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| eVALUATION OF THE visit program  OPEN SUPPORT |

Final Report

**Date 17 June 2020**

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**HILDA data**

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CONTENTS

[Tables. 5](#_Toc61430901)

[Figures 5](#_Toc61430902)

[Executive summary 7](#_Toc61430903)

[The evaluation 7](#_Toc61430904)

[Key findings 7](#_Toc61430905)

[Visitor Program impact on the severity of the negative effects of social isolation 7](#_Toc61430906)

[Visitor Program impact on the prevalence of the negative effects of social isolation 8](#_Toc61430907)

[The appropriateness of the service model 8](#_Toc61430908)

[Recommendations 9](#_Toc61430909)

[1. The evaluation 11](#_Toc61430910)

[1.1 The project 11](#_Toc61430911)

[1.2 Key evaluation questions 11](#_Toc61430912)

[1.3 Methods 12](#_Toc61430913)

[1.4 Ethics review 14](#_Toc61430914)

[1.5 Confidence in the findings 14](#_Toc61430915)

[2. The Visit Program 17](#_Toc61430916)

[2.1 The policy context 17](#_Toc61430917)

[2.2 The Visit Program 17](#_Toc61430918)

[3. Client profile 26](#_Toc61430919)

[3.1 Client demographcis 26](#_Toc61430920)

[3.2 Physical and mental health conditions 27](#_Toc61430921)

[3.3 Client supports 30](#_Toc61430922)

[3.4 Relevance of the program for other population groups 31](#_Toc61430923)

[4. Client experience 33](#_Toc61430924)

[4.1 The referral process 34](#_Toc61430925)

[4.2 Program intensity 37](#_Toc61430926)

[4.3 Program services 40](#_Toc61430927)

[4.4 Support provided to clients by coordinators 45](#_Toc61430928)

[4.5 Relationship with visitors 46](#_Toc61430929)

[5. Visitor experience 49](#_Toc61430930)

[5.1 The visitors 50](#_Toc61430931)

[5.2 Recruitment process for volunteer visitors 50](#_Toc61430932)

[5.3 Recruitment and retention of staff visitors 53](#_Toc61430933)

[5.4 Training visitors 53](#_Toc61430934)

[5.5 Visitor supports 56](#_Toc61430935)

[5.6 Working with clients 58](#_Toc61430936)

[5.7 Sustaining a visitor workforce 61](#_Toc61430937)

[6. Program impact 64](#_Toc61430938)

[6.1 Overall health (SF-12) 64](#_Toc61430939)

[6.2 Wellbeing and mental health 66](#_Toc61430940)

[6.3 Social connectedness and loneliness 69](#_Toc61430941)

[6.4 Self-confidence 71](#_Toc61430942)

[6.5 Physical health 72](#_Toc61430943)

[6.6 HILDA comparison analysis 75](#_Toc61430944)

[7. Economic value of the Visit Program 78](#_Toc61430945)

[7.1 Outcomes used in the economic evaluation 78](#_Toc61430946)

[7.2 Costs and benefits 79](#_Toc61430947)

[7.3 Cost-effectiveness analysis 83](#_Toc61430948)

[7.4 Cost-benefit analysis 84](#_Toc61430949)

[Appendix 1. Literature review 86](#_Toc61430950)

[1. Scope and purpose 86](#_Toc61430951)

[2. Defining social isolation 87](#_Toc61430952)

[3. Effects of social isolation 91](#_Toc61430953)

[4. Responding to social isolation 95](#_Toc61430954)

[References 103](#_Toc61430955)

Tables and figures

Tables

[Table 1. Data collection methods 12](#_Toc43385930)

[Table 2. Site, gender and age range of Visit Program clients 27](#_Toc43385931)

[Table 3. NDIS and My Aged Care application status 31](#_Toc43385932)

[Table 4. Number of visitors and clients per program site 50](#_Toc43385933)

[Table 5. Recruitment strategies for volunteer visitors 51](#_Toc43385934)

[Table 6. Training provided to visitors 54](#_Toc43385935)

[Table 7. Time needed to recruit and train new volunteers 63](#_Toc43385936)

[Table 8. Average PCS-12 and MCS-12 scores pre- and post-program 65](#_Toc43385937)

[Table 9. How much were clients limited by their health in doing moderate activities (such as moving a table, pushing a vacuum cleaner, recreational activities), pre the Visit Program vs post 73](#_Toc43385938)

[Table 10. How much were clients limited by their health in climbing several flights of stairs, pre the Visit Program vs post 74](#_Toc43385939)

[Table 11. Derived mental and physical health scores for Visit Program clients and HILDA respondents, aged 45 years and over 76](#_Toc43385940)

[Table 12. Derived mental and physical health scores for Visit Program clients, HILDA respondents with no reported mental illness and HILDA respondents with a reported mental illness, aged 45 years and over 76](#_Toc43385941)

[Table 13. Hospitalisation rates 77](#_Toc43385942)

[Table 14. Average PCS score, MCS score, Sf-6D index and aggregated qalys, pre vs post 80](#_Toc43385943)

[Table 15. Social isolation can occur across four levels 88](#_Toc43385944)

[Table 16. The Visit Program’s model - success factors 101](#_Toc43385945)

Figures

[Figure 1. Visit Program: Program logic 22](#_Toc43385946)

[Figure 2. Visit Program structure 24](#_Toc43385947)

[Figure 3. Clients’ health issues on entry into the Visit Program (n=115) 29](#_Toc43385948)

[Figure 4. Visit Program clients’ mental health conditions (n=115) 30](#_Toc43385949)

[Figure 5. Time in the program for current clients 39](#_Toc43385950)

[Figure 6. On average, clients self-reported general health has increased since joining the Visit Program (n=57) 66](#_Toc43385951)

[Figure 7. On average, clients less often feel ‘Downhearted and blue’ and think that their physical health or emotional problems are interfering less with their social activities (n=57) 66](#_Toc43385952)

[Figure 8. On average, clients are more often (1) ‘Feeling calm and peaceful’ and (2) feeling like they ‘Have a lot of energy’ (n=57) 67](#_Toc43385953)

[Figure 9. Overall, less clients have had issues doing and completing regular activities due to emotional problems (n=57) 68](#_Toc43385954)

[Figure 10. Clients are feeling less lonely and more satisfied with their levels of social interaction (n=57) 69](#_Toc43385955)

[Figure 11. The frequency at which clients get together socially with friends or relatives has remained stable (n=57) 70](#_Toc43385956)

[Figure 12. On average, clients see themselves as (1) more confident, (2) more relaxed in social situations, and (3) slightly better at meeting new people (n=57) 72](#_Toc43385957)

[Figure 13. On average, the extent to which pain has interfered with clients doing normal work (including housework) has remained stable (n=57) 73](#_Toc43385958)

[Figure 14. Overall, slighly less clients have had issues doing regular activities as a result of their physical health (n=57) 74](#_Toc43385959)

[Figure 15. ICER calculation 84](#_Toc43385960)

Executive summary

This is a report of an independent evaluation of Open Support’s Visit Program, which is for people who are socially isolated and aims to improve clients’ health and wellbeing.

A volunteer ‘visitor’ or staff member visits each client on a regular basis for up to two hours at a time to provide a social experience, with the activities being chosen by the client. The Visit Program also offers small group activities for some clients to give them opportunities to broaden their social connections. Services are provided at no cost to clients and participation is not time limited.

In 2020, the service had 115 clients across two sites in Sydney—the eastern suburbs and the south western suburbs of Sydney. Clients are typically older women and the majority have poor physical and/or mental health, which limits their ability to socialise outside of their home or immediate neighbourhood. The services are provided by seven paid (staff visitors) and fifteen volunteer visitors.

The evaluation

Open Support engaged ARTD Consultants to evaluate the Visit Program to assess the appropriateness of the service model, the benefits of the program to clients, and its cost-efficiency. The evaluation used a mixed-methods design, synthesising qualitative data collected from program staff, volunteer coordinators, visitors, and clients, with quantitative data from client surveys, HILDA Wave 18 Survey data and program activity and costs data.

Overall, we are confident that the final report provides an accurate picture of the service model’s strengths and weaknesses and of its benefits for clients.

Key findings

The Visit Program is highly valued by partner agencies, program staff and clients because it fills a service need not met by other providers where it is offered. Clients feel less socially isolated and look forward to the visits from their visitor, enjoy the activities they do with them, and appreciate having someone to talk to confidentially, who is non-judgmental and can offer advice or a new perspective.

The evaluation sought to answer questions about whether or not the program reduces the negative effects of social isolation and if any components of the service model should be changed and the client group expanded.

Visitor Program impact on the severity of the negative effects of social isolation

The Visit Program has had a positive impact on clients’ overall wellbeing. Results from the Client Survey showed a statistically significant impact on client mental health before and after joining the Program. Clients also reported a slight increase in overall health, improved mood and energy levels, and increased satisfaction with their level of social interaction. On average, clients are more confident and relaxed in social situations. They also reported a reduction in the impact of their health or emotional problems on social activities, and on feelings of loneliness.

Visitor Program impact on the prevalence of the negative effects of social isolation

Almost one third of Visit Program clients (29%) reported mental health improvements that saw them transition from clinically mentally unwell to wellness.

The appropriateness of the service model

The evidence suggests that the current service model is meeting individual clients’ needs and is aligned with best practice approaches for reducing social isolation. The service is client-centred, and from the clients’ perspectives, of sufficient intensity to make a difference to their feelings of social isolation. Although, varying the frequency of visits and time spent together to meet individual client’s preferences would make the service even more client-centred.

However, delivering the service model has had its challenges. Demand for the service is not being met and management resources are stretched. The program (especially the south western Sydney program site) has experienced ongoing problems recruiting and retaining suitable volunteer visitors, and the cycle of recruiting, training and supporting new volunteers is resource intensive. There is nothing to suggest this will change for the better in the future.

Clients are increasingly presenting with complex health issues, and program staff believe such clients’ needs are best met by paid professional staff. The COVID-19 crisis has seen the service respond by replacing face-to-face visits with phone calls, and these are being done by paid staff.

A key element of the service model is the mix between volunteers and paid staff as visitors. The service started with only volunteer visitors and the question has been raised about whether or not volunteers should be replaced with paid staff. We believe this decision is mainly a business one. It should take into account the demand for services and balance the cost of hiring more paid visitors versus the costs of recruiting, training and supporting volunteers. Our evidence shows that volunteer visitors receive sufficient training to provide the desired support to most clients. There is no difference in outcomes for clients between paid and volunteer visitors.

Another key element of the service model is that clients can participate in the program indefinitely (61 per cent have been involved in the Visit Program for two years or less, 19 per cent for over five years), which makes actively managing the waitlist a challenge. But the underlying causes of a person’s social isolation are not addressed by the intervention and as such we do not recommend a change here.

The service has been offering some group activities, and these have been welcomed by most clients who have attended. Our literature review indicates that interventions that used a mix of group- and individual-based design elements yielded significant positive results. But expanding these offerings within existing resources would likely mean fewer individual visits, and the evidence is that individual visits make a difference to people’s lives. In addition, volunteer visitors may need additional training to manage group dynamics effectively. We suggest that Open Support does more to link clients in with existing groups or partner with other organisations to provide group activities.

#### Should the program cater for a broader spectrum of client groups

In recent years, Open Support has become aware through its referral partners that the program may be suitable for a broader client group experiencing social isolation. These groups include people from all backgrounds who have complex health needs, people who have recently experienced homelessness and are now living in accommodation services, informal caregivers, and Aboriginal and Torres Strait Islander people. It may be that skilled professionals would be in a better position to support this broader spectrum of vulnerable clients than volunteers.

Economic value

Overall, the economic evaluation showed that the Visit Program is a sound investment for the community. A simple cost-benefit analysis showed that Visit Program is delivering economic value to the community with a benefit-cost ratio of roughly 2:1 and a net benefit of over $500,000 largely due to the program’s impact on its clients’ quality of life. A cost-effectiveness analysis showed that for every point gained on a validated mental health measure (Mental Health Composite Score derived from the SF-12), the Visit Program delivered approximately $60,000 (savings and benefits) to the community.

Recommendations

#### Program intensity

* Adapt the frequency and mode of client visits to individual client needs – this provides a more client-centred approach, a cornerstone of the program’s philosophy.

#### Client experience

* Offer more group activities by partnering with other organisations, such as councils, to organise and run joint activities; and also link clients in with existing social opportunities.
* Support visitors who attend group activities with their clients to be skilled in group interaction processes.

#### Volunteer and staff visitor mix

* Phase out volunteer visitors when the costs of recruiting and retaining volunteers are more than employing paid staff.

#### Training and supporting volunteer visitors

* Provide all visitors with mandatory training in ‘understanding grief and loss.’
* Offer mandatory modules online to increase timely access to the training and ensure that all visitors had completed the training before starting their role.
* Complement buddy visits with other modes of training to address the logistical difficulties in scheduling the buddy visits; the difficulty in sometimes finding clients who are willing to participate in the process; and a concern that the buddy visits do not prepare all volunteer visitors for the role.

#### Management of the program

* Both program sites should have dedicated Visit Program staff, which would enable the program coordinators to focus on the Visit Program.
* Expand administration support at the eastern suburbs program site to assist the coordinator to manage the large number of volunteers.

# The evaluation

## The project

Open Support contracted ARTD Consultants in July 2019 to evaluate the Visit Program and provide advice on building capacity for future monitoring and evaluation activities. The project has involved:

* conducting an impact and economic evaluation of the Visit Program
* developing a program logic; and a monitoring and evaluation framework for the program
* preparing a literature review that explored the following areas: what is social isolation; who is likely to experience social isolation; what are the effects of social isolation on the individual; what is the cost of social isolation to society; and, what kinds of programs are being used to combat social isolation.

### This report

This is the **final report**, which summarises the findings from our data collection to answer the key evaluation questions. It includes a review of the social isolation literature, as well as a cost-effectiveness analysis.

### Purpose

The evaluation aims to support Open Support to make informed decisions about the future direction of the Visit Program and efforts to secure ongoing funding for the program. It explores the medium to long-term impacts of the Visit Program on reducing social isolation in its target cohort of clients; and the cost-efficiency of the Visit Program through a comparison between the costs and the outcomes of the program for physical and mental health and those of the alternative (not running the program).

## Key evaluation questions

This report addresses the following key evaluation questions:

* Does the Visit Program reduce the prevalence or severity of the negative effects of social isolation at an individual level and/or at a community level, according to the measures agreed to?
* Should the Visit Program continue in its current model or be expanded to include a broader spectrum of client groups?
* Do any other components of the model need to be changed? What are they?

The literature review (Appendix 1) looks at these key evaluation questions:

* What is social isolation?
* What negative effects does social isolation have on mental health and/or physical health and/or quality of life?

The Monitoring and Evaluation framework addressed the following key evaluation questions:

* What measures should be used to determine the impact of the Visit Program on the individual client’s mental health and/or physical health and/or quality of life?
* What measures should be used to determine the impact of the Visit Program at a community level?

## Methods

The evaluation used a mixed-methods design, synthesising qualitative data collected from program staff, volunteer coordinators, visitors, and clients, with quantitative data from client surveys, HILDA Wave 18 Survey data and program activity and costs data.

All focus groups and most interviews were recorded, with consent, and written up and analysed using a grounded theory approach – an established method for systematically analysing qualitative data. We developed a coding framework based on the evaluation questions and interview guides, in order to identify key themes and findings. We then systematically reviewed the interview and focus group write-ups in accordance with the framework, condensing the data and refining the themes. Direct quotes were used to illustrate findings and give voice to participants.

Client survey data and HILDA Wave 18 Survey data were analysed in Tableau and SPSS, generating mean calculations and frequency tables for client surveys that had been entered before May 1, 2020. The administrative data provided by Visit Program staff were cleaned in Tableau Prep and analysed in Microsoft Excel. All tables and graphs were created in Microsoft Excel. We synthesised this with the qualitative data and the literature to triangulate findings and develop conclusions.

1. Data collection methods

| Data source | Sample | Timing |
| --- | --- | --- |
| Focus groups and discussions with Visit Program staff | Three Visit Program staff at the first focus group; three Visit Program staff and two Open Support volunteer coordinators at the second (online) focus group. | Focus groups in August 2019 and April 2020  Ongoing discussions |
| Assessment of existing administrative data | Data included monthly reports, assessment and re-assessment data, and aggregated statistics. | Ongoing, continuing as additional data is provided |
| Focus groups with visitors | * Focus group 1: Four volunteer visitors and four staff visitors from the eastern suburbs program site. * Focus group 2: Three staff visitors from the south western suburbs program site. | October 2019 |
| Retrospective pre-post surveys | * All current Visit Program clients as at October 2019 who were considered by Open Support staff to be able to participate, and gave consent, were asked to complete a survey that asked questions about their wellbeing and behaviour prior to their involvement in the Visit Program, and then since they have been involved in the program. * Surveys were provided to clients in hard copy by their visitor. * At the end of April 2020, we received 57 retrospective surveys, which represents 53% of all surveys distributed—34 from the eastern suburbs program site (from a total of 75 distributed), and 23 from the south western suburbs program site (from a total of 33 distributed).   Note that at the eastern suburbs site, 10 clients declined completing a survey; 7 clients were considered too unwell to ask to complete the survey; 5 clients exited the program, although 4 of the 5 still completed the survey; and 23 others did not complete the survey for a number of reasons, including not interested, and didn’t consider the survey to be important.  At the south western suburbs site, 4 clients declined completing a survey; and 6 clients were considered too unwell to ask to complete the survey.   * Impact of COVID-19. We had initially planned to follow up any unreturned surveys at the end of April, to incorporate into our evaluation. But because of the restrictions put in place as a result of COVID-19, particularly social isolation measures, it was decided (in conjunction with Visit Program staff) that after the end of March we would not follow up any unreturned surveys. | October 2019 |
| Pre and post surveys | * All new Visit Program clients who entered the program during October 2019 – January 2020, who were considered by Open Support staff to be able to participate, and gave consent, were asked to complete two surveys—one when they joined the program, asking questions about their wellbeing and behaviour prior to their involvement in the Visit Program; and another survey after they had been part of the program for at least three months, to capture any changes in their wellbeing and behaviour. * Surveys were provided to clients in hard copy by their visitor. * We received 5 pre surveys for clients who entered the program during the data collection period (3 from the south western suburbs site, and 2 from the eastern suburbs site), however no corresponding post surveys were received by ARTD. As with the retrospective surveys, because of COVID-19 it was decided (in conjunction with Visit Program staff) that we would not follow up any unreturned surveys after the end of March. The 5 pre surveys were therefore unable to be included in the analysis. | October 2019–March 2020 |
| Interviews with clients | * We interviewed 15 Visit Program clients (10 from the eastern suburbs program site, and five from the south western suburbs program site). * Clients were randomly selected by ARTD from lists of clients considered well enough by Open Support to participate in an interview – at the eastern suburbs site, a total of 17 clients were selected, as 7 declined to be interviewed; and at the south western suburbs site, a total of 9 clients were selected, as 2 were not well enough to participate in an interview and 2 declined to be interviewed. | November–December 2019 |
| Interviews with external stakeholders | * We interviewed five external stakeholders who refer clients to the Visit Program. | November–December 2019 |
| Economic evaluation | * ARTD conducted an economic evaluation, including a cost-effectiveness analysis and a simple cost-benefit analysis. The cost-effectiveness analysis determined the incremental cost-effectiveness ratio (ICER) between the benefits and costs of the Visit Program and those of no intervention. The cost-benefit analysis determined the net benefit and cost-benefit ratio of the Visit Program. | May–June 2020 |

## Ethics review

A submission for ethics approval was made to the St Vincent’s HREC on 2 September 2019. Ethics approval was granted on 15th October 2019 – ethics approval number is 2019/ETH12880.

