent do you have problems with transport?
39. How much do difficulties with transport restrict your life?
40. Do you have enough energy for everyday life?

41. Are you able to accept your bodily appearance?
42. To what extent are you able to carry out your daily activities?
43. How dependent are you on medications?
44. Do you get the kind of support from others that you need?
45. To what extent can you count on your friends when you need them?
46. To what degree does the quality of your home meet your needs?
47. Have you enough money to meet your needs?
48. How available to you is the information that you need in your day-to-day life
49. To what extent do you have opportunities for acquiring the information that you feel you need?
50. To what extent do you have the opportunity for leisure activities?
51. How much are you able to relax and enjoy yourself?
52. To what extent do you have adequate means of transport?
53. How satisfied are you with the quality of your life?
54. In general, how satisfied are you with your life?
55. How satisfied are you with your health?
56. How satisfied are you with the energy that you have?
57. How satisfied are you with your sleep?
58. How satisfied are you with your ability to learn new information?
59. How satisfied are you with your ability to make decisions?
60. How satisfied are you with yourself?
61. How satisfied are you with your abilities?
62. How satisfied are you with the way your body looks?
63. How satisfied are you with your ability to perform your daily living activities?
64. How satisfied are you with your personal relationships?
65. How satisfied are you with your sex life?
66. How satisfied are you with the support you get from your family?
67. How satisfied are you with the support you get from your friends?
68. How satisfied are you with your ability to provide for or support others?
69. How satisfied are you with your physical safety and security?
70. How satisfied are you with the conditions of your living place?
71. How satisfied are you with your financial situation?
72. How satisfied are you with your access to health services?
73. How satisfied are you with the social care services?
74. How satisfied are you with your opportunities for acquiring new skills?
75. How satisfied are you with your opportunities to learn new information?
76. How satisfied are you with the way you spend your spare time?
77. How satisfied are you with your physical environment (e.g. pollution, climate, noise, attractiveness)?
78. How satisfied are you with the climate of the place where you live?
79. How satisfied are you with your transport?
80. Do you feel happy about your relationship with your family members?
81. How would you rate your quality of life?
82. How would you rate your sex life?
83. How well do you sleep?
84. How would you rate your memory?
85. How would you rate the quality of social services available to you?
86. How often do you suffer (physical) pain?
87. Do you generally feel content?
88. How often do you have negative feelings, such as blue mood, despair, anxiety, depression?
89. Are you able to work?

90. Do you feel able to carry out your duties?
91. How satisfied are you with your capacity for work?
92. How would you rate your ability to work?
93. How well are you able to get around?
94. How much do any difficulties in mobility bother you?
95. To what extent do any difficulties in movement affect your way of life?
96. How satisfied are you with your ability to move around?
97. Do your personal beliefs give meaning to your life?
98. To what extent do you feel your life to be meaningful?
99. To what extent do your personal beliefs give you the strength to face difficulties?
100. To what extent do your personal beliefs help you to understand difficulties in life?

(WHO, 1995).

a2.6 World Health Organization – Quality of Life BREF

1. How would you rate your quality of life?
2. How satisfied are you with your health?
3. To what extent do you feel that physical pain prevents you from doing what you need to do?
4. How much do you need any medical treatment to function in your daily life?
5. How much do you enjoy life?
6. To what extent do you feel your life to be meaningful?
7. How well are you able to concentrate?
8. How safe do you feel in your daily life?
9. How healthy is your physical environment?
10. Do you have enough energy for everyday life?
11. Are you able to accept your bodily appearance?
12. Have you enough money to meet your needs?
13. How available to you is the information that you need in your day-to-day life?
14. To what extent do you have the opportunity for leisure activities?
15. How well are you able to get around?
16. How satisfied are you with your sleep?
17. How satisfied are you with your ability to perform your daily living activities?
18. How satisfied are you with your capacity for work?
19. How satisfied are you with yourself?
20. How satisfied are you with your personal relationships?
21. How satisfied are you with your sex life?
22. How satisfied are you with the support you get from your friends?
23. How satisfied are you with the conditions of your living place?
24. How satisfied are you with your access?
25. How satisfied are you with your transport?
26. How often do you have negative feelings such as blue mood, despair, anxiety depression?

(WHO, 1996).

a2.7 World Health Organization – Quality of Life OLD

1. Impairment to senses affect daily life
2. Loss of sensory abilities affect participation in activities
3. Problems with sensory functioning affect ability to interact
4. Rate sensory functioning
5. Freedom to make own decisions

6. Feel in control of your future
7. People around you are respectful of your freedom
8. Able to do things you'd like
9. Satisfied with opportunities to continue achieving
10. Received the recognition you deserve in life
11. Satisifed with what you've achieved in life
12. Happy with things to look forward to
13. Have enough to do each day
14. Satisfied with the way you use your time
15. Satisfied with your level of activity
16. Satisfied with your opportunity to participate in the community
17. Concerned about the way you will die
18. Afraid of not being able to control death
19. Scared of dying
20. Fear pain before death
21. Feel a sense of companionship in life
22. Experience love in your life
23. Opportunities to love
24. Opportunities to be loved

(Fleck, Chachemovich & Trentini (2006).

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