## Confidence in the findings

Overall, we are confident that this draft final report provides an accurate analysis of the implementation and impact of the Visit Program. Using a mixed-methods design, this report triangulates the results of surveys of clients; interviews with clients, visitors, Open Support Program staff and stakeholders from referral agencies; analysis of program data; analysis of the economic value of the program; analysis of HILDA Wave 18 Survey data; and a review of the social isolation literature. We are confident the evaluation is based on a sufficient set of evidence to support the conclusions and recommendations made. Overall, there was a strong consistency in the findings across the range of stakeholder groups consulted, the literature on social isolation and the results of the client surveys.

### Limitations

Key data limitations for the evaluation are detailed below.

* **Data fidelity**. The Visit Program does not have a digital client management system (which is appropriate given the size of the program). Program staff conduct routine assessment and reassessment of clients’ health, living situation and needs, and store this data on paper at each site. Visit Program staff manually entered the most recent assessment data (and other administrative data, such as client exits) into Excel spreadsheets for use in this evaluation, but didn’t have capacity to enter all of the available assessment data on their client cohort (which is more than reasonable given the time constraints staff already face). This meant that we were unable to explore in depth finer details about clients, such as whether clients aged 65 and over had previously applied to NDIS. We were also unable to distinguish between diagnosed and suspected mental health conditions. However, the findings of the analysis of client assessment data was aligned with evidence from the literature about the high prevalence of mental health conditions amongst people experiencing social isolation and previous internal research conducted by the Visit Program about the prevalence of mental health conditions amongst their client cohort.
* **Survey data sample size**. Fifty-seven out of a possible 108 (approximately) survey responses were received in time[[1]](#footnote-1) to be included in analysis for this report. This is a response rate of 53 per cent, a strong response rate for a survey of this kind.
* **Retrospective pre-post surveys; and pre and post surveys**.A retrospective pre-post survey was distributed to existing Visit Program clients to improve the sample size for the impact and economic assessments. Although retrospective pre-post designs have some disadvantages in comparison with traditional pre-post designs, they are a valid approach and do have some advantages over traditional pre-post designs (such as a reduction in response-shift bias[[2]](#footnote-2)). A vast majority of the survey responses received were to the retrospective version of the survey, which is to be expected as most respondents had already been part of the program for some time and thus did not qualify for the traditional pre-post survey approach. Regarding the pre and post surveys for new clients, because no post surveys were received from new clients a comparison could not be made between the two time points for these respondents and so they were not included in the analysis. This low number of traditional pre-post responses is likely due to the low number of new clients entering the program at this time and the suspension of survey follow-up due to COVID-19.
* **HILDA Wave 18 Survey data**.We extracted a subset of HILDA Wave 18 Survey data that (1) was of a comparable age range (45 and over), and (2) satisfied criteria for experiencing social isolation that we extracted from the literature review. We compared client survey results with the HILDA subset on matched items, including items from the SF-12 and frequency of hospital admissions.
* **Economic evaluation**. There were some limitations in calculating the monetary benefit and cost-effectiveness of the program. Firstly, results from the SF-12 questionnaire (version 1) items that were included in the survey could not directly calculate quality of life adjusted years (QALYs). To do so, results from the SF-12 items had to be first converted into SF-6D scores (a related scale) using an equation appropriated from a pre-existing study. This study was conducted in a comparable but small population, which could decrease the reliability of the economic evaluation. Secondly, there were also several limitations in terms of calculating the costs of not running the Visit Program, which was used as the ‘alternative scenario’ to calculate the cost-benefit and cost-effectiveness of the program. The costs of not operating the Visit Program are the costs to the government of the negative outcomes (in terms of mental and physical health) that are averted by the program. These costs have been calculated at the governmental level for two reasons; first, the cost implications of social isolation and loneliness fall heavily on the government, and second, these are the most readily available and calculable costs when using publicly available data. The costs as stated leave out many indirect costs of the mental and physical effects of loneliness and social isolation. These costs (such as decreases in productivity and income tax and increases in transfers) would be incurred at a governmental level; however, the amount and rate at which these would occur are unknown. Therefore, it is likely that the program is more cost-effective than indicated by the analysis. The costs that would have been incurred by clients had the program not existed have not been included. There are likely out-of-pocket healthcare costs and other costs auxiliary to poor mental or physical health that would have fallen to these individuals. To ameliorate these limitations, a conservative approach to the economic evaluation was used, decreasing the likelihood of over-estimating the economic value of the Visit Program. The implication of this is that the economic value of the Visit Program may be higher than what is reported in this document.

# The Visit Program

## The policy context

Social isolation is defined by having limited contact with other people[[3]](#footnote-3), [[4]](#footnote-4). Current research suggests that social isolation has significant and diverse impacts on the health and wellbeing of people who experience it. Many studies have linked social isolation with decreased mental and physical health (see Literature Review in Appendix 1 for more detail); other research has suggested that social isolation increases people’s engagement in health-risk behaviours, such as smoking[[5]](#footnote-5). The long-term effects of social isolation appear to be severe, with longitudinal research suggesting that increased levels of social isolation are predictive of early mortality[[6]](#footnote-6).

The issue of social isolation has received some recent attention in the public sphere and in policy circles, largely due to the work of the *Campaign to End Loneliness*, which began in 2011 in the United Kingdom. The Campaign aims to improve the availability of effective services to support people experiencing loneliness by advocating to government and service providers about loneliness; increase networking amongst researchers and practitioners; and run large-scale public campaigns. The Campaign has inspired a similar organisation to be set up in Australia – the Australian Coalition to End Loneliness (ACEL) – whose members include universities, government and non-government organisations[[7]](#footnote-7). ACEL has an explicit goal to raise awareness of and address social isolation (as well as loneliness) through evidence-based responses.

In 2018, the United Kingdom launched its first loneliness strategy and appointed a Minister for Loneliness[[8]](#footnote-8); there is currently no equivalent policy framework or initiative at a federal or state level in Australia. There are a range of programs that aim to address social isolation – these are mainly targeted at the elderly and/or those with disabilities. See section 4.3 Other in Appendix 1 for a description of programs that aim to address social isolation.

## The Visit Program

Open Support is a not-for-profit, community service organisation that addresses the unmet and changing needs of the most vulnerable community members. The Visit Program is one of a suite of programs delivered by Open Support.

The Visit Program began in 1996 in the eastern suburbs of Sydney. A small number of volunteer visitors provided a ‘cup of tea and a chat’ to people identified as ‘falling through the cracks’, and who would benefit from having support through someone visiting them in their home. As the program became known, demand for support grew and the program expanded to include paid staff visitors and a larger number of volunteers, as well as services that clients could not access through other channels such as respite, shopping, driving to medical appointments, and leisure outings. Over time the program has narrowed its focus to become a more typical ‘befriending program’, where visitors spend time with clients and provide companionship. We have no information to describe why this change in the focus of the program occurred.

In 2009 the Visit Program expanded to the south western suburbs of Sydney. At first, referrals to the program were slow in this region, however the program is now in high demand. Although we have no information as to why and when paid visitors became part of the program at this site, a long-term visitor at the site suggested that paid visitors were employed because there was heavy demand and limited volunteers available.

A long time Visit Program employee suggested that perhaps paid visitors have ‘*always been necessary to assist clients with more complex issues, train new visitors and provide consistency to clients*.’

### Program clients

People referred to the Visit Program must:

* identify as socially isolated and have limited or no community interaction
* be over 18 years of age
* be willing to agree to abide by the program guidelines and sign a client agreement outlining expectations, rights and responsibilities.

The current clients of the Visit Program fulfil the eligibility criteria for the program. See chapter 3 for more information on client demographics.

### The model

The Visit Program provides no cost fortnightly one-and-a-half to two-hour visits to people assessed as being socially isolated. Visits are conducted by staff or volunteer ‘visitors’ and clients are referred to the program through a range of avenues. Some clients are also offered the opportunity to participate in group activities. See chapters 4 and 5 for further detail on the model.

Visitors provide non-judgemental companionship and social support to clients through one-on-one visits, either in the home or through outings such as to a café, and organised social opportunities. Clients receive unconditional positive regard, and a meaningful therapeutic relationship that some may not have in their life.

While most visits involve one-on-one home visits, small group activities in the community are becoming more popular and regular, with the hope that some clients could build new social connections to help them integrate socially into the community.

As noted in the Literature Review (Appendix 1), a scoping review found that one-on-one interventions are relatively common (O’Rourke et. al. 2018); although a more recent review found that, of the interventions included in their review, nearly two-thirds used a group-based design, while only one in ten interventions were one-to-one (Bessaha et. al. 2019). A point of difference with the Visit Program and other similar programs is that it is at no cost to the client and not time limited.

### Meeting demand

The Visit Program is in high demand, with waitlists at both program sites. Program coordinators are reluctant to turn away referrals, with one describing it as a ‘moral dilemma’ when they know there are people who need their support, but the service is at full capacity.

Program coordinators said it can be difficult to give referring agencies an indication of the wait time because of the uncertainty of when clients will exit the program. According to a program staff member: ‘*You could have 10 referrals and one exit in a month, and then 3 referrals and 8 exits a month. It’s quite variable.*’ Program coordinators occasionally refer those on the waitlist to other services if the client is or will be waiting for longer than 3-6 months.

### The impact of COVID-19 on the model

The delivery of the Visit Program has been significantly affected by COVID-19, particularly by the social distancing regulations, given the program’s focus is on face-to-face contact between clients and visitors.

In response to COVID-19, Visit Program staff made changes to the program to ensure it can continue to provide support to clients—these include using telephone and online platform sessions (using platforms such as Skype) between clients and visitors instead of face-to-face visits; and temporarily suspending volunteer visitors.

As the situation with COVID-19 escalated, Open Support recognised that a large proportion of the volunteers providing support across Open Support programs were vulnerable to the risks associated with COVID-19. The decision was taken to suspend all volunteers across all Open Support programs, in the interests of their health and safety. Open Support staff commented that having different arrangements for volunteers across different programs would have been confusing and difficult to communicate clearly, especially with often daily changes. It was also recognised that a significant proportion of the Visit Program volunteers were themselves very anxious about the situation. There was some concern that the volunteer visitors may inadvertently increase the level of anxiety for clients during this time, and so Open Support shifted its focus to supporting the volunteers rather than asking them to continue supporting others.

It was also recognised that in shifting the service delivery model from face-to-face to entirely remotely, the program coordinators would benefit from having a smaller number of people to manage; and staff visitors had the capacity to take on the volunteer visitor client load for the short-term.

Program staff noted that COVID-19 may lead to disruptions in staffing across referral agencies, with the result that knowledge of the program within some agencies may be lost.

Risk with COVID-19 is that staff (in the referral agencies) may change a lot – people who refer may not be there anymore. (Visit Program staff)

#### New ways of connecting with clients

As mentioned above, staff visitors have been allocated all clients who previously had a volunteer visitor. Five clients from the eastern suburbs site (who previously had a volunteer visitor) have been reallocated to staff visitors in the south western site, to help manage numbers. Generally, the same visitor will ring a client each time; although this person may not have been the visitor who visited the client prior to COVID-19. Ten clients in the eastern suburbs program site were assessed by program staff as not suitable for telephone support; the program coordinator at this site has contact with a third party in most cases, and has asked them to update her with any significant changes with the client during the COVID-19 period.

Visitors contact clients at least weekly, with the program coordinators assessing how much contact each client needs; some clients want frequent contact, while others want only infrequent contact. The phone/ online sessions generally last between 1.5-2 hours (i.e. approximately the same time as a visit), although some only last for 10-15 minutes – length is dependent on the client’s preference. Visitors at the eastern suburbs program site are encouraged to limit phone calls to one and a half hours. The staff visitors use staff phones and these contact details are provided to clients.

At first, some staff visitors found it difficult to make a connection with clients via phone/ skype, especially for those visitors who have taken on clients they are not familiar with. As time has gone on, though, and both client and visitor are familiar and comfortable with each other and the new mode of communicating, this has become less of an issue.

Some staff visitors have observed that video sessions such as skype are beneficial for some clients, such as those from some cultural backgrounds who might use body language to express themselves.

Staff visitors identified some downfalls with phone contact, describing it as ‘draining’ if they are on the phone all day. Some clients want to mainly focus on the pandemic – visitors try to be upbeat and positive, and have said that using media such as skype, that provides some semblance of face-to-face contact, enables diversions to be suggested to change the tone of the conversation.

Clients have expressed a range of views on the new contact approaches. Some clients are appreciative that the connection with a visitor has been maintained during the pandemic, while others miss the face-to-face interaction with their visitor. At the beginning of the pandemic, a small number of clients wanted to leave the program as they were concerned that people would be coming to their home.

#### ‘Suspending’ volunteers

Whilst volunteer visitors are suspended, the volunteer coordinators are maintaining contact with them.

#### After COVID-19

Whilst phone and video contact with clients are new and unexpected modes of interaction for the Visit Program, there is the potential that they could be retained for interaction with some clients in the future once the COVID-19 crisis is over. With the COVID-19 situation stabilising and the level of risk and uncertainty in the community lessening, Open Support is in the process of re-engaging suitable volunteers in a modified capacity within the Visit Program (e.g. providing phone support) and within some other areas of the organisation.

Our literature review indicates that telephone contact can be beneficial in some circumstances, allowing frequent contact between staff/ volunteers and socially isolated consumers where geographical barriers exist, or where people may not feel comfortable about having people come to their homes or meet face-to-face (Devine 2014).

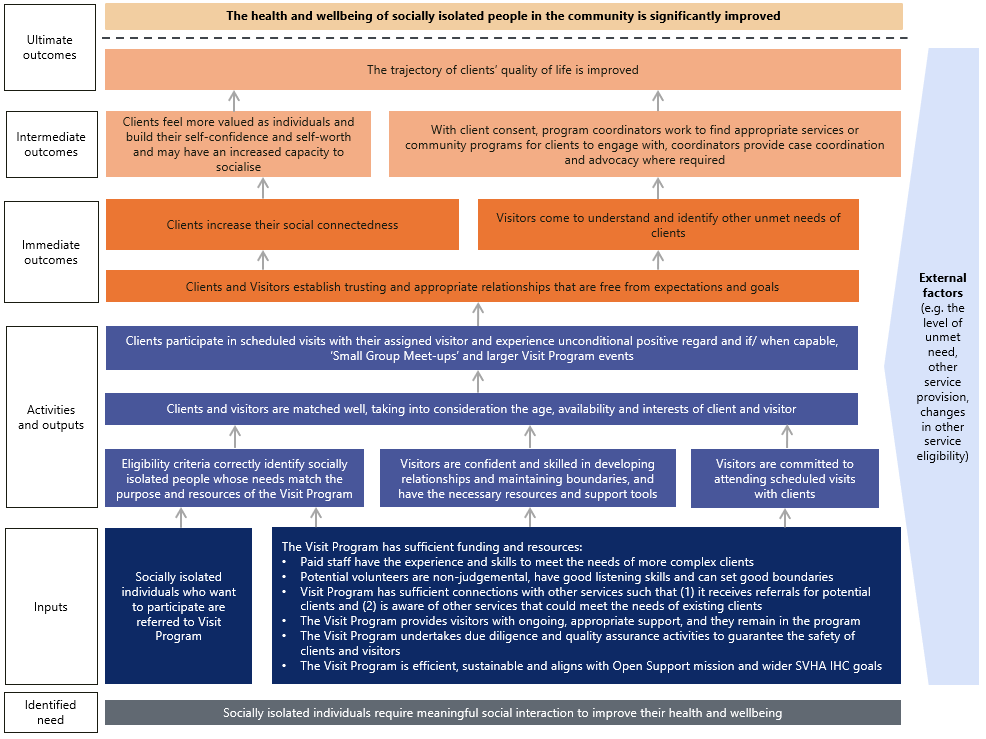
### Intended outcomes

Figure 1 shows the program logic. It is designed to be read from bottom-to-top, showing the causal links between the need the program is aiming to address, the processes involved, and the intended short, medium and long-term outcomes.

In summary, the model identifies that through sufficient funding and resources, appropriate clients and visitors are suitably matched, scheduled visits provide unconditional positive regard to clients and positive outcomes for clients result. In the immediate term, clients are expected to build positive relationships with visitors and increase their social connectedness. If this is achieved, it is expected that clients feel more valued as individuals, build their self-confidence and self-worth and have increased capacity for socialising, leading to an improved quality of life. Visitors are expected to understand and identify their clients’ needs, enabling them to connect them to appropriate programs and services.

The ultimate aim of the program is to significantly improve the health and wellbeing of socially isolated people. The dashed line before the ultimate outcome recognises that the Visit Program is only one contributor to population level outcomes for people who are socially isolated. And the grey box on the right recognises the external factors that are likely to impact the extent to which outcomes are achieved.

1. Visit Program: Program logic



### Governance

The Visit Program is overseen by an Operations Manager, who manages the two program coordinators. The Operations Manager also has oversight of a Domestic and Family Violence program, as well as management of organisational risk, quality and incidents across Open Support.

#### The role of program coordinators

The Visit Program has two program coordinators—one for the eastern suburbs site, and the other for the south western suburbs site. The two positions have a different scope.

The program coordinator at the eastern suburbs site is employed 28 hours a week and works exclusively on the Visit Program. The program coordinator at the south western suburbssite is employed 28 hours a week, with 60 per cent of her time devoted to the Visit Program. She also manages a court support program and manages the house in which the programs are located. Both coordinators conduct screening, assessment and reviews for Visit Program clients in their region; schedule visits and match visitors to clients within their team; and facilitate events and small group activities.

#### Differences in management of the program at the two sites

The difference in management of the program at the two sites is due to historical reasons (see Figure 2).

1. Visit Program structure

Volunteer coordinators and Visit Program leadership staff

Shared policies and procedures

**Eastern suburbs program site**

* Established 1996
* Part-time dedicated program coordinator
* Visitor who provides additional administrative support

**South western suburbs program site**

* Established 2009
* Part-time program coordinator, also coordinates another Open Support program
* Part-time intake and assessment officer, also provides administrative support and is a visitor

Program staff indicated that the management of the Visit Program has improved over time,

particularly in recent years with the employment of new Open Support leadership staff and a focus on streamlining and consolidating management processes. In 2020, Open Support has a common operations manual and policy and procedures across the two sites, and these include improved information on safety precautions and how to address issues that may arise with clients.

Program staff noted though that it is problematic having the two program sites administered differently. They suggested that consistency in administration across the two sites would make overall management of the program more streamlined. The coordinator at the south western suburbs site said it can be difficult having to ‘juggle’ her time across two programs, as well as manage the running of the house.

We suggest that both program sites have dedicated Visit Program staff who have no other roles outside managing the Visit Program – this would mean that both program coordinators could focus all their time and attention on the Visit Program, and the overall management of the Visit Program by the Operations Manager would be more efficient. For example, at the south western suburbs program site, the running of the house, the management of the other program, and administration support could be delegated to another staff member, and the role of Visit Program intake and assessment officer could be incorporated into the role of the current program coordinator.

#### Volunteer coordinators

Open Support employs two volunteer coordinators who work across the Open Support programs. Each coordinator works part-time, and they job share the role, overlapping on Wednesdays when most of the planning for their role occurs.

One volunteer coordinator works 18 hours a week and their role focuses on recruiting volunteers; and the other coordinator works 24 hours a week, and her main focus is on organising and providing training for volunteers. For more on the role of the volunteer coordinators, see chapter 5.

# Client profile

Key findings

There are currently 115 clients supported by the Visit Program across the two program sites. Of these, most (83%) are female and a majority (67%) are over 70 years of age; the social isolation literature suggests that this demographic is to be expected.

Clients present with a range of health conditions. Mental health issues are prevalent – the most common being mood disorders (52%), and anxiety and fear-related disorders (34%). Eighteen per cent of clients are recorded as having mobility issues, and three per cent as having a physical disability.

In recent years, an influx of younger; more culturally and linguistically diverse; and clients with more complex needs has been reported. With the program’s focus on addressing social isolation of those most vulnerable, these target groups should continue to be considered and accommodated.

With the appropriate training and support for visitors, the Visit Program could possibly be expanded to include other client groups such as people recently released from prison, people at risk of homelessness, people who have experienced domestic violence, new mothers, and cancer patients – cohorts identified by our literature review and interviews with stakeholders as at risk of social isolation.

## Client demographcis

As of February 2020, the Visit Program has 115 clients (Table 2), with 28 people on the waitlist. This is a substantial increase since October 2019 when we reported 13 people on the waitlist, indicating high demand for the program. Approximately two-thirds (67%) of clients are involved with the eastern suburbs program site, and approximately a third (33%) are involved with the south western suburbs program site.

Most Visit Program clients are female (83%, Table 2). The majority of clients (67%) are aged over 70 years, and around one quarter (27%) are aged between 51-70 years of age (Table 2), with only 6 per cent being aged less than 51 years. This profile is consistent with the social isolation literature: older people are at a heightened risk of social isolation and are the most commonly researched and reported on demographic[[9]](#footnote-9),[[10]](#footnote-10). Older men are also less likely than older women to seek out social networks[[11]](#footnote-11), which is reflected in the Visit Program client demographics.

1. Site, gender and age range of Visit Program clients

|  |  |  |  |
| --- | --- | --- | --- |
| Demographics | | n | % |
| **Site** |  |  |  |
|  | Eastern suburbs | 77 | 67% |
|  | South western suburbs | 38 | 33% |
| **Gender** |  |  |  |
|  | Female | 95 | 83% |
|  | Male | 20 | 17% |
| **Age range (years)** | |  |  |
|  | 21-30 | 1 | 1% |
|  | 31-40 | 2 | 2% |
|  | 41-50 | 4 | 3% |
|  | 51-60 | 11 | 10% |
|  | 61-70 | 19 | 17% |
|  | 71-80 | 37 | 32% |
|  | 81-90 | 35 | 30% |
|  | 91-100 | 6 | 5% |
| **Total** |  | **115** | **100%** |

Source: Visit Program administrative data, February 2020.

## Physical and mental health conditions

Clients present a range of health conditions (Figure 3). Mental health issues are prevalent: according to the administrative data, seventy-four clients (64%) have a known or suspected mental health issue. The most common are mood disorders (52%, n=60), and anxiety and fear-related disorders (34%, n=39). Figure 4 illustrates in more detail the breakdown of the most commonly reported mental health conditions, e.g. major depressive disorder (48%, n=55) and generalised anxiety disorder (33%, n=38).

This data is to be expected for a social isolation program, with literature suggesting that social isolation and mental health conditions are interrelated. Many studies show links between social isolation and psychological distress[[12]](#footnote-12), depressive symptoms[[13]](#footnote-13), anxiety symptoms[[14]](#footnote-14), suicidal ideations[[15]](#footnote-15) and possibly even dementia[[16]](#footnote-16). It appears that a person’s perception of social isolation and/or loneliness may be causing and/or caused by mental health conditions[[17]](#footnote-17).

Physical disability is also a common health issue, with 18 per cent of clients recorded as having mobility issues and 3 per cent recorded as having a physical disability. Thirteen per cent of clients are recorded as having a physical illness (such as including diabetes and cancer). Small percentages of clients are recorded as having a learning disability or intellectual disability, neurodegenerative illness or a hearing or vision impairment.

#### Identifying health needs

Identifying clients’ physical and mental health conditions at the time of assessment is dependent on what health information is included in the referral form. Interviews with stakeholders from referral agencies indicated they include information about their client’s situation, and health status and needs. Visitors said it is helpful to know if the client has undergone/ is undergoing any treatment and if they have any diagnosed physical or mental health issues.

It depends on the information that the referrer gives, especially when they do not tell you the whole truth. We’re not given all the information sometimes. (Staff visitor, eastern suburbs program site)

It does help to know if they are going through treatment though. That is the only thing you can find out. (Volunteer visitor, eastern suburbs program site)

Visitors from the south western suburbs program site said that when the program was first established in that region some clients self-referred. Visitors were sometimes not aware of any physical or mental health issues that clients may have had (unless the client disclosed this) and may not have become aware of them until they had visited the client a few times.

There are no standard diagnostic criteria used to assess clients’ health conditions on entry to the Visit Program. Sometimes a diagnosis is given by the referring agency, particularly if it is a specific mental health condition such as schizophrenia, and program staff note that this is very useful; at other times a referral agency will write a brief description of the patient’s health condition, such as ‘depression’ or ‘anxiety’. And at other times there will be no description of any client health issues, and it is only when the client has been in the Visit Program for a while that they may inform Visit Program staff or visitors that they have a health condition such as depression or anxiety; this is then written in their client notes.

We suggest that the section on the referral form called ‘Reason for Referral’ be enhanced with more specific categories of information, such as ‘Diagnosed Health Condition’. This is especially important for clients with mental health issues, to both ensure that appropriate clients are referred to the program, and also to ensure that clients with these conditions are matched with staff visitors who have more training and experience in responding to the needs of this cohort of clients. Currently, people who are acutely unwell with severe mental health issues are excluded from the program.

1. Clients’ health issues on entry into the Visit Program (n=115)

Note: Clients can have multiple conditions.

Source: Visit Program client assessment data, February 2020.

1. Visit Program clients’ mental health conditions (n=115)

Note: Clients can have multiple conditions.

Source: Visit Program client assessment data, February 2020.

## Client supports

Most Visit Program clients are not eligible for support through the National Disability Insurance Scheme (NDIS) because they are aged over 65 years, although a small number have applied. A larger proportion of clients have applied for and/or received support through My Aged Care[[18]](#footnote-18) (Table 3). Visit Program staff noted that *‘people who can’t access the NDIS and My Aged Care, seem to be referred here*’, acknowledging that the Visit Program provides support to those who cannot access this type of support from other avenues.

1. NDIS and My Aged Care application status

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Supports |  |  | Under 65 | 65 and over | |
| **NDIS status** | | n | % | n | % |
|  | Approved | 5 | 17% | 2 | 2% |
|  | Pending | 6 | 20% | 0 | 0% |
|  | Not approved | 3 | 10% | 0 | 0% |
|  | No NDIS | 16 | 53% | 83 | 98% |
| **My Aged Care status** | |  |  |  |  |
|  | Approved | 1 | 3% | 46 | 54% |
|  | Pending | 0 | 0% | 6 | 7% |
|  | No My Aged Care | 29 | 97% | 33 | 39% |
| **Total** |  | 30 | 100% | 85 | 100% |

Note: It is possible that some clients aged 65 and over applied for NDIS – this is not available in the data provided for this report. The data also cannot tell us the date when someone applied for support; or if people have applied for both NDIS and My Aged Care.

Source: Visit Program client assessment data, February 2020.

## Relevance of the program for other population groups

In recent years, clients who are younger, and/or are from culturally and linguistically diverse (CALD) backgrounds, are increasingly being referred to the program. Visit Program staff suggested two core reasons for the change in profile of clients. There is increased awareness of the Visit Program amongst different referral agencies; and greater recognition that social isolation is not just an issue for the elderly. Also, mental health case managers increasingly encourage clients to seek out social connection as part of their case plan.

Stakeholders from referral agencies suggested the Visit Program is an appropriate program for other at risk cohorts who also experience social isolation, including new mothers or mothers with postpartum depression; people exiting prison; people living in accommodation services who have recently experienced homelessness; people experiencing domestic violence; and people living with cancer or undergoing cancer treatment.

Our review of the literature revealed that there is a wide range of cohorts at risk of social isolation, including people who are chronically ill, informal caregivers, Aboriginal and Torres Strait Islander people, LGBTQIA+ peoples, people from culturally and linguistically diverse backgrounds including refugees and a range of others[[19]](#footnote-19). With the program’s focus on addressing social isolation of the most vulnerable in the community, these target groups should continue to be considered and accommodated.

Changing client profiles will require adaptation. One stakeholder from a referral agency stressed the necessity of visitors having appropriate training to be able to interact appropriately with different client cohorts. Visitors, particularly in the south western suburbs program site, stressed that if the program was to take on clients who may not be proficient in English, there would be a need to recruit visitors who can speak different languages. This might be problematic in this program location as it is already difficult to recruit volunteer visitors in that area.

# Client experience

**Key findings**

The Visit Program provides valuable experiences for its vulnerable clients. Clients we spoke with were overwhelmingly positive about the relationship they had with their visitor, saying they looked forward to their visits and enjoyed the activities they do with them. Existing evidence stresses the importance of relationships in reducing social isolation. Visit Program clients value having someone who is non-judgemental to talk to confidentially about any worries or concerns they may have and who can offer a new perspective.

Many clients were referred to the program by health agencies, including hospital staff such as social workers, and disability agencies; referrals were also via family members, or their church. Stakeholders from referral agencies described the referral process as easy and transparent.

More than half of the clients we spoke with said the main reason they wanted to be part of the program was because they were lonely. Four clients noted a range of health conditions, including depression, limited mobility and other mental health conditions, as their reason for wanting to participate in the program.

On average (pre-COVID 19), clients meet with their visitor once a fortnight for one-and-a-half to two hours. While clients are very happy that they have a regular visit, four clients would like more frequent visits – two were lonely, and another two had physical limitations that limited the extent to which they could leave their home. Six clients would like the visits to be longer so that they could spend more time with their visitor, which they enjoy, and do activities that may take longer. We suggest the program considers adapting the frequency and mode of visits to individual client needs – this provides a more client-centred approach, a cornerstone of the program’s philosophy. This could be managed within current resources.

There is no maximum length of time that clients can remain in the program—most clients (61%) have been involved in the Visit Program for two years or less, though a small proportion (19%) have been involved for over five years. Clients generally only leave the program if they move into a care facility, experience a deterioration in health or other circumstances that make them unable to participate in the program, or die. Under the current service model, the only way to expand the number of clients in the program would be greater resourcing.

Generally, clients meet with their visitor one-on-one either at their home, or in a public place such as a cafe. Activities are chosen by the client, which aligns with the literature on successful social isolation interventions. A factor of successful social isolation interventions is that service users are actively engaged in their improvement and can make their own choices.[[20]](#footnote-20),[[21]](#footnote-21) As well as providing one-on-one visits with clients, the Visit Program also offers small group activities with clients who meet specific criteria. Almost all clients we spoke with who had attended group activities enjoyed them, with evidence to suggest that these facilitate positive social connections and build client confidence in socialising. We suggest the Visit Program consider organising more frequent group activities for those interested. We know that organising and running group activities is resource intensive and to address this we suggest that program staff, or it could be a role for volunteers, look into applying for grant funding, for example though councils, philanthropic organisations, utilities, banks. Other options are to partner with other organisations, such as councils, to organise and run joint activities; and also, to link those clients, for whom it is considered suitable, with existing social opportunities.

Program staff emphasised that good visitors were reliable, committed and non-judgemental. The literature is mixed about what makes a good visitor for a program such as the Visit Program—some facilitating attributes may include similar age, common interests and activities, expectations regarding visits, background and life history and personality. This accorded with what Visit Program staff said were the qualities of good visitors.

Clients commonly said their visitor makes them feel calmer and cheers them up when they are depressed. Clients also liked that their visitor was easy to talk to; and could provide them with advice or a new perspective. Many clients were open to the idea of changing visitors and could understand why this might be necessary, but many would also like to remain with their current visitor because of the strong existing relationship.

## The referral process

Generally, the referral process works well: the program is promoted to appropriate referral agencies, staff at these agencies are familiar with the referral criteria, and on the whole appropriate clients are being referred.

The referral agency stakeholders we spoke with were positive about the referral process – with one describing the process as *‘clear and transparent’*. Most clients they refer engage with the program because they are lonely and have limited social contacts.

Because the client group is socially isolated, they are most likely to come to the program via interactions with health and other care and support services. Clients we spoke with commonly heard about the Visit Program via a health agency or support service, indicating that promotion of the program to these avenues has been effective.

One client described in detail how they came to know about and become part of the Visit Program through a hospital visit.

I had a fall, fractured my pelvis and spent three weeks in a geriatric unit in hospital. People came here to my home for 12 weeks after I left the hospital, like a physio … After the 12-week program finished, a social worker or psychologist suggested the Visit Program to me. (Visit Program client)

Other clients heard about the program from family members who had been involved with the program, or who had come across the program online whilst searching for support; and another heard about it through their church. Some clients could not recall how they found out about the program.

Program staff noted that self-referrals are rare.

### Knowledge of the Visit Program by referral agencies

Our interviews with referral agency stakeholders indicate that the Visit Program is generally well known, and data from the Visit Program indicates that a range of referral agencies at each program location have referred clients.

The Visit Program in the eastern suburbs has been established for many years and has been well promoted over that time. Referral agencies include the Transitional Aged Care Program, Prince of Wales Hospital (e.g. OT, social worker), St Vincent’s Hospital (e.g. social worker, dementia nurse), Brown Nurses, and Uniting War Memorial Hospital.

As a new program site, program staff in the south western suburbs actively promoted the program to referral agencies in the early days of the program and subsequently. This appears to have been successful, with a range of agencies referring clients to the program, including the Connect to Wellbeing Program, Braeside Hospital, Liverpool Hospital, Partners in Recovery and Wellways.

### Referral agency stakeholders’ understanding of the program

Referral agency stakeholders generally understood the program to be one that involved home visits and providing companionship. However, it appears that for some stakeholders clarity may be required around who provides the visits, and also more definition around who can and cannot be referred to the program. One stakeholder understood the program to be a peer support service. Although some visitors may perhaps be classified as ‘peers’ because of their age, this is not the focus of the program. Another stakeholder said they were sometimes unsure about the suitability of the program for some clients with mental health issues. This may indicate a need to reiterate the program’s focus to referral agencies.

Four of the five referral agency stakeholders we spoke with heard about the Visit Program through colleagues; the other stakeholder was sent an email about the Visit Program but couldn’t recall who sent the email.

The program fills a service gap for social support and is valued by referral agencies. One stakeholder emphasised the importance of having a program that focused on providing social support, complementing functional support, which is the main type of support provided by agencies to this cohort.

*The Visit Program is the first step in building the interaction, building those communication skills – great first step. It’s like the Visit Program is targeting the social element rather than functional.* (Referral agency)

Stakeholders recognise the prevalence of social isolation among their clients. For some, the isolation is because clients may have outlived their friends, or have no family, or have no family living nearby. Other stakeholders talked about social isolation being because clients have mental or physical health issues that restrict their movements. Stakeholders value the program because it provides face-to-face contact and is no cost to the client. One stakeholder described the importance of the program for their clients, *‘it is a growing need, and our clients are getting more vulnerable re complexity.*’ The Visit Program complements the Transitional Aged Care Program, with some clients in this program moving to the Visit Program upon exit.

For some referral agencies, the program model is more appropriate for women; men have tended to prefer group supports, such as Men’s Sheds. However, we suggest the program continues its promotion to men, given evidence that, while men are less likely to engage in such interventions, feedback from clients indicates that men find the program valuable.

Some stakeholders said they knew of no or very few other programs like the Visit Program in their area; with one stakeholder saying the Visit Program compared favourably with another similar service they refer clients to.

*The Visit Program has volunteers and Compeer [a similar program] sometimes doesn’t have any available, or I can’t find a stable visitor and I had to chase them up. So, I usually pick the Visit Program as my first choice—it’s more efficient, they turn up to scheduled appointments with the client. There are no challenges.* (Referral agency)

Acknowledging the value of the program, a lack of other similar programs for this cohort and increasing client need, a couple of referral agency stakeholders suggested the program be promoted to other agencies so that more organisations are aware of it.

### The referral process

Most referral agency stakeholders described the referral process positively. The referral was often given over the phone, and stakeholders described Visit Program staff as responsive to enquiries.

Referral agency stakeholders carefully thought about the appropriateness of the program before they approached their clients to ask if they would like to be part of the program; for example, determining if their clients were keen for face-to-face interaction and enjoyed socialising. They noted that almost all clients approached take up the referral.

Stakeholders spoke positively of the swift response of the Visit Program team to referrals, with one praising the response of Visit Program staff to meeting and matching a client after a referral was made to the program.

*Normally it has been a really quick time with meeting with our clients to carry out an assessment, and they are normally matched within two weeks after that.* (Referral agency)

Program staff noted that COVID-19 may lead to disruptions in staffing across referral agencies, with the result that knowledge of the program within some agencies may be lost.

### Assessment

On referral to the Visit Program, clients are assessed by Visit Program staff (generally the program coordinator) and this takes place in the client’s home. Many clients we spoke to could not remember this visit as it was often quite a while ago (some clients have been in the program for a number of years), but those who remembered the process were comfortable with it, as one client described,

*The [person who told me about the program] and [program coordinator] came to my house and told me about the Visit Program, gave me a brochure on the program and I signed consent, we spent a lot of time together – they were getting to know me to make sure it was a good link, asked me my age and what work did I used to do, what problems I was having after leaving hospital,; what stress and anxiety I might be having.* (Visit Program client)

### Reasons for client engagement

A waitlist at both program sites indicates high demand because the program is meeting social needs. Most commonly, clients we spoke with chose to connect with the Visit Program because they were lonely, illustrated by clients’ comments.

I was quite lonely and quite depressed; they thought the Visit Program might be able to help … I thought it sounded good as I live on my own and have no family. (Visit Program client)

*I wanted support, to talk with someone – I don’t have many people to talk with*. (Visit Program client)

Other clients chose to engage because of issues affecting their ability to make social connections, such as limited mobility, grief, PTSD and trauma, family caring responsibilities, and strained family relationships. For example, one client said:

I was depressed and tired. I felt lonely. I needed some company … I loved my work before ... Now I’m retired and my children don’t live in NSW. (Visit Program client)

## Program intensity

Client visits generally occur fortnightly and last for one and a half to two hours. Clients appreciate the visits, saying they enjoy the company of their visitor and look forward to their visit. Some clients would enjoy more frequent or longer visits. We suggest the program considers adapting the frequency and mode of visits to individual client needs – this provides a more client-centred approach, a cornerstone of the program’s philosophy. This could be managed within current resources.

### Frequency of visits

Clients spoke very positively of the program and were generally happy with the frequency of visits. Some clients have many medical appointments to schedule each week, and so fortnightly visits suit their availability; and for others, less frequent visits (that is, fortnightly rather than e.g. weekly) suit them due to personal or health reasons. Four clients though suggested they would enjoy more frequent visits – two of these clients have physical limitations that limit their capacity to go outside their home and engage in social interactions, and another two would like more frequent visits because they ‘feel alone’ even though they are living with other people.

I would like the visits to be weekly, just because I like the program, and for them to be for 2 hours. (Visit Program client)

*It would be better if [my visitor] could come more regularly, get me out of the house*. (Visit Program client)

One client, perhaps conscious of the demand for the program, said that even though they would like more frequent visits because they enjoy them and look forward to them, they ‘don’t want to take anyone’s spot.’

It is difficult to know if having more frequent visits would positively impact on the health and feelings of social isolation of clients. There is no consensus in the literature about best practice regarding the frequency of home visits, or how the frequency of home visits impacts the success or effectiveness of a social isolation intervention—though commonly, other programs also have fortnightly client visits. For befriending interventions, such as the Visit Program, service staff are often told by service users that they really value the social contact they get from the program[[22]](#footnote-22), and the quality of social support appears to play a large part in an older person’s perception of life satisfaction[[23]](#footnote-23). This may be why some clients in the Visit Program have asked for more frequent visits. The desire for more frequent visits confirms both that they enjoy their interactions with their visitor, as well as the opportunities the visits afford to go outside their home.

### Length of the visit

Around half of the clients we spoke with said they would like longer visit times. Clients suggested that extending the length of the visit would enhance their positive experience, most commonly by enabling activities to be undertaken that required longer than the time available. Clients also want longer visits because they enjoy the company of their visitor and the visits help them feel less isolated and lonely.

I’d love to have 2 hours [per visit], just because it’s longer, it’s more time with somebody. (Visit Program client)

I’d love to go to other places with my visitor but there isn’t enough time, we only have one and a half hours. (Visit Program client)

One visitor also suggested that flexibility to change the length of the visits would contribute to achieving the best outcomes for clients.

### Exiting the program

The Visit Program is not time-limited. Most clients (62%) have been involved with the program for two years or less (see Figure 5). Approximately one fifth of clients have been involved with the program for between three to five years (19%) or for longer than five years (20%).

1. Time in the program for current clients

Source: Visit Program administrative data, February 2020.

Clients leave the program when their circumstances change, often because their health has deteriorated, and they are no longer able to care for themselves or are deceased. A few clients leave the program because they no longer meet other program criteria, which hinders their ability to participate. For example, their mental health deteriorates, or they are non-compliant with program requirements, such as refraining from smoking during visits or minimising squalor/ hoarding. In these situations, program staff reassess the client to ensure that the exit procedure is fair and equitable and within program guidelines. Very few clients have left the Visit Program because they feel like they can socially reintegrate back into society without any support, and/or no longer need the support of a visitor. Some clients are offered a reduced service, where they receive less visits, rather than being exited.

Some clients are never going to integrate socially into the community. There wouldn’t be a time limit for them. Others have the capacity to perhaps reconnect and may need our service less as time goes on … We would continue with the client if they wished. Some clients have told us that they no longer need the service, which is great. (Visit Program staff)

It rarely happens; someone becoming socially comfortable enough [to exit the Visit Program] … You can count on one hand how many people have [exited the program in this way]. (Visit Program staff)

If a client is assessed as no longer suitable for the Visit Program (e.g. has moved into care) or does not wish to continue as a client of the program, the coordinator implements an exit plan. The client’s visitor visits them one month after exiting the program, and a Visit Program staff member will ring the client after two months to see how they are going.

So, [exiting the Visit Program] is a gentle process of letting go. (Visit Program staff)

If a client repeatedly cancels their scheduled visits, then it may also be appropriate that they exit the Visit Program. One staff visitor commented that one of their clients exited the program because they were upset that the Visit Program did not provide functional support such as meal provision or assisting with groceries.

Client turnover is higher in the eastern suburbs program site than in the south western suburbs site. In 2019, the turnover rate in the eastern suburbs was 56 per cent, compared to 37 per cent in the south western site. Program staff noted that the makeup of clients in the two sites is not too dissimilar, and the difference in turnover may be due to differences in staffing and resources, such as volunteer and staff hours.

Clients’ suitability for the program is typically re-assessed annually, though sometimes more often if, for example, a client’s visitor leaves the program. The reassessment process enables the program to assess if a client still requires visitor contact, and if not, the client can be exited from the program, which enables other potential clients who could benefit more from having a visitor to participate in the program.

## Program services

Clients enjoy one-on-one contact with their visitor, and those who have participated in group activities generally enjoy the social interaction and chance to be in the community that these activities allow.

### One-on-one visits

As described earlier, the Visit Program involves a visitor meeting with their client one-on-one, either at their house or in public, for example at a café. A referral agency stakeholder was particularly positive that this model accounts for the mobility limitations of clients with physical disability who may find it difficult to leave their house. This is illustrated in comments from three clients.

*We have family and they help us with the shopping, but they are working. I can’t walk much and get dizzy spells as I have a circulation issue. I was an outside person, I used to walk a lot, now I am an inside person.* (Visit Program client)

*(Visitor) comes to my house – mobility is difficult for me; I’m afraid to go out as I’m afraid I’ll fall*. (Visit Program client)

*I have a mobility scooter so need to look for a place that I can manoeuvre into, usually an outside table. I like going out for coffee. We talk about what I want to do – I said I’d like to go out for coffee and the visitor worked out where to go (re my mobility requirements), and she worked out where to go for the Christmas lunch the two of us had together*. (Visit Program client)

In contrast, three clients described why they like getting out of their house during the visits.

*I am at home alone – I love to go out as I have a very good time.* (Visit Program client)

*I have a lot of problems with my husband and I had to get out of the house for a while, they can help me.* (Visit Program client)

The best thing about having a visitor, and I am always looking ahead to the day that [my visitor] comes, is when I’m getting out of the house. (Visit Program client)

Clients very much enjoy their interaction with their visitor. The visits are client-driven, with clients suggesting to their visitor what they would like to do during the visits; sometimes visitors may make suggestions, particularly if the client has difficulty thinking of activities. Being cognisant of a client’s capabilities was suggested by one visitor as an important part of planning activities — this visitor said that they will first try to do an informal assessment of the client to see what they might be capable of participating in, before suggesting options of what to do.

It’s up to the client. You give them some options. Usually they will say, ‘What do you want to do?’ and we say, ‘It’s not about us, it’s about you,’ but we give options to them. (Staff visitor, south western suburbs program site)

*(Visitor) asked me at the first meeting with (program coordinator) what I liked to do and what we might like to do together, and the best day for her to visit. I think this was well-handled. I like a regular schedule; routine is very important for me. I said I really like to walk, and I have a dog, and I like to talk. So, we decided she would come here to my home and if it was nice weather we’d go for a walk, can be for an hour. Sometimes we stay at home and talk if I’m not feeling great*. (Visit Program client)

This approach is consistent with the Visit Program’s model of service, which focuses on giving clients control over the services they receive, and contrasts with more formal services, such as case manager-directed services. Our review of the literature also identified that social isolation interventions are generally successful when clients are actively engaged in directing their improvement; and when clients are involved in the design and implementation of interventions.[[24]](#footnote-24) By choosing what they want to do during the visits, clients are given the agency to engage with their needs.

A strength of the program is its flexibility in meeting the diverse companionship needs of clients. Clients described a range of activities they do with their visitor, including chatting, singing together, browsing in shops, playing board games, sitting in the sun and talking, and going for a drive.

*When (visitor) comes to see me, we chat and she asks me how I am - now I know her better I discuss more with her and open up with her, it didn’t take me long to open up to her. We mostly stay here at my house - once we went to a restaurant/ bakery... We have a chat about everything.* (Visit Program client)

A couple of visitors though described challenges they have in engaging with clients, with one saying it can be challenging if the client does not talk much, noting that if this happens in the client’s home they can suggest doing something such as watching television together, but they cannot do so when out at a café or restaurant. Another visitor was concerned that the activities they did at each visit were repetitive, although it is unclear if this is a concern of the client. We are aware that visitors are provided with suggestions for activities, but it may be useful for the program to provide visitors with a more extensive list of activities available in the visitor’s local area, and perhaps visitors could share ideas.

### Group activities

The Visit Program recently initiated group activities for some clients, including small group activities that typically involve a small number of clients and visitors meeting for coffee and a cake, and also an annual Christmas party. Overall, group activities provide a positive experience for clients.

The decision to offer group activities was based on the rationale of program staff that ‘*although home visits lessen the burden of social isolation, they do not create new social connections*.’ While one-on-one visits do provide a single social connection to a client, group visits provide opportunities for clients to further broaden the number of their social connections. A recent review of loneliness interventions among non-elderly adults found that, of the interventions included in their review, half of all interventions that used a mix of group- and individual-based design elements yielded significant positive results[[25]](#footnote-25), which points to the benefits of including both one-on-one visits and group activities in the Visit Program. However, there is no consensus in our literature review on whether group interventions are more effective than one-to-one interventions in reducing social isolation.

A couple of stakeholders we spoke with appreciated the benefits that attending small group events offer those who are socially isolated. One suggested it would be beneficial if they happened more regularly, for example, if appropriate, some clients could link in with other existing groups.

Not all clients are offered the opportunity to participate in group activities. Criteria for inclusion can include the following:

* those who are interested
* the fitness/ health of the client
* if the visitor feels their client will feel comfortable meeting people in a group setting in public
* the accessibility of the venue, and the accessibility needs of the client
* the mix of clients attending the activity (e.g. not having a socially isolated woman who has experienced domestic and family violence in a group activity with all men)
* whether the clients have care workers and whether the venue can accommodate them
* the client’s cultural background and whether they need an interpreter or whether the venue/ activity is culturally appropriate.

Visitors make an informal assessment about which clients would be suitable for group activities, and then suggest these clients to Visit Program staff, who make the final decision. The process is described by one visitor below.

[Our coordinator] does ask us which of your clients would be up for a group activity. Some clients would be open to group settings, so [the coordinator] gets our feedback as to which clients would be suitable for an outing and then they try to match that. (Visitor, eastern suburbs program site)

Given the success of the group activities, this process seems to be appropriate and we suggest that it should continue.

Many of the clients we spoke with had attended a group activity, and the majority enjoyed them, emphasising the benefits of the opportunity to meet new people and to get out of their house. Below are comments from clients describing what it is about the outings that they enjoy, and commonly this was about meeting with other people.

*Sometimes I get depressed… group activities were something to look forward to.* (Visit Program client)

*I like the group activities – see many people, music, I was very happy as I don’t see anyone – every day is the same… I tell (visitor) if there are ever any group activities to tell me – I want to meet people, to pass the time*. (Visit Program client)

*I did go to a luncheon with the Visit Program, a Christmas lunch… I wanted to see (program staff) and (visitor) was going to be there and also I was going to get to meet his other client, only 12 people which worked well for me as it is difficult to talk to any more than 12. Loved the connection, the meeting and seeing other faces, other clients and hearing their stories, meeting these other people helped me feel connected further*. (Visit Program client)

One client said that they liked the group activities so much that they would not mind paying for them in the future if that was necessary.

A small number of clients said that although they sometimes struggled initially to get over their shyness when attending group activities, they still enjoyed them.

A small number of clients expressed a preference for attending the smaller gatherings rather than the larger Christmas party gatherings, and this was usually related to their anxiety issues, as one client described:

*The most recent Christmas lunch was a small group of ten to twelve. Being smaller is a little more intimate and non-anxiety provoking. The Christmas party last year had more people than this year and I found it quite confronting. This year, because it was a smaller group, we got to have a little bit of conversation with other people, it was more intimate, there was no stress when I got there as it was smaller and relaxed… A smaller group is not so threatening from a social perspective, I felt very relaxed – and it is hard, meeting 8-9 new people. This year I enjoyed that the Christmas party was in a normal environment, a café, we had lunch, it felt like a normal thing to do*. (Visit Program client)

Two clients compared the Visit Program’s group activities favourably with other organisations’ activities they had attended.

Some organisations, the groups are really cliquey. It’s not like that here. (Visit Program client)

I’ve been invited to other social events by other organisations, but you have to get there by yourself, you don’t know anyone. (Visit Program client)

A small number of clients expressed interest in attending more group activities because they enjoyed the chance to meet other people. Visitors also described positive stories of clients meeting others at group activities and exchanging contact details with the view to possibly meeting up. One visitor felt the small group activities helped to reduce a dependency some clients had on their visitor.

We have started small group things, we have brought people here for morning tea, so that clients do not become too dependent on you. If you are the only person that they are seeing it is good they can come and meet others … That has been quite successful. It means we get clients together every couple of months. (Staff visitor, south western suburbs program site)

Visitors at one site we spoke with were concerned that it is usually the same clients who want to attend the small group activities – but given it is the client’s choice to attend group activities or not, this would appear to be in keeping with the ethos of the program.

Four clients we spoke with were not particularly interested in attending group activities or continuing to attend group activities, and this was often because they had health issues that made it difficult to be in group situations, as two describe:

*I can’t go out as I am on a walker and there are steep ramps to go down and the physio won’t allow me to do that so (visitor) comes and sits beside me, we just have a chat. That’s what I want to do – I can’t do other things*.(Visit Program client)

*I went to a group lunch in September… I have hearing problems and it is difficult for me to hear in a group setting*. (Visit Program client)

A staff visitor commented:

Some [clients] do not want to [attend group activities]. They … prefer one-on-one. I think it comes with trust issues. They just want one-on-one – they do not want to be involved in groups. Sometimes I will still ask because you never know, right? (Staff visitor, south western suburbs program site)

#### Challenges of group activities

A small number of visitors talked about challenges that group activities can present for visitors, including the different skills needed for interacting with a group of clients rather than one-on-one, and the need for and importance of facilitating groups so they are inclusive of all clients. This may suggest a need for a briefing and reminder for visitors that when attending group activities their role is broader than focusing on their client/s, and perhaps some training in group interaction processes.

Another concern about group activities was expressed by Visit Program staff members who were concerned that small group activities could potentially encourage inappropriate or unhealthy relationships between some clients, where personal boundaries are crossed. This was illustrated by a program staff member describing an incident where they felt an inappropriate relationship had developed. To address this risk, we suggest program staff continue to hold brief check-ins with attendees after events.

Although there is a demand for more group activities from some clients, the program is constrained in providing more group activity opportunities because of funding resource limitations. Since the main reason that clients enjoy the group activities is the opportunity to meet with others, an option is for the program to link clients in with other suitable group activities provided in the local area. It may be necessary for the visitor to attend the first one or two visits with the client until they feel comfortable attending alone, or one or two clients could attend together. Another option is to partner with other organisations, such as councils, to organise and run joint activities. If the program wanted to expand the number of group activities they could offer clients, program staff, or potentially volunteers, could look into applying for grant funding, for example though councils, philanthropic organisations, utilities, banks.

## Support provided to clients by coordinators

As well as meeting regularly with their visitor, clients also meet occasionally with the program coordinator. A formal meeting with the program coordinator occurs in the client’s home after they express interest in participating in the program. A small number of clients remembered this meeting, and described the coordinator telling them about the program and asking if they would like to be involved.

After the initial visit, the program coordinators maintain regular contact with clients, generally through phone interviews, and they also conduct an annual review with each client. If the client is experiencing a lot of challenges personally, additional reviews may be conducted.

Clients also have the opportunity to interact with the coordinators at the annual Christmas parties and at other small group events. This level of contact allows clients to build a rapport with the coordinators, which in turns means that they have someone else in the program to talk to. This is especially useful if they have any issues with their visitor or the program that they need to discuss—though this is rare.

Clients who have had contact with the coordinators describe them as ‘very kind’ and willing to go above and beyond to ensure the program is beneficial for clients. Clients felt positively about the coordinators and many highlighted that they had a good relationship.

## Relationship with visitors

Clients had very positive relationships with their visitors, and this is key to achieving positive outcomes. Although most clients prefer to have the same visitor, they were generally open to a change in visitor. This addresses a concern of Visit Program staff that clients may become dependent on their visitor and be resistant to change.

### The qualities of a good visitor

Our literature research indicates that an enabler for befriending interventions, such as the Visit Program, is recruiting and retaining appropriate visitors (Australian Healthcare Associates 2017). Visitor appropriateness may encompass age, common interests and activities, expectations regarding visits, background and life history and personality (Chal 2004). However, compatibility may be hard to define and measure. Having visitors who are compatible with their clients results in developing more meaningful relationships.

Our literature review found that there is no information in the literature about the qualities of a visitor’s personality that increases the effectiveness of social isolation interventions. Visit Program staff were asked to describe the desirable traits and qualities that the program looks for in visitors; these included having a good understanding of their role, being reliable and committed, and being able to put aside their own feelings. Visitors must also be non-judgemental when conversing, acknowledge another person’s opinion, and possess a high emotional intelligence.

Clients we spoke with were asked what they liked about their visitor. Although some found it difficult to articulate the specific qualities of their visitor that contributed to their positive experience the traits described were the same as those identified by program staff, e.g. being non-judgemental, reliable, able to listen.

Clients commonly said their visitor makes them feel calmer and less stressed and cheers them up when they are depressed. Clients also liked that their visitor was easy to talk to; and could provide them with advice or a new perspective. Having someone to talk to about their problems, who is non-judgmental and doesn’t try to ‘fix’ their problems but offers advice if asked for, was also mentioned. The following quote illustrate clients’ feedback on what they enjoy about their visits.

*I enjoy (visitor’s) company - she’s a nice person, understanding, intelligent, I feel I can discuss different things that are happening with her. She is very understanding… we have a lot in common. She is a very nice person. She has a great sense of humour – I adore people with a sense of humour*. (Visit Program client)

Some clients said they enjoy the company of their visitors so much that they wait with anticipation for their next visit.

I count down the days until [my visitor] comes … We talk about children, we laugh, and we cry. They make me happy. (Visit Program client)

Visitors also described the skills and attributes they consider necessary to work effectively with clients, drawing several parallels with those mentioned by program staff. These include being non-judgemental about the client’s life story or living situation, as well as being showing compassion and empathy. Other desirable traits visitors noted were being an active listener and having a curiosity about clients’ life stories, patience with clients, a positive attitude and sense of humour and to be present

*[You must] be positive and cheerful. Have a bit of a sense of humour, as they are usually quite isolated, and they are very down … The focus is on them not you, not about how your day has been … You also have to be in tune with how they are … You have to observe, really listen … You need to be a people person, you need to be interested in their life story. Good listening skills and of course compassion, empathy and patience*. (Staff visitor, south western suburbs program site)

One visitor spoke about how it takes time to develop rapport with a client, and that doing so requires sincerity, tact and politeness. Program staff pointed out that a key benefit of the program for clients, and a point of difference with other support programs, is that the relationship between the client and the visitor is on more of an ‘equal footing’ than, for example, the relationship between client and case manager.

Clients have more control over the services they receive from us than they do from other formal services. This is where our relationship is different; it’s about what they want to do. I assume this would give our clients more empowerment and dignity. (Visit Program staff)

All clients we spoke to said that their visitors had never done anything that made them unhappy, and they did not want their visitor to do anything differently.

### Changes in visitor

Clients we spoke with very much enjoy the company of their visitor, but most were also not concerned if their visitor had to change. Just over half the clients we spoke with (8 of 15 clients) explicitly said they were open to the idea of changing visitors if that was necessary/ required. The remaining clients were either a little concerned about changing visitors (generally because they really liked their visitor and didn’t want to lose them) or did not express an opinion either way.

I’d be disappointed [if my visitor changed], but you have to face reality. If the Visit Program wants to send someone else, that’s fine. (Visit Program client)

Some clients have had up to three visitors over the course of their time in the Visit Program, and this was okay with them; others have had the same visitor the whole time. One client though, who has recently changed visitors, said that it has taken some time to get their relationship with their new visitor to the same level as with their previous visitor.

[My first visitor] was like a friend, I could talk and unwind with them. I have not got to that point with [my new visitor] yet … I felt real at home with [my old visitor], I could break down and cry with them … I don’t know if I could do this with [my new visitor]. (Visit Program client)

One visitor suggested that some clients may be troubled by the idea of changing visitors, describing one of their clients who became upset when an extra volunteer visitor came along to a buddy visit, and the client thought the new volunteer would replace their current visitor whose company they enjoyed. This may point more to a need to clearly explain the buddy system to clients, and to give the client advanced warning if a visitor is to be replaced. Some visitors noted that when a visitor goes on leave for a short time, some clients are willing to forego visits until their visitor returns.

When I’ve gone on leave and asked the clients, ‘Would you like someone else to visit you?’ most of them say, ’No, we will wait for you.’ We had [a client] who, when their volunteer [left the program], had a hard time adjusting. They were okay with having a new visitor but wanted to know why their volunteer stopped. I had to explain that the volunteer had other commitments. Clients can feel like they have done something wrong. (Staff visitor, south western suburbs program site)

# Visitor experience

Key findings

There are currently 22 visitors delivering the Visit Program—seven staff visitors and fifteen volunteer visitors. Volunteers can each visit a maximum of four clients, while staff visitors can visit up to sixteen.

Two Open Support volunteer coordinators promote Open Support’s programs (including the Visit Program) to recruit volunteers and organise and provide training for volunteers. These tasks are split between the two coordinators, one focusing on promotion and recruitment, and the other on training.

There are a number of challenges in recruiting volunteer visitors, mainly related to the specific requirements of the role and the nature of the clients. The program requires volunteers to commit to regular hours for an extended period, whereas many people interested in volunteering may be less inclined to volunteer with such consistency.

There are a number of formal steps involved in applying for and being accepted as a volunteer visitor, including an EOI and a series of interviews. The application process appears to be clear and straightforward so we would suggest it remains in place.

Successful applicants undertake a training process, involving participation in training modules and buddy visits. Findings from the literature review show that appropriate training appears to be an enabler of any successful intervention to combat social isolation. Overall, visitors were satisfied with the training, however program staff suggested additional training topics could be included, for example, understanding grief and loss. This is supported by visitors. Professional supervision that provides an opportunity to debrief could also be useful.

Visitors are provided with a range of supports, including both formal support (such as team meetings) and informal phone conversations. At the south western suburbs site, the program coordinator routinely checks-in with visitors after their first six visits with a new client and again after twelve months. This support provides opportunities to pick up any issues or ‘flag’ any potential issues. We suggest that these supports be continued. We also suggest that more formal debriefing be provided to visitors, especially when they experience traumatic events, such as the death of one of their clients.

Staff visitors and volunteers generally feel very supported by Visit Program staff, saying their coordinators are readily available to provide support.

Visitors valued the connections made with clients, describing their role as very rewarding. They understand the qualities needed to build rapport and work effectively with clients, including listening, being non-judgemental, empathic and positive.

Overall, it appears that visitors are being well matched to clients, with staff indicating that matching processes have improved over time.

The Visit Program invests a lot of time and money in volunteer recruitment, which is an issue in the south western suburbs program site, where it has always been difficult to recruit volunteers. At the eastern suburbs program site, which has a large number of volunteers, it is difficult for the program coordinator to balance the lengthy time requirements needed to support and manage the volunteers with the demands of the other aspects of managing the program. We suggest some options for how the program can address these issues.

## The visitors

Twenty-two visitors deliver the Visit Program; seven are staff visitors (all part-time), and fifteen are volunteers (Table 4). Most volunteer visitors are retirees, and the majority are women.

The Visit Program recently changed its guidelines regarding the number of clients that volunteers can visit, from an unlimited number to around four. however volunteer visitors generally have two clients each. Staff visitors can have up to sixteen clients each.

Staff visitors support and mentor volunteer visitors, assist the program coordinators in buddy visits, and facilitate small group activities for clients.

1. Number of visitors and clients per program site

|  |  |  |
| --- | --- | --- |
| Program area | Number of staff visitors | Number of volunteer visitors |
| Eastern suburbs | 4 | 13 |
| South western suburbs | 3 | 2 |
| **Total** | **7** | **15** |

Source: Visit Program staff focus group.

The program also has student volunteer visitors, who tend to be younger than other volunteer visitors. Over the past year there have been approximately four student volunteers in the program. Student volunteers go through the same recruitment, induction and compliance checks as other volunteer visitors. Long-term commitment to the program can be challenging for student volunteer visitors with some on study placement for a specified length of time, and others leaving within a 12 -24 months period due to study and work commitments.

Student volunteers are allocated clients who are considered appropriate for the student’s level of maturity and the level of client need and complexity. Program staff report that student volunteers are important to the program because of the difficulty in recruiting volunteers, however they express concern that some student volunteers are slow to prepare their client reports.

## Recruitment process for volunteer visitors

Recruitment of volunteer visitors is the responsibility of Open Support’s two volunteer coordinators, who work across all Open Support programs. They promote the programs, recruit volunteers and organise and provide training for them. One of the coordinators focuses on promotion and recruitment, and the other on training. The volunteer coordinators job share, overlapping on Wednesdays when most of the planning occurs.

The volunteer coordinators promote the Visit Program through a range of avenues (see Table 5). Flyers on noticeboards at Visit Program offices and notices in community venues were the main ways that volunteers we spoke with came to the program.

1. Recruitment strategies for volunteer visitors

|  |  |
| --- | --- |
| Promotional avenues | Promotional strategies |
| On site | * flyers on noticeboards at Visit Program sites * promoting the program through volunteer networks * liaising with Open Support’s communications manager to explore additional communication channels. |
| Traditional advertising | * advertisements in local newspapers * posters and bulletin boards in local council/ community areas. |
| Community strategies | * promoting the program at volunteer and university expos * developing partnerships with universities and organisations so they can promote the program * providing information packs to charities and NGOs that have a strong interest in reducing social isolation, e.g. Men’s Sheds * engagement by program staff with key volunteer and community centres or organisations. |
| Digital media | * promotion through social media * engaging with volunteering websites * corresponding via email with church parishes, and current donors and volunteers * using SMS to promote messages using existing contact lists. |

### Challenges in recruiting volunteer visitors

Program staff identified a number of challenges in recruiting volunteer visitors, mainly relating to the specific requirements of the role, and the nature of the clients. Clients may have complex issues, and visits mainly occur in clients’ homes. The position description and desired traits of a volunteer visitor (see section 4.5.1) mean the potential pool of applicants is invariably small.

To become a volunteer visitor, the person must be available during working hours and be able to commit to giving at least two hours a week of their time for a minimum six months period. Program staff said many people prefer to volunteer only occasionally, or for a short time-limited periods, given other demands on their time such as family, other interests and employment.

*The long-term commitment involved in volunteering is off-putting and people might not have the skills. The nature of this volunteer work (visiting clients in their homes) might be seen as confronting and can put people off.* (Visit Program staff)

Since the establishment of the program in south western Sydney, this site has faced difficulties recruiting enough volunteers to meet demand. According to program staff possible reasons for this are the size of the catchment area, which means visitors may have to travel relatively long distances to visit clients and, for some cultural groups in south western Sydney, volunteering is something they would prefer to do in groups rather than providing one-to-one support.

Another challenge in recruiting volunteers is that it appears that some potential volunteers express interest in volunteering to satisfy the conditions attached to their Centrelink payment applications. Program staff also noted that at certain times, for example during natural disasters, it can be difficult to recruit volunteers because of competing demands from agencies and NGOs for support.

### Applying to be a volunteer visitor

The process of applying to be a volunteer visitor involves a number of steps, including an EOI and a series of interviews, each step designed to ensure that the applicant is committed to and appropriate for the position. Program staff noted that screening processes for volunteers have improved a lot, and unsuitable people are rejected earlier in the process, so the program is recruiting more efficiently.

If an applicant is successful, the program coordinator organises for the visitor to attend a buddy visit (see section 5.4.1). Visitors we spoke with did not provide feedback on the appropriateness or ease of the process for them, however the application process appears to be straightforward and we suggest it remains in place.

It is preferred that volunteers have the capacity to use email and Excel, and have a driver’s licence although this will not necessarily preclude them from becoming a volunteer – two volunteers in the eastern suburbs program site do not have a driver’s licence. The program also prefers volunteers to take on two clients but again this will not necessarily preclude someone from becoming a visitor.

### Motivations for becoming a volunteer visitor

Volunteers told us they were motivated to become a visitor because they had an interest in helping people and in giving back to the community. Most volunteers had done other volunteering in the past.

*I felt that I had rapport with older people, you know, so I thought I could do some good. I like working with old people, I think they are neglected in our community.* (Volunteer visitor, eastern suburbs program site)

For some, being a visitor enabled them to use their skills gained in their occupation or in other volunteer roles. A couple of volunteers described the visitor role as a good fit with their skills, with one saying they had recently retired, while another had worked as a counsellor.

## Recruitment and retention of staff visitors

Some of the staff visitors we spoke with had established links with Open Support programs: one had been involved with another Open Support program for twelve years, and another had been a volunteer visitor with the Visit Program for two years before applying to be a staff visitor because they enjoyed the role. Another staff visitor heard about the program through an online advertisement.

*[I wanted a] change of career. When studying community services, I needed work experience. Then, when I saw the ad for volunteers in the parish bulletin … I applied for it and started from there … When the job did come up eventually, I was overjoyed.* (Staff visitor, south western suburbs program site)

We have no evidence to indicate if there are any issues with the recruitment, appropriateness and retention of staff visitors.

## Training visitors

Visitors provide a valued support to vulnerable clients and must be appropriately trained and feel adequately prepared.

### Visitor training – what is provided

The importance of providing high quality training is supported by findings from the literature review, which show that appropriate training opportunities appear to be an enabler of any successful intervention to combat social isolation (Findlay 2003; Landeiro et al. 2017).

The Visit Program provides a range of training opportunities to staff and volunteer visitors, both mandatory and voluntary (see Table 6). Training is provided monthly (except in December and January). Training topics are based on position description requirements, as well as advice from program staff. Some training sessions, such as ‘professional boundaries and duty of care,’ are provided regularly because of their relevance to the role.

Relevant also, and suggested by program staff, is training for visitors in understanding grief and loss: some visitors we interviewed described the impact on them and need for support when their clients die. We note that at present this training is available but not mandatory. We suggest that it be added to the training schedule as a mandatory unit.

Most training sessions are run from both the south western suburbs program office and the eastern suburbs program office, to maximise attendance – visitors can attend training at either location.

1. Training provided to visitors

|  |  |  |
| --- | --- | --- |
| Training provided/ offered | Staff visitors | Volunteer visitors |
| St Vincent’s Private Hospital General Orientation Day of training | Checkmark |  |
| Online training modules | Checkmark |  |
| Open Support Orientation Day, which covers responsibilities and expectations (but does not have training module) |  | Checkmark |
| Visit Program induction that covers work tasks, priorities, policies and procedures and assistance on documentation for each client visit | Checkmark | Checkmark |
| Mandatory for volunteers: WH&S and privacy, accidental counsellor, professional boundaries and duty of care, safe home visiting, first aid, mental health first aid |  | Checkmark |
| Recommended but not compulsory for volunteers: includes active listening, recognising early stage dementia, understanding grief and loss, and other training opportunities as suggested by program coordinators |  | Checkmark |
| Buddy visits |  | Checkmark |

Note: Blue shaded rows indicate mandatory training.

#### Buddy visits

One of the most practical supports for volunteer visitors are ’buddy visits’. After volunteer visitors have completed their induction process, they attend approximately four buddy visits, which involve accompanying their program coordinator or an experienced staff visitor on a visit to a client. Buddy visits provide a valuable opportunity for new visitors to build confidence and gain experience. The volunteer visitors are then accompanied for the first one or two visits to the client assigned to them before they begin to visit alone. Volunteer visitors commented that this process was helpful.

When I started, we buddied up with another person … We buddied up for four or six visits … Those buddy visits were terrific. (Volunteer visitor, eastern suburbs program site)

This view was echoed by Visit Program staff who said the buddy visits are helpful in finding out if new volunteers are suitable for the Visit Program, although one volunteer visitor seemed to feel they were being judged during these visits.

The training was only to check you out … You go with someone for one or two visits. That was hardly training. (Volunteer visitor, eastern suburbs program site)

Program staff also saw the buddy visits as useful for helping new volunteer visitors decide if they want to become a visitor. Sometimes after attending a buddy visit, volunteers decide the role is not for them. Program staff noted ‘*until you’ve done it you might not realise it’s not your cup of tea.*’

Although most volunteer visitors are positive about the buddy visits, and they provide ‘real life’ exposure to what the role entails, program staff and visitors highlighted some challenges with the buddy visit process. Some of these challenges are simply logistical involving scheduling the visit to suit the client, current visitor or program coordinator and the new volunteer visitor, but there is also potential for discomfort. Some clients may not be comfortable with having an unknown person at their home. Program staff have tried to address this by checking with the client beforehand or suggesting buddy visits to clients they know will not mind having another person at the visit. Nevertheless, problems can arise if clients no longer wish to participate in this process, as has happened at the south western suburbs site.

Another example of discomfort concerns clients who mistake the new visitor as a replacement for their regular visitor. Clients may also feel they are missing out on their regular one-on-one visit and to address this the program compensates clients by organising an additional visit with just their regular visitor. This has been difficult to organise at the south western site because the team has no additional capacity to provide extra visits.

We suggest that the buddy system be continued with participating clients continuing to be compensated with extra visits. This could be offered by phone if it is not possible to provide the extra face-to-face visit. Phone support appears to be a successful engagement tool, as demonstrated during the COVID-19 crisis. We also suggest buddy visits be complemented with other modes of training, such as discussing visitor-client scenarios and role play that provide examples of situations that could occur and how to respond.

### Visitors’ reactions to training modules/ formal sessions

Visitors commonly described the training they had received as appropriate and comprehensive. Training is conducted once a month (with one topic each month) and because of this it may be some months before some visitors have the opportunity to attend training on some topics. Volunteer visitors believe that mandatory training on core modules should be completed **before** commencing in the role, particularly professional boundaries and duty of care, and safe home visiting because visiting clients without a full understanding of the role and its boundaries is less than optimal.

Offering mandatory modules online could increase timely access to the training and ensure that all visitors complete the training before starting their role. We suggest the Visit Program investigate providers of online training of the mandatory modules.

One volunteer visitor wanted training in supporting clients with complex needs.Currently, program coordinators match clients who have complex needs with staff visitors. However, clients’ health can deteriorate so that over time the needs of clients who have volunteer visitors may become more complex. We are aware that the program undertakes a review of clients annually and we suggest this includes (if it does not already) a discussion with the visitor as to how they are managing, and what further training/ support they may need.

#### Visit Program staff feeback re training

Visit Program staff would like to make it mandatory for volunteers to attend all training. However, they are conscious of maintaining flexibility and are aware that some volunteers may not be able to attend because of competing demands on their time. Online training that can be completed by volunteers at a time convenient for them, would help address any variation in knowledge and skills across the volunteers.

One program coordinator reported that staff visitors wanted training targeted specifically for them, rather than being for both volunteers and staff visitors, training that would enable a deeper exploration of issues and be of more benefit for them. The program coordinator is conscious of this and is always looking for new training opportunities for staff visitors.

## Visitor supports

Visitors are provided with a range of supports, including both formal support such as team meetings and also informal phone conversations.

Monthly team meetings and bi-monthly lunches

Both program sites organise formal meetings that involve the program coordinator and visitors.

The eastern suburbs site has a monthly team meeting that provides an opportunity to discuss client allocations and schedules, safety management, and for visitors to discuss any issues they have encountered. Attendance at the meetings is not compulsory, and not all visitors are able to attend all team meetings.

The program coordinator at the south western suburbs program site organises a lunch every two months for visitors. This site is currently trialling informal group reflection for staff visitors, and we suggest this be monitored to assess its usefulness for visitors, and if considered beneficial, be rolled out at both program sites.

Program staff believe that the meetings provide a forum for informal learning opportunities for visitors. We suggest that the regular team meetings and lunches continue as they appear to be valuable for those who attend and are considered important by the program coordinators. So that every visitor has the opportunity to participate, those who are unable to attend might be given the opportunity to provide input, and minutes from the meetings distributed afterwards.

#### Informal irregular support from program coordinators

Visitors were also positive about the informal support provided to them by their program coordinator. Visitors described the coordinators as thoughtful and responsive. They appreciated their availability whenever they required support; and their ability to ‘read between the lines’ and know that support was needed before the visitors recognised it themselves. They appreciated their coordinator periodically ‘checking in’ with them to see how they were going. Visitors are encouraged to ring their coordinator for support if required and visitors spoke highly of the emotional support the program coordinators provided, saying they were always available to debrief if, for example, one of the visitor’s clients had told them a traumatic story.

The program coordinators said the extent to which they provide support to visitors depends on the needs of the visitors, ranging from those who require daily contact to others who they rarely hear from.

#### Formal check-ins – south western suburbs program site

At the south western suburbs site, Visit Program staff now routinely check-in with visitors after their first six visits with a new client and again after twelve months to see how the relationship is tracking. This is useful as it provides another opportunity to pick up any issues or ‘flag’ any potential issues. Staff noted that this protocol did not exist when this program site first started. We suggest it be continued and include both program sites.

#### Support for the program coordinators

Support for the two program coordinators is provided by quarterly meetings with the Operations Manager – this was considered sufficient by the program coordinators, who also feel comfortable contacting the Operations Manager informally by phone or email if required.

The two program coordinators talk weekly by phone and meet face-to-face every three months. Again, informal contact by phone or email supports the coordinators to keep in touch with each other.

Adequacy of supports

Although visitors were generally positive about the support provided to them, Visit Program staff felt support for visitors could be more comprehensive and formalised – their concern was particularly around the lack of formalised supervisory processes, such as regular scheduled debriefing, which they felt might be affecting the morale and satisfaction of visitors. This reflects comments by four visitors who said it can be difficult to know when to raise their concerns about a client with their coordinator.

*Dealing with clients with mental health can be quite challenging sometimes … Sometimes it is hard to tell when it is something you should bring up to someone.* (Staff visitor, eastern suburbs program site)

Program staff are currently developing a formal debriefing process for visitors, that is regular and accessible, and this should help to address these issues.

A small number of visitors expressed the wish to be able to take a break from being a visitor when they have a client who has died or a client they no longer saw because he or she was ill. Rather than moving straight on to being allocated another client they want to be able to grieve, particularly if they had been seeing the client for a long time. If this is possible (if the visitor has no other clients) we suggest that the visitor be supported to take a break; if this is not possible due to the visitor having other clients, we suggest that program coordinators formalise a debrief process for those visitors when situations like this occur.

*One of my clients died recently. That person was my first and I had been seeing them for eight years. I felt like I lost a part of my family. Luckily at this time I had a chat with [program coordinator].* (Staff visitor, south western suburbs program site)

Professional development policy

Open Support does not currently have a staff professional development policy. Recognising the importance of increasing the professionalism of the organisation to reflect its maturity, staff are currently developing a formal professional development policy to provide opportunities for staff to expand their knowledge. The new policy will apply across all Open Support programs and may include opportunities for Visit Program visitors.

## Working with clients

Visitors enjoy interacting with their clients, indicating appropriate matches are being made. Despite some concerns by staff that clients may develop a dependency on their visitor, we have no evidence to indicate this occurs, and appropriate training appears to be in place to define these boundaries.

### Matching clients with visitors

Ideally, clients are matched with a visitor based on the client’s needs, the experience and skills of the visitor, and shared interests. Clients with complex needs are generally matched with staff visitors. It is expected that staff visitors have the skills to adapt to each client individually.

Clients can express a preference about who they are matched with, illustrated by a client who asked for a particular type of visitor with certain skills and background, and this was organised.

Our literature review indicates there is broad evidence to support appropriate matching as a key success factor in achieving outcomes for befriending interventions[[26]](#footnote-26), [[27]](#footnote-27). Given that the clients we spoke with were all happy with their visitor, it appears that the matching process is working well. Visit Program staff noted that the client and visitor matching process has improved over time, as program staff have become more experienced in assessing what matches will work well.

I get a gut instinct when talking to a client as to which visitor they would be best matched with, as I know my visitors. The greater the skill of the visitor, the less important it is to match based on shared interests; they will have the skills to be able to be matched and get on with anyone. (Visit Program staff)

As one visitor illustrated below, having a good match is integral to the success of the visitor-client relationship.

I think the matching is really important, not just for the client but for us as well to maintain that relationship. (Staff visitor, eastern suburbs program site)

However, program staff noted it is often difficult managing the workload of staff visitors as they all work part-time, and a match may come down to being based on the availability of a visitor. This is especially the situation at the south western suburbs program site, where there are proportionally fewer available visitors than at the eastern suburbs program site. This does not appear to be a concern for clients we interviewed, as all were satisfied with their visitor, indicating an appropriate match.

### The visits

Visitors enjoy the time they spend with their client, and value the connections they make with their client, the positive mutual impact of the relationship and learning patience. For some visitors, the connection with their client extended after their client exited the program. One volunteer visited their client after they had exited the program and gone into care. Other visitors attended their respective client’s funerals.

*[I was surprised by] the connection you feel towards the client as well. It is a two-way street, and the responsibility of letting them down is huge in my mind … I am clearly very connected to them as they are to me. I get something out of it as well.* (Volunteer visitor, eastern suburbs program site)

*You see the possibilities of change in them … and it is rewarding … It makes you happy when you see them happy and they are happy to see you… It is not just what we are doing, it is what they are doing for us too. I feel like I myself have grown a lot as a person.* (Staff visitor, south western suburbs program site)

### Managing client dependency

Program staff raised a concern that having no maximum length of time in the program could potentially result in some clients becoming dependent on their visitor. But there appears to be no strong evidence indicating that visitors or clients have crossed this boundary, or that visitors lack the skills to prevent such situations occurring. Long-term visitors said that professional boundaries are clearly set out, in contrast to the early days of the program when they were not so clear.

*We are clear at the assessment on things we do not do. We do not help you shower, no housework, no shopping. We are all about conversation, to catch up with you again and meet up with you at your place.* (Staff visitor, south western suburbs program site)

*I felt clients needed more than companionship. They wanted someone to accompany them to doctors but I knew it was not in the job description.* (Staff visitor, south western suburbs program site)

Even so, some visitors and clients do struggle with accepting the boundaries of the role, e.g. some visitors would like to provide more for their clients, although they know it is not part of their role as a visitor; and some clients would like more support than visitors are able to provide.

*It’s hard [maintaining boundaries] with some clients if you are their only contact. That is extremely hard, especially when you are saying this is a companionship and they are in a situation of need. Sometimes boundaries are a bit unreasonable.* (Staff visitor, eastern suburbs program site)

Program staff have worked hard to ensure that all visitors have access to training on setting professional boundaries. One visitor said that clients who receive functional support from other programs appeared to be more understanding of the Visit Program’s boundaries. Visitors also said that being direct and clear with clients has helped maintain the relationship at the appropriate level. Strategies such as ‘shifting the blame,’ have also helped, for example, saying that the Visit Program’s insurance does not cover certain activities.

### Keeping client notes

During each client visit, visitors are required to make notes that document each visit, particularly noting any changes in their client’s health or living situation. These are used to make comparisons and assess change in clients’ situations or needs, although any changes of immediate concern are usually addressed with Visit Program staff straight after a visit.

Visit Program staff said the processes around keeping client notes, and the quality of client notes, have significantly improved, attributable to a recognition that the Visit Program has a duty of care over their clients. According to Visit Program staff, incident reporting and elder abuse reporting are now more accurately reported.

### Identifying other client support needs

Visit Program staff carefully explain to clients and visitors that the program does not provide case management for clients. The program can enable linkages between clients and other services, if appropriate, but at its core the Visit Program is about providing companionship and ‘unconditional positive regard.’ If a client’s health deteriorates, visitors notify their coordinator who subsequently escalates this concern. Visitors do not directly contact services on behalf of their clients but can provide clients with contact numbers should they want to access other services.

*We might recognise [clients] have other needs, and at times we’ve been able to link them with other services. We don’t see this as a core part of our service, but it is a good thing … as no-one else might have recognised these needs.* (Visit Program staff)

Visitors we spoke with (one volunteer visitor and four staff visitors) said they had observed deterioration in the wellbeing of their clients over time, including forgetfulness or paranoia, and changes in speech and hearing. If the visitor considers the change to be relatively minor, like cleanliness or a bruise, they will bring it up with their client. However, for more serious issues, like concerns about mistreatment of the client by their carer, they will talk with their coordinator, who will then escalate the concern.

Although none of the clients we interviewed could recall being told by their visitor about other services that they could access, possibly indicating they had no additional identified support needs, we feel it is important for visitors to continue to be another ‘pair of eyes’ (as described by a referral agency) and be alert to and document any change in client circumstances, as they are often one of the few or only external people the client has contact with.

*You’ve known them for years so you can say things without being disrespectful. For example, you notice an elderly person has bruising or something like that. You ask them, ‘Oh, what happened there?’ You always ask them what has happened over the fortnight, how they have been, who has been around. Especially with the elderly … they become forgetful; they may have forgotten they had a fall.* (Staff visitor, south western suburbs program site)

*I had an incident when I was visiting a client and their carer was knocking on the door, calling them and the client tried to avoid them. I was concerned for the client and went straight to [the coordinator]. This is when she made a few phone calls.* (Staff visitor, south western suburbs program site)

## Sustaining a visitor workforce

### Retention

Visitors we spoke with (both staff and volunteer) have been involved with the Visit Program from two to 20 years. When volunteer visitors decide to leave the program, it is usually within the first six months, when they decide they are not suited to the role of a visitor.

The churn rate of volunteers across the whole of Open Support is approximately 8 per cent, and this would be the same for the Visit Program – Open Support staff consider this a high percentage, but our experience indicates this is in fact quite low, especially considering the role requires a substantial commitment of time.

Few staff visitors have left the program, indicating satisfaction with the role.

### Viability of volunteer visitors

Program staff highlighted challenges inherent in using a volunteer workforce in this role. Some of these challenges raise issues about the viability of the model, particularly in south western Sydney where recruitment of volunteers is difficult.

#### Need for training, greater supervision and support

Volunteers have varied backgrounds, skills, training needs and abilities to deal with complex needs. Although training is offered in essential skills (such as active listening, recognising early stage dementia, and understanding grief and loss), not all volunteers attend these training modules, so there can be varying skill levels within the volunteer pool. This has potential ramifications, for example, volunteers not feeling confident or not being competent to respond appropriately to clients experiencing mental decline.

By contrast, staff visitors are required to have appropriate professional qualifications for the role, so they have the skills to deal with the range of client needs.

Currently, program staff allocate staff visitors rather than a volunteer visitor where they are concerned that a volunteer would not have appropriate expertise to take on a client with complex health needs but clients’ health conditions and needs can become more complex over time. Even for clients not identified as having complex issues, there is a potential risk that volunteers may not have sufficient skills to properly deal with a client’s problems or health needs, and may need supervision to debrief properly.

#### Costs of recruitment and training

Staff noted the investment required in recruiting and training volunteers. It is estimated that each year five volunteers go through the recruitment and training process in the eastern suburbs program site and two in the south western suburbs program site.

The recruitment costs are a particular issue in the south western suburbs program, as the investment in advertising for volunteers and responding to enquiries from people interested in the position nevertheless results in very few people going on to become volunteers.

It takes approximately 15 hours of a program coordinator’s time to induct a new volunteer visitor so that they are ready to conduct solo visits to a client. This equates to approximately $600 per volunteer. There are also ongoing costs in managing and supervising volunteer visitors, estimated at $250 per volunteer, per year. This cost consists of two hours of monthly follow-up per volunteer and regular training.

These costs are lost if a volunteer leaves the program within a short time. This has been an issue for the south western suburbs program site as there has been no more than two volunteer visitors at any one time in the last five years (despite attempts to recruit more).

1. Time needed to recruit and train new volunteers

|  |  |
| --- | --- |
| Task | Time needed |
| Advertising for volunteers and responding to enquiries | 1 hour per volunteer |
| Application processing (including interview, police check and working with children’s check) | 4 hours per volunteer |
| Training and mentoring new volunteers | 10 hours per volunteer |
| Total | 15 hours per volunteer |

#### Options for the program model

The program has a number of issues and challenges to resolve: the costs associated with promotion and recruitment of volunteers, especially in the south western suburbs program site where it has always been difficult to recruit volunteers; the difficulties in ensuring consistent training and skills acquisition across the group of volunteer visitors; the time involved in managing a large number of volunteers in the eastern suburbs program site.

To resolve these issues, we provide the following options for the program model:

* Cease volunteer recruitment in the south western suburbs program site. Given that recruitment of volunteer visitors has remained difficult over the life of the program at this site, there is nothing to suggest this will change in the future. The program could either remain at its current level of client numbers or, given there is a client waitlist that reflects obvious demand for the program, expand by employing more staff visitors.
* Provide volunteer visitors with more options for accessing training, such as online modules to make it easier for volunteers to do the training; and provide more support such as debriefing, which would help to ensure consistent approaches and skills across the visitor pool.
* Support the program coordinator at the eastern suburbs program site to manage the large number of volunteers, together with staff visitors, and to manage the overall program. We suggest the administrative support role be expanded.
* Gradually phase out volunteers. Since the program is professionalising, this may be an appropriate option in the long-term.

Having all staff visitors would ensure consistency of qualifications; would require less supervision and management as there would be smaller numbers; and would involve less ‘juggling’ when matching more complex clients with visitors, as all visitors would have qualifications to work with complex clients.

# Program impact

The Visit Program aims to improve the trajectory of the quality of life of clients. It seeks to reduce the way in which social isolation can negatively impact a person’s health, wellbeing and quality of life.

This chapter is based on findings from 57 retrospective client surveys and 15 client interviews. We also compared client survey data to HILDA Wave 18 Survey data[[28]](#footnote-28) of people in the community who are likely to also be socially isolated.

Key findings

Overall, the results indicate that the Visit Program has had a positive impact on clients. This impact is strongest for client mental health, evidenced by a statistically significant improvement in overall mental health (mental health component score). Comparative analysis to the HILDA Wave 18 Survey data also suggests that the program has had a positive impact, although these results are less conclusive.

Clients reported improvements in their mental health and wellbeing, including the extent to which emotional problems interfere with their social and regular activities, the decreased frequency of feeling downhearted and blue, increased frequency of feeling calm and peaceful, but also energetic. Some described the program as a breakthrough for their mental health, helping them with their depression and even reducing suicidal feelings.

The program has also had a positive impact on clients’ social connectedness and loneliness, although the frequency of socialising with friends and relatives remained relatively stable. This outcome is not unexpected as most people’s social circles shrink as they age, and this is exacerbated by physical and mental health conditions. Interviews suggested that group activities are particularly valuable in building social connections.

Clients also reported improved confidence in social settings, viewing themselves as more confident, better able to meet new people and more relaxed with others. Anecdotes from visitors highlight increased confidence of clients in group or public settings.

Across most domains, clients’ physical health has remained stable or improved slightly since joining the program. This suggests that the Visit Program may have ameliorated their overall wellbeing, which is notable given the client group is predominantly an ageing population.

## Overall health (SF-12)

The client surveys and qualitative interviews both indicated that the Visit Program has had a positive impact on clients’ overall wellbeing and mental health. In what follows we refer to clients before entering the Visit Program as ‘pre’, and clients since entering the Visit Program as ‘post’, and all figures will be averages unless specifically stated.

The outcomes of the Visit Program were largely measured (other items were included in the Client Survey) using the Short Form 12 (SF-12) survey—a self-reported outcome measure that assesses the impact of health on an individual's life. [[29]](#footnote-29) Two summary scores are reported from the SF-12—a mental health component score (MCS-12) and a physical component score (PCS-12). Both scores can range from 0 to 100, with a higher score indicating better health. The United States population average PCS-12 and MCS-12 are both 50 points,[[30]](#footnote-30) though this varies for some demographic groups (for example, older people have a lower average PCS-12).[[31]](#footnote-31) Previous research has established that it is acceptable to use United States population averages and weights when calculating the PCS-12 and MCS-12 in an Australian context.[[32]](#footnote-32)

Baseline readings for both the PCS-12 and MCS-12 scores were obtained for the Visit Program sample. This was done through ‘pre-program’ questions in the retrospective survey, where clients were asked to recall their physical and mental health before they became involved with the program. A ‘post-program’ reading was obtained by asking clients to report in the retrospective survey their current physical and mental health states.

There was a difference between the MCS-12 scores from before and after involvement with the Visit Program (Table 8). On average, scores increased by 8.72 points after an individual was involved with the Visit Program. This difference was statistically significant at the .05 level.[[33]](#footnote-33) There was very little difference between the pre- and post-Visit Program PCS-12 scores, and this difference was not significant at the .05 level.[[34]](#footnote-34) This is perhaps to be expected as the program mainly focuses on providing emotional support and alleviating the psychological impacts of isolation, rather than addressing physical ailments or sourcing treatments. Therefore, the current cost-effectiveness analysis focused on examining the costs in relation to differences in the mental health outcomes for program participants.

1. Average PCS-12 and MCS-12 scores pre- and post-program

|  |  |  |  |
| --- | --- | --- | --- |
| Summary score type | Average pre-program score | Average post-program score | Difference |
| PCS-12 | 33.18 | 33.15 | -0.03 |
| MCS-12 | 33.57 | 42.33 | 8.76 |

Source: Pre and Post Surveys. 49 respondents provided sufficient information for summary scores to be calculated.

## Wellbeing and mental health

Post clients reported a small improvement in their general health (Figure 6). Pre clients reported a general health score of 2, equivalent to a rating of ‘fair’ health, whereas post clients reported a general health score of 2.5, indicating that their health has improved to be approximately halfway between ‘fair’ and ‘good’.

1. On average, clients self-reported general health has increased since joining the Visit Program (n=57)

Source: Visit Program Client Surveys.

Overall, in relation to feeling that their physical or emotional problems interfered with social activities, pre clients reported a score of 2.4 representing ‘most of the time’ or a ‘good bit of the time’, but post clients exhibited an increase in this score to 3.4, indicating a ‘good bit of the time’ and ‘some of the time’.

In addition, post clients were less likely to report being frequently ‘downhearted and blue’ (Figure 7) since pre clients reported a score of 3.3, which indicates ‘a good bit of the time’, compared to post clients reporting a score of 4.1, meaning just ‘some of the time’.

1. On average, clients less often feel ‘Downhearted and blue’ and think that their physical health or emotional problems are interfering less with their social activities (n=57)

Source: Visit Program Client Surveys.

Overall, post clients reported that they more often felt (1) calm and peaceful, and (2) had a lot of energy (Figure 8). Pre clients reported feeling calm and peaceful between ‘a little of the time’ and ‘some of the time’ (a score of 2.6), but this increased significantly for post clients who had a score of 3.6, indicating between ‘some of the time’ and a ‘good bit of the time’. Furthermore, post clients (2.8) reported having a ‘lot of energy’ slightly more often than pre clients (2.5), although both groups fell between the categories of a ‘little of the time’ and ‘some of the time’.

1. On average, clients are more often (1) ‘Feeling calm and peaceful’ and (2) feeling like they ‘Have a lot of energy’ (n=57)

Source: Visit Program Client Surveys.

Overall, a lower proportion of post clients reported that emotional problems are impacting on their ability to do regular activities since they joined the program (Figure 9). While seventy-five per cent of pre clients reported they did not ‘do work or other activities as carefully as usual’ due to emotional problems, only sixty-six per cent of post clients reported that emotional problems have been impacting on their ability to do these activities.

There was also a lower proportion of post clients reporting that emotional problems are impacting on their ability to complete tasks (‘Accomplished less than you would like’) (Figure 9). Eighty-six per cent of pre clients reported this was the case, and this decreased to seventy-five per cent of post clients.

1. Overall, less clients have had issues doing and completing regular activities due to emotional problems (n=57)

Source: Visit Program Client Surveys.

These survey findings align with the qualitative data collected from clients, who reported that the Visit Program was a breakthrough for their mental health, explaining that the program has helped them with their depression and even pulled some back from the brink of suicide. Others explained that they were more at peace or had become more active since joining the Visit Program.

When I started with the Visit Program, I was ready to commit suicide; my life was terrible. The visitor was someone to talk to about my problems… They just listened. (Visit Program client)

When [my visitor] was coming, they pulled me out of a hole. I was down and out. (Visit Program client)

Another client, diagnosed with a serious mental health issue, noted the program minimised their emotional distress.

*And having someone coming to my home, sometimes I can go months when I can’t get things together – just having the regularity, and at a time of day that suits me as I take a lot of medication and so I am not so good in the morning... routine is so important and so is support – and some of my friends still don’t understand my illness, so it’s the regular support and non-judgement that’s really refreshing sometimes for me, and someone of a similar age, interests and background.* (Visit Program client)

Similarly, one referral agency said they have noticed improvements in the wellbeing of the clients they refer.

The wellbeing of participants referred to the Visit Program is a lot more improved. Obviously getting … psychological support and the visitor being the social aspect, covering all aspects; the wheel of the holistic model has all bases covered. (Referral agency)

Another noted the program improves clients’ self-esteem, through social interaction, making clients feel valued and positively impacting their mental health.

*Benefits of the Visit Program – the power of social interaction and community benefits, a person is not just their health condition/s. Helps most people’s self-esteem, feel valued, makes people feel ‘seen’ - like they are a part of something, someone to share their stories with. Good for mental health, mood*. (Referral agency)

Visitors also shared anecdotes of how their clients had showed positive outcomes after participating in group activities, for example becoming better at dealing with grief, over the years they had been visiting them. Visitors said that they had noticed changes in their clients’ demeanours and that they had become more trusting and engaged in conversations.

## Social connectedness and loneliness

Both the client survey and qualitative interviews indicated that the Visit Program has had a positive impact on clients’ social connectedness and loneliness.

Overall, post clients are feeling less lonely (Figure 10). Pre clients reported a score of 2.2 indicating that they ‘agreed’ that they often felt very lonely, but the post client score increased to 3.1, equivalent to ‘somewhat agree’ that they felt very lonely. In addition, pre clients reported a score of 2.6 to the question ‘People didn’t visit me as often as I like’, indicating they ‘somewhat agree’. However, for post clients there was an increase to a score of 3.1, indicating that clients only ‘somewhat agree’ that people did not visit them as often as they like.

1. Clients are feeling less lonely and more satisfied with their levels of social interaction (n=57)

Source: Visit Program Client Surveys.

On the whole, clients’ levels of social connectedness have remained stable since joining the Visit Program (Figure 11) remaining at 3.5, indicating that clients get together socially ‘about once a month’.

1. The frequency at which clients get together socially with friends or relatives has remained stable (n=57)

Source: Visit Program Client Surveys.

These positive findings align with qualitative data collected from clients, who reported that visits break up their loneliness and provide them with companionship they would not otherwise have. Some said they also look forward to the group activities so they can meet other people, with some clients saying their social circles have expanded.

When I go to Visit Program events, I feel a million dollars … The best thing about the Visit Program is that I go out of the home; I go to parties, everything is good … Before the Visit Program I always cried, I had no-one to talk to … My heart opened when I met everyone (in the program). It’s good and I’m happy, happy. (Visit Program client)

It’s nice to have something like this as I’ve got no-one … I look forward to the visits as I’m so alone here, and I can’t get out now because my leg is playing up. There’s a couple of ladies I’ve known through the group activities and they’ve asked me to go to their houses. (Visit Program client)

*Loved the connection, the meeting and seeing other faces, other clients and hearing their stories. Meeting these other people helped me feel connected further.* (Visit Program client)

Anecdotal evidence suggests that at group activities some clients swap phone numbers with the aim of perhaps catching up later and, for a couple of clients we spoke with, this occurred. This is a positive step towards social integration for some clients, one of the aims of the program.

At the last group activity, I met a woman who I knew straightaway we would get on like a house on fire. [My visitor] noticed this and they said that the next time they organise a group activity, they will invite both of us. (Visit Program client)

I have taken clients to a small group gathering and they hit it off. So, we organised for a second meeting, actually for this morning but unfortunately the other client could not make it, but it is still on the cards to do another meeting with those two. Maybe establish that ongoing friendship from that. (Staff visitor, eastern suburbs program site)

Visit Program staff described the gap that the program fills in clients’ lives. Although some clients receive support packages from other agencies, these focus on addressing practical support needs rather than social supports. Referral agencies we spoke with agreed that the Visit Program filled a service gap for clients, with some saying it is the only service of its kind they are aware of that is at no cost and focuses on personal connections rather than functional help. The positive outcomes of the Visit Program are supported by population-level longitudinal research that suggests the number of social connections people have is a robust predictor of self-assessed wellbeing over time[[35]](#footnote-35) (see 3.1 in Appendix 1).

## Self-confidence

Clients are, overall, feeling more resilient and confident since entering the Visit Program, as evident in Figure 12. Clients reported an increase from ‘neither agreeing nor disagreeing’ to ‘somewhat agreeing’, in relation to (1)’ I would describe myself as a confident person’ and (2) ‘When I am with others, I feel relaxed’. There was also a smaller average increase in agreement with the statement ‘Meeting new people is something I am good at’.

Qualitative consultations supported these findings, with clients and visitors reflecting on the positive impact of the group activities on clients’ confidence. Visitors related positive stories of changes in their clients after participating in group activities, such as ‘coming out of their shell’, opening up about their life, and making friends with other clients.

Visitors also outlined how clients benefited from the Visit Program as a whole.

During my first visits with [one of my clients], they used to take 3 to 4 Valium before getting out of house. Lately, they haven’t been taking any because over time they have been feeling more confident … It is nice to see. Even going to the coffee shop, you could not get them inside. But lately that’s changed. (Staff visitor, eastern suburbs program site)

[A client] I visited would not come to the group activities and could not even be at ease in a restaurant or having a coffee, because they were frightened that they might be attacked. They have come so, so far and they are not the only one. There are other examples where people have changed a great deal. (Volunteer visitor, eastern suburbs program site)

I brought [a client] to a morning tea. We had just started having the visits, he was on the third visit only. Right at the beginning he was very much like ‘I don’t like meeting new people; I don’t like talking to people’. Then he started opening up so much and really understanding what the program was about. That day (at the morning tea) he met [another client] and they kind of became friends afterwards and exchanged phone numbers. (Staff visitor, eastern suburbs program site)

One visitor shared two anecdotes about their clients – one who would initially never invite their visitors inside, and another who would never change out of their pyjamas or want to go outside. Both showed growth indicative of positive changes in their mental health.

*[A client] used to meet me at the gate then we’d go off and do whatever … I never got in the house. Then I got invited in … that was a big thing. I have another client who, when I go, is in their pyjamas. I would say, ‘You know, if you want to, we can go out one time’ and they were like, ‘Oh no, I don’t think I’m up to it.’ … We were talking about something one time—always in pjs—then I had said something about Costco one day and they asked me, ‘Would you like to go?’ Next time, they are all dressed and ready … So, when you have someone doing something like that, there is no pressure, so it is an achievement. We got them out and dressed!* (Staff visitor, south western suburbs program site)

1. On average, clients see themselves as (1) more confident, (2) more relaxed in social situations, and (3) slightly better at meeting new people (n=57)

Source: Visit Program Client Surveys.

## Physical health

Across most domains, clients’ physical health has remained stable or improved slightly since joining the Visit Program. This is notable, given the client group is predominantly an ageing population.

Overall, clients reported a small improvement in the negative impacts that their health has had on their ability to do moderate activities (Table 9). Over half of clients (59%) reported that before becoming involved with the program they were ‘limited a lot’ by their health in doing moderate activities, while a third of clients (32%) reported they were ‘limited a little’. Only nine per cent (n=5) reported being ‘not limited at all’ by their health in doing moderate activities before entering the program. Since participating in the Visit Program, there was a slight decrease in the proportion of clients who reported they were ‘limited a lot’ in doing moderate activities (from 59% to 50%), and a slight increase in clients who were only ‘limited a little’ (from 32% to 38%). The proportion of clients who reported being ‘not limited at’ all by their health in doing moderate activities increased after entering the program from nine per cent to thirteen per cent.

1. How much were clients limited by their health in doing moderate activities (such as moving a table, pushing a vacuum cleaner, recreational activities), pre the Visit Program vs post

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Pre |  | Post |
|  | n | % | n | % |
| Yes, limited a lot | 33 | 59% | 28 | 50% |
| Yes, limited a little | 18 | 32% | 21 | 38% |
| No, not limited at all | 5 | 9% | 7 | 13% |
| Total | 56 | 100% | 56 | 100% |
| Missing | 1 |  | 1 |  |

Source: Visit Program Client Surveys.

The extent to which pain interferes with clients doing normal work (including housework) has decreased slightly since joining the Visit Program (Figure 13). Pre clients reported an average score of 2.8, but post clients a score of 2.9, indicating that their pain has remained at the ‘moderate’ level but decreased slightly.

1. On average, the extent to which pain has interfered with clients doing normal work (including housework) has remained stable (n=57)

Source: Visit Program Client Surveys.

Overall, the impact of physical health on the ability of clients to do work or other activities (including housework) as carefully as usual has remained stable (see Figure 14). Eighty-two per cent of clients indicated (by ticking ‘yes’) that their physical health impacted their ability to do work or other activities as carefully as usual in their life, the same for pre and post clients.

The impact of physical health limitations on the ability of clients to complete regular activities has decreased for post clients (Figure 14). A smaller proportion of post clients reported that physical health was having an impact on their ability to accomplish as much as they would like (82%), compared with eighty-nine per cent for pre clients.

1. Overall, slighly less clients have had issues doing regular activities as a result of their physical health (n=57)

Source: Visit Program Client Surveys.

The only negative finding relating to physical health was in clients’ ability to climb several flights of stairs, which has decreased for some clients since participating in the Visit Program (Table 10). The proportion of clients who reported being ‘limited a lot’ in climbing several flights of stairs has increased from forty-seven per cent to fifty-four per cent. In contrast though, the proportion of clients who reported being ‘limited a little’ and the proportion who reported ‘not limited at all’ has decreased by a small amount.

1. How much were clients limited by their health in climbing several flights of stairs, pre the Visit Program vs post

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Pre |  | Post |
|  | N | % | n | % |
| Yes, limited a lot | 26 | 47% | 30 | 54% |
| Yes, limited a little | 21 | 38% | 19 | 34% |
| No, not limited at all | 8 | 15% | 7 | 13% |
| Total | 55 | 100% | 56 | 100% |
| Missing | 2 |  | 1 |  |

Source: Visit Program Client Surveys.

## HILDA comparison analysis

The impact of the Visit Program on clients was also explored through a comparative analysis between the outcomes of Visit Program clients captured in the retrospective client survey, and a representative sample of the general population. HILDA Wave 18 Survey data (that collected survey responses from Australians across 2018) was used in the analysis because it included specific items on hospitalisation rates and mental illness status that were not included in Wave 18. We extracted a subset of HILDA Wave 18 Survey data that (1) was of a comparable age range (45 and over), and (2) satisfied criteria for experiencing social isolation, that we obtained from the literature review. We created matched items between the Client Survey and items collected in HILDA Wave 18 Survey data and compared the results.

### Impact on wellbeing

The available evidence suggests that the wellbeing of Visit Program clients after participating in the program for a minimum of three months is higher when compared with other people living in similar circumstances who are experiencing social isolation. However, this conclusion was only reached after taking into consideration variation in the average age and mental illness status between the Visit Program clients and the HILDA comparison group. Visit Program clients had a higher average age (72 years of age for the clients included in this analysis) and incidence of mental illness (64% in the administrative data), than the HILDA comparison group (65 years of age, and 28% respectively). The precise impact of the higher rates of mental illness among Visit Program clients could not be quantified, as the Visit Program’s administrative data on mental illness status could not be linked with individual client survey responses.

Overall, there were no meaningful differences in the derived mental health and physical health scores (SF-12 and SF-36) between the Visit Program clients and the HILDA comparison group[[36]](#footnote-36) (Table 11). The average mental health scores across both groups was largely equivalent, with Visit Program clients having an average mental health score of fifty-seven per cent (where higher scores indicate improved mental health) and the HILDA comparison group having an average mental health score of fifty-nine per cent (Table 11). The average physical health scores were also on par – Visit Program clients had an average score of fifty-one per cent and HILDA respondents had an average physical health score of fifty-three per cent (Table 11).

1. Derived mental and physical health scores for Visit Program clients and HILDA respondents, aged 45 years and over

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Visit Program clients | | HILDA respondents | |
|  | n | % | n | % |
| Derived mental health score | 53 | 57% | 39 | 59% |
| Derived physical health score | 53 | 51% | 39 | 53% |

Sources: Visit Program Client Survey data and HILDA Wave 18 Survey data.

When the HILDA comparison group was split into respondents who did, and did not report having a mental illness, the mental health score of HILDA respondents without a mental illness was much higher (68%) than HILDA respondents with a mental illness (33% – see Table 12). The physical health of HILDA respondents with a mental illness (37%) is also much lower than HILDA respondents with no mental illness (59% - Table 12). Given that (1) the prevalence of mental illness is much higher in the Visit Program client group (64% – see chapter 3) than the HILDA comparison group (28%), and (2) that there is likely to be a similar difference in derived mental health scores between Visit Program clients who do and do not have a mental illness, it is likely that the impact of the Visit Program on client wellbeing was significantly higher than suggested by the overall comparison (Table 12). In other words, Visit Program participants had poorer mental health before entering the program than the HILDA comparison group. This is supported by the results of the pre-post retrospective survey analysis that shows a significant improvement in mental health after participating in the program.

1. Derived mental and physical health scores for Visit Program clients, HILDA respondents with no reported mental illness and HILDA respondents with a reported mental illness, aged 45 years and over

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Visit Program clients | | HILDA respondents with no mental illness | | HILDA respondents with mental illness | |
|  | n | % | n | % | n | % |
| Derived mental health score | 53 | 57% | 28 | 68% | 11 | 33% |
| Derived physical health score | 53 | 51% | 28 | 59% | 11 | 37% |

Sources: Visit Program Client Survey data and HILDA Wave 18 Survey data.

### Hospitalistion rates

In light of research in an Australian context[[37]](#footnote-37) suggesting that people experiencing social isolation are more likely to contribute to avoidable hospitalisations, the evaluation also explored any differences in the hospitalisation rates (measured in hospital admissions and nights spent in hospital) between Visit Program clients and the HILDA comparison group.

The results of this analysis were inconclusive. Although the comparison suggests that Visit Program clients presented to hospital at higher rates than the HILDA comparison group (Table 13), multiple confounding factors were identified. The average age of Visit Program clients was higher than the HILDA comparison group, which probably increased the likelihood of Visit Program clients presenting to hospital with legitimate health concerns. Clients are also often referred to the Visit Program just after a significant health-related incident involving a recent hospitalisation, which also may have acted as a confounder. Moreover, some clients are referred to and identified as appropriate for the program when they are still in hospital. Data collection issues also reduced the reliability of the rates of hospitalisation reported by Visit Program clients. Some surveys were returned in which clients had written caveats for their responses to the survey items on hospitalisation, including around particular health concerns they had received hospital treatment for or statements indicating that their own estimations were unreliable.

1. Hospitalisation rates

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Visit Program clients | | HILDA respondents | |
|  | n (responses) | Yearly average (n) | n (responses) | Total for 2018 (n) |
| Hospital admissions | 47 | 4.76 | 39 | 1.26 |
| Nights spent in hospital | 47 | 5.05 | 39 | 2.33 |

Sources: Visit Program Client Survey data and HILDA Wave 18 Survey data.

# Economic value of the Visit Program

Through improvements in mental health and wellbeing and a reduction in social isolation, the Visit Program aims to increase clients’ quality of life. Improvement in quality of life is important from a program perspective, but it is also significant for the economic health of the wider community.

This section discusses the economic evaluation of the Visit Program. It reports the findings of two types of economic analyses: cost-effectiveness analysis and cost-benefit analysis.

Key findings

An economic evaluation was conducted to determine the cost-effectiveness and net value of delivering the Visit Program. This included both a cost-effectiveness and a cost-benefit analysis. The cost-effectiveness analysis was conducted to compare the relative costs and outcomes between the Visit Program and an alternative. In this case the alternative is a situation where the Visit Program does not exist, and the people who would have received visits as part of the program continue as they had been before becoming involved in the program. The cost-benefit analysis compared the cost of delivering the program with the benefits of the program (including cost savings and the monetary value of the program’s impact on client quality of life).

The findings of both analyses show that the Visit Program is delivering economic value to the community. The cost-effectiveness analysis found that for each increase in the average client MCS score (see chapter 6) the program saved the community approximately $60,000, suggesting that the program is unequivocally cost effective. The cost-benefit analysis showed that the Visit Program created over $500,000 in net benefit to the community with a cost-benefit ratio (CBR) of approximately 2.0, suggesting a 2:1 return on investment for each dollar spent on the program.

Given the assumptions and limitations involved in the current analysis (as outlined in section 1.5.1), it is suggested that this economic information be used as a starting point for discussion around allocation of existing (and additional) resources within the program. The model is somewhat limited because a sensitivity analysis was not able to be conducted due to budget and time constraints. However, a conservative model was used to improve the reliability of the findings, this included a conservative estimate of the monetary benefits of the program and a narrow definition of the potential cost savings of the program.

What this analysis does not tell us is how this money could be spent to achieve this change. Further analysis of similar programs and approaches is needed to understand where any additional investment could be best allocated.

## Outcomes used in the economic evaluation

As discussed in chapter 6, the outcomes of the Visit Program were measured in part using the Short Form 12 (SF-12) survey—a self-reported outcome measure that assesses the impact of health on an individual's life. Baseline readings for both the PCS-12 and MCS-12 scores were obtained for the Visit Program sample. There was a significant difference between the MCS-12 scores from before and after involvement with the Visit Program (see Table 14). There was no statistically meaningful difference between the pre- and post-Visit Program PCS-12 scores (see Table 14). The subsequent cost-effectiveness analysis focused on examining the costs in relation to differences in the mental health outcomes for program participants. The cost-benefit analysis made use of both the PCS and MCS scores to calculate the impact of the program on client quality of life and estimate the dollar-value benefit of the program.

## Costs and benefits

### Cost of the Visit Program

The annual cost of the Visit Program is approximately $334,544 or $2,909 per client per year. The cost of delivering the program to clients who were involved in the Visit Program up to and including November 2019 is $527,498.67.

### Benefits of the Visit Program

The benefits of the Visit Program are largely defined by the improvement in client wellbeing, particularly mental health (see chapter 6). These improvements have a significant impact on clients’ quality of life, which can be measured and costed using quality of life adjusted years (QALYs).

QALYs can be calculated using preference-based measures of health[[38]](#footnote-38). Preference-based measures of health involve self-reported questionnaires that describe various aspects of a person’s health and wellbeing. Responses to the questionnaire items are converted into an index or score using an algorithm. Although a range of health measures use a similar approach, preference-based measures of health specifically use algorithms derived from surveying the general public on their preferences for the possible health states (the various combinations of item responses) described by the questionnaire. The resulting index ranges from 0 to 1, where 1 indicates the highest possible state of health and 0 indicates the lowest possible state of health (usually death). QALYs can be calculated by multiplying the index with a discrete period of time. For example, if a person was surveyed about their health over the period of their 5-year involvement in a program, and the resulting health index was 0.6, their QALYs over this period would be 3 QALYs.

The MCS and PCS scores, and the SF-12 (version 1) instrument from which those scores are derived, are not preference-based measures of health, so they cannot be used to directly calculate QALYs. However, given the widespread use of the SF-12 (both versions) in evaluation in the health sector, some researchers have developed tools and approaches to estimate preference-based measures of health using the SF-12 and/or MCS and PCS scores[[39]](#footnote-39).

This evaluation borrowed one such approach, using PCS and MCS score in combination with age and gender to estimate SF6-D (a related instrument) indices to calculate two QALY measures for each client who was included in the economic evaluation (n=49) [[40]](#footnote-40). The equation used to estimate SF6-D scores was:

Each client had two SF-6D indices calculated, one ‘pre’ and one ‘post’. One QALY measure was calculated by multiplying the ‘pre-SF-6D’ index based on the pre-MCS and pre-PCS scores (derived from the ‘pre-‘ component of the Client Survey) over the number of years that each client had been involved in the Visit Program – creating an estimate of the QALYs that each client would have experienced if they hadn’t participated in the Visit Program. The other QALY measure was calculated by multiplying the ‘post-SF-6D’ index based on the post-MCS and post-PCS scores (from the ‘post-‘ component of the Client Survey).

Due to time and budget constraints, a sensitivity analysis could not be conducted. Therefore, the analysis incorporated some changes to produce a more conservative estimate of the program’s impact on quality of life. Given that the estimated pre-SF-6D indices were based on client-reported information collected retrospectively, we increased each client’s pre-SF-6D by 1 standard error. The calculation of the post-QALY measure also included a consideration to create a more conservative result by using the pre-SF-6D index to calculate QALYS for 3 months (0.25 years) of each client’s time in the program, effectively assuming that no progress in quality of life was made during the program’s maturation period (of 3 months).

Aggregating across the client cohort, the projected QALYs based on the pre-SF-6D scores was approximately 102 QALYs. The projected QALYs aggregated across the client cohort based on the post-SF-6D scores was approximately 107 QALYs, meaning that the Visit Program increased the quality of life experienced by its clients by approximately 5 QALYs. Based on the 2019 estimate of the value of one year of life ($213,000 AUD)[[41]](#footnote-42), the monetary value of the Visit Program’s estimated impact on its clients’ quality of life is $1,036,438.10.

1. Average PCS score, MCS score, Sf-6D index and aggregated qalys, pre vs post

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Pre | Post | Difference |
| PCS (SF-12) (average) | 33.18 | 33.15 | -0.03 |
| MCS (SF-12) (average) | 33.57 | 42.33 | 8.76 |
| SF-6D (average) | \*0.54 | 0.61 | 0.07 |
| QALYs (aggregate) | 102.2 | 107.1 | 4.9 |

\*SF-6D pre indices were increased by 1 standard error to create a more conservative estimate of impact on QALYs.

### Costs of the alternative

The alternative to funding and running the Visit Program, for the purposes of this analysis, is having no program at all. While this would save the cost of the program, it would also incur costs that are otherwise averted through the services that the Visit Program offers.

This evaluation has focused on the impacts of the Visit Program on clients’ mental and physical health. The total costs estimated to be saved through the existence of the program could be as high as $319,734.70 per year. This is made up of costs saved through increased quality of life experienced by Visit Program clients and their reduced need for mental health care.

The costs included in this analysis are conservative estimates of the costs averted due to the work of the program. This is due to the fact that some costs to the government were unable to be estimated, including the implications for income tax forgone, productivity decreases and transfer increases (increased utilisation of disability pensions and unemployment) due to poor mental and/or physical health.

This analysis also excludes some personal and social costs that may be avoided through the existence of the Visit Program, such as out of pocket healthcare costs for clients. Potential cost savings for government through any changes in the use of physical healthcare services was not included.

#### Cost for mental health treatment

Lower MCS-12 scores (those below 45) are indicators of mental ill health.[[42]](#footnote-43) Twenty-nine per cent of Visit Program clients moved from an MCS-12 score indicating mental illness (less than 45) to one indicating good general mental health (45 or higher) between the pre-program questions in the retrospective survey and the post-program questions in the retrospective survey. A recent study of Australians [[43]](#footnote-44) found that 53 per cent of people with anxiety or depression (the most common mental illnesses among Visit Program clients) reported accessing any healthcare services for their mental health, and that the total cost of an individual with anxiety or depression to the healthcare system was $985 per treatment period (this figure includes consultations, any hospitalisation and medication). Therefore, it can be said that the existence of the Visit Program likely averted 34 cases of mental illness (from the 116 current participants), of whom 18 would have sought treatment. This would have incurred a total cost to the healthcare system of $17,730 across all those seeking treatment. This calculation excludes the significant personal costs of experiencing mental illness (monetary and non-monetary), as this analysis is of government/ system level costs.

Given that a majority of Visit Program clients are aged over 70 years, impacts on productivity and income tax forgone through the impacts of mental ill health have not been included. However, some clients with mental ill health may have been of working age and had their employment impacted by a mental health condition—the extent to which this applies is not known. This means that the above figure is likely to be an underestimation of the true costs averted by improvements in mental health among Visit Program clients.

#### Costs for physical health treatment

The potential avoided costs to government for providing physical healthcare treatment to Visit Program clients was considered, but ultimately excluded from, the cost-effectiveness and cost-benefit analyses. The reasoning for this decision is discussed below.

GP visits

Chronic loneliness is associated with a higher number of doctor visits per year. One study found that on average, chronically lonely people (such as those who access the Visit Program) visit the doctor 1.2 times more per year than non-lonely people.[[44]](#footnote-45) This may be partly to do with the fact that lonely people are more likely to rate their health as poor,[[45]](#footnote-46) which aligns with the current sample who have poorer average physical health than the general population (as indicated by a lower than average PCS-12 score). As noted above, the Visit Program did not have a significant impact on clients’ physical health ratings; however, this may not impact the number of doctor visits clients make as it has been posited that chronically lonely people visit the doctor for emotional and psychological support and connection, as much as for physical issues.[[46]](#footnote-47) Each General Practitioner (GP) appointment costs the healthcare system $38.20 (for the consultation only, does not include any associated medications or further appointments). Therefore, the maximum total cost that could have been averted through decreases in GP utilisation for the current clients of the Visit Program in the past year is $5,271.60.

However, as clients were not surveyed about their GP visits, this potential cost saving was not included in the analyses.

Hospital admissions

In an Australian study, social isolation was identified as an important contributory factor in frequent and/or avoidable hospital admissions.[[47]](#footnote-48) This seems to have been borne out in the survey results from this evaluation, where clients visited hospital 42 per cent more frequently each year before they started the program, compared with once they were in the program.

The cost of an average public hospital service provided to acute admitted patients in metropolitan NSW (where the Visit Program operates) is $4,911.[[48]](#footnote-49) The average number of hospital admissions for women aged over 65 years (who make up the majority of the Visit Program’s clients) is 1.24 per year[[49]](#footnote-50). If Visit Program clients would have been admitted 42 per cent more than this average, they would have been admitted 1.76 times per year. Preventing these extra .52 admissions per year for each of the 115 Visit Program participants could save the healthcare system $293,677.80 per year.[[50]](#footnote-51)

However, these potential cost savings were not included in the cost-effectiveness or cost-benefit analyses. Firstly, this figure does not take into account that socially isolated people are likely to stay in hospital longer than individuals who are not socially isolated—for an average of 2.6 days in some cases.[[51]](#footnote-52) It also does not include the costs associated with the increased emergency department use seen by lonely people (loneliness can increase emergency department presentation by up to 60 per cent per year).[[52]](#footnote-53) Lastly, the hospital admissions data that was collected as part of the Client Survey was deemed to be unreliable (see 6.6.2).

## Cost-effectiveness analysis

These cost-effectiveness results take into account the costs (of the program and the costs of lower quality of life and increased mental health service use by Visit Program clients) and the outcomes of the program (expressed in terms of mental health gains due to involvement in the program).

A cost-effectiveness analysis typically produces an incremental cost-effectiveness ratio (ICER). This is a statistic that summarises the cost-effectiveness of the intervention by examining the differences in cost between two possible interventions (Visit Program and no program),and dividing this by the difference in their effect. The ICER calculation in the current analysis was -$60,122.08, suggesting that the program is unequivocally cost effective. The result suggests that for each point gained on the average MCS score, the Visit Program produced $60,122.08 in savings for the community when compared with the alternative (no Visit Program).

1. ICER calculation

This analysis does not necessarily shed light on how any additional money could be spent to achieve changes in mental health outcomes. Further analysis of similar programs and approaches is needed to understand where any additional investment could be best allocated. Given the assumptions and limitations of the analysis, it is expected that the above figures be used as a catalyst for discussions about resource allocation.

The figures used for the cost of the Visit Program and for the alternative (no program) are conservative as the costs of the alternative are likely understated due to some governmental, and all personal and societal costs not being included in the analysis.

## Cost-benefit analysis

The cost-benefit analysis (CBA) considers the costed outcomes (benefits) of the program, the cost savings of the program and the cost of delivering the program. The benefits of the program included the overall monetised impact on QALYs for clients who could be included in the economic evaluation for the duration of their participation in the program, costed at $1,036,438.10 (see 7.2.2). The cost savings included only the savings from avoided mental healthcare treatment, costed at $17,730 (see 7.2.3); other healthcare system cost savings (such as hospital visits) were not included as the results that were collected as part of the Client Survey were concluded to be unreliable (see 6.6.2). The cost of delivering the program was defined as the cost of delivering the program to the clients who were included in the economic evaluation for the duration of their participation in the program, based on the unit cost of delivering the program per year ($2,909; see 7.2.1).

The total cost of the program is different in this section as it needed to be calculated differently to reflect the time period that the cost benefits were captured over. This time period was defined on a per client basis, and as some clients had participated in the program for longer than 1 year, the CBA needed to estimate the total cost of delivering the Visit Program to the clients included in the economic analysis. The total cost was calculated by multiplying the time (in years) each client spent in the program by the unit cost of the program and adding these products together. This calculation produced a total program cost of $527,498.67.

The estimated net benefit of delivering the Visit Program to the clients that were included in the economic evaluation is $526,669.43. These results suggest that the benefits of delivering the Visit Program outweigh its operational costs, and that the program is a good investment for the community.

The cost-benefit ratio (CBR) of the Visit Program is approximately 2.0, meaning that each $1 AUD spent on the program leads to a return of $2 AUD.

1. Literature review

## 1. Scope and purpose

This literature review, conducted between August 2019 and April 2020, builds upon the review conducted by Open Support and included in the Request for Tender. It aims to provide a comprehensive summary of the social isolation literature from the last decade (however, 16 references are of academic articles or grey matter published before 2009, two of which were published in the 1990s). The review targeted the following questions:

* What is social isolation?
* How is it different from loneliness?
* Is there an operational definition?
* Are there any measures of social isolation?
* Who is likely to experience social isolation?
* Is there any literature on cohorts outside of the elderly and those with mental illness?
* What are the effects of social isolation on the individual?
* What are the effects on: wellbeing, physical health, mental health and behaviour?
* What is the cost of social isolation to society?
* What are the economic benefits of reducing social isolation?
* What kinds of programs are being used to combat social isolation?
* What models do they use?
* Who do they target?
* How do they differ from Open Support’s Visit Program?
* Have there been any impact evaluations or cost-benefit analyses on these programs?
* Is there any evidence on the benefits of therapeutic relationships in combatting social isolation?

### Search terms

Social isolation, Social isolation operational definition, Social isolation emergency services, Social isolation cost, Social isolation economy, Social isolation economics, Social isolation therapeutic relationship, Therapeutic relationship isolation, Social isolation effects mental, Social isolation effects physical, Social isolation heart, Social isolation sleep, Social isolation refugees, Social isolation immigrant, Social isolation Indigenous, Social isolation Aboriginal, Effects of social isolation, Social isolation program, Social isolation intervention, Social isolation RCT, Social isolation visit, Loneliness, Loneliness vs social isolation, Social isolation gender, Social isolation chronic, Social isolation population, Social isolation programs NSW, Social isolation HIV, Social isolation intervention Australia, Social isolation intervention NSW, social isolation evaluation, social isolation visitor, social isolation volunteer, social isolation success, social isolation effectiveness, social isolation relationship, social isolation facilitator, social connectedness, social prescribing.

### Databases

We consulted the following databases: Web of Science; Google Scholar. Websites and promotional material of other social isolation interventions were also forwarded by Open Support staff and ARTD staff, and similar programs were investigated after hearing about them during data collection.

## 2. Defining social isolation

Our literature review found many definitions and measurements for social isolation (Courtin & Knapp 2015; Fine & Spencer 2009; Hawthorne 2006; Masoom 2016), many of which are interrelated, identical or confused with other distinct but related phenomena (Biordi & Nicholson 2013). The most common overlap or tension arises when differentiating between social isolation and loneliness, and whether/ how these states interact.

**Social isolation** is most commonly defined as an objective, quantifiable state of limited human contact or other social content (Biordi & Nicholson 2013; Steptoe et al. 2013). Many studies have been devoted to developing and validating various tools to measure indicators of social isolation (McHugh et. al. 2017; Valkorta et. al. 2016) and relate them to causal factors (Menec et. al. 2019)and to effects such as physical and mental health outcomes (Ge et. al. 2017; Shankar et. al. 2011; Yu et. al. 2018).

**Loneliness** has been conceptualised in various ways (Smith & Victor 2019), but is typically defined as a subjective, emotional state (Biordi & Nicholson 2013), as a person’s internal perception of the quality and, in some definitions, quantity of their social engagement (de Jong Gierveld et. al. 2006; Friedler et. al. 2015).

However, while some define loneliness as a distinct, separate phenomenon that contributes to social isolation (Fine & Spencer 2009; Zavaleta et. al. 2017), others define loneliness as *subjective social isolation* (Cacioppo et. al. 2009; Taylor et. al. 2018). It appears that social isolation and loneliness are comorbid conditions and must be examined as such (Friedler et. al. 2015; Smith & Victor 2019)’; it is important to consider though that those who are lonely (or subjectively socially isolated) may not be objectively socially isolated, and vice versa (Taylor et. al. 2018).

In this review we follow the thinking that social isolation and loneliness are distinct, and relate to a quantifiable sociologic status and a subjective psychological state respectively, but that the two are inextricably linked such that, depending on analysis and circumstances, social isolation can be the cause, process or response to loneliness (Biordi & Nicholson 2013). That is, social isolation often involves a vicious cycle whereby the factors that constitute causes are also consequences (Pettigrew et. al. 2014). For example, cognitive decline can reduce one’s ability to socialise, and reduced social interaction is related to further cognitive decline (Shankar et. al. 2013).

There are many ways to objectively measure social isolation, including current/ desired networks or number of visitors/ visits/ phone calls per week (Dickens et. al. 2011). A range of scales and indexes have also been developed to measure social isolation and loneliness, such as the [de Jong Gierveld Loneliness Scale](https://mvda.info/sites/default/files/field/resources/De%20Jong%20Gierveld%20Lonliness%20Scale.pdf), the Wohlford Hope Scale (see also, the [Adult Hope Scale](https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/PURPOSE_MEANING-AdultHopeScale.pdf); Snyder et. al. 1991), the [Personal Resource Questionnaire](http://www.ncacbsa.org/wp-content/uploads/2015/10/Personal-Resource-Questionnaire.pdf), and the Friendship Scale (Hawthorne 2006).

### 2.1 The how

Social isolation occurs along a scale from a personal level to a societal level (Biordi & Nicholson 2013; Masoom 2016). Social isolation can occur across one, some, or all four levels at the same time, at varying degrees of intensity and duration (Table 15).

Social isolation can result from various factors and is commonly a result of frail health limiting people to their homes; carers are also at risk, for example a caregiver of a family member with dementia having no time to engage with the wider community. Lower levels of income, poorer health proﬁles, degraded neighbourhood and community environments, and reduced access to formal resources are a few of the recognised social, economic and health risk factors for social isolation (Chatters et. al. 2018). These risk factors increase the chances of a person experiencing social isolation and are more common for certain demographic groups than others, discussed in more detail in the next section.

1. Social isolation can occur across four levels

|  |  |  |
| --- | --- | --- |
| Level | Description | Example |
| Personal | An intellectual or sensory disability that reduces a person’s ability to apprehend and interpret relationships. | A person who is visually and/or hearing impaired may feel like they cannot make any new or meaningful relationships. |
| Interpersonal | Reduction in relationships with family, friends, significant other(s) and even acquaintances. | A person who cares for a chronically ill family member may see their friends and family less than they used to. |
| Organisational | Reduced contact with institutions that provide structure, such as schools, work and churches. | A person with an intellectual disability may face barriers in entering the workforce. |
| Societal | Isolation from the larger societal structure, reduced access to services and other resources. | A refugee who does not speak the language of the country they now reside in may feel disconnected from society. |

### 2.2 The who

In terms of who experiences social isolation, the literature mainly refers to the elderly (Mance 2018; Steptoe et. al. 2013), and to a lesser extent the chronically ill (Ursula & Holley 2007). Because there is no widely accepted definition of social isolation—including no clear definition to differentiate it from loneliness—and a multitude of measurement tools described throughout the literature, there is no consensus on which groups of people are most likely to experience social isolation, apart from the elderly and the chronically ill. For example, while studies often claim that social isolation affects men more than women (Chatters et. al. 2018; Fine & Spencer 2009; Klinenberg 2016; Menec et. al. 2019), some studies conclude the opposite (Coyle 2016; Rohde et. al. 2015). It appears that men and women have different pathways to experiencing social isolation (Fine & Spencer 2009), with women particularly at risk in old age following widowhood (Baltes et. al. 1999).

There are a range of other people who may be at risk of experiencing social isolation (Fine & Spencer 2009, page 19), including:

* people suffering from mental illness, such as
* post-natal mothers
* people experiencing homelessness
* imprisoned people
* young people
* people with disability or functional impairment
* informal carers (Kovaleva et. al. 2018) of people with disability or chronic illness, including older people who are HIV positive (Courtin & Knapp 2015)
* Indigenous peoples
* people from culturally and linguistically diverse groups, such as
* international students
* young refugees
* newly arrived migrants
* culturally and linguistically diverse men
* people on low incomes, and the unemployed (Anderson & Thayer 2018)
* single mothers and grandparents caring for children (Mance 2018)
* victims of trauma, such as
* women and children experiencing domestic and family violence
* people seeking asylum
* veterans and others suffering from PTSD
* children whose carers work long hours or travel frequently
* people experiencing addiction (substance, gambling or otherwise)
* lesbian, gay, bisexual and transgender people (Anderson & Thayer 2018; Klinenberg 2016).

#### 2.2.1 The elderly

In most of the literature on social isolation, elderly people, particularly those who are frail and ill, are the most commonly researched and reported on demographic (Rohde et. al. 2015). Elderly people are at a heightened risk of social isolation, with many studies documenting how they may come to experience social isolation (Pettigrew et. al. 2014; Pirhonen et. al. 2018), documenting the effects of social isolation on them (Shankar et. al. 2011; Steptoe et. al. 2013; Yu et. al. 2018), and what can be done to combat social isolation in this cohort (Au et. al. 2019; Shaw et. al. 2019; Fields et. al. 2019; Lopez et. al. 2019). Typically, as some people become frailer as they age, they also become more housebound thus limiting their social interactions and reducing contact with friends and family members (Choi & McDougall 2007). Being homebound—unless counteracted with coping resources such as social support and physical exercise—also increases the likelihood of depressive symptoms in older people (Taylor et. al. 2018).

This is especially problematic when the homebound state acts as a barrier to people’s mental health needs being diagnosed and treated, e.g. depression may reduce the ability to socialise, further impacting on their mental state. Men who are elderly are less likely than women who are elderly to join clubs, associations and seek out social networks (Fine & Spencer 2009), reducing their social contact further.

#### 2.2.2 The chronically ill

People who are chronically ill, particularly those who are functionally impaired, are also at risk of social isolation—including those with physical or intellectual disability. They may experience diminished social circles due to (Ursula & Holley 2007):

* decreased mobility, less energy, fatigue, and pain leading to fewer outings
* reduced or altered ability to interact socially due to personality changes related to neurological disorders
* feelings of loneliness due to cognitive disabilities being misunderstood and/or seemingly invisible
* reduced employment, due to capacity, ability or perceptions of employers
* related financial strain may also mean they can only afford the necessities for survival and health care, leading to fewer social outings
* dependence on specific types of transportation that are not readily available, particularly in rural areas.

#### 2.2.3 Caregivers

Caregivers, particularly older, informal carers (Courtin & Knapp 2015), are also at risk of social isolation and loneliness (or ‘subjective social isolation’). The responsibilities of caregiving are time intensive and emotionally draining, reducing the priority of activities such as socialising (Kovaleva et. al. 2018). Feelings of loneliness can also occur if the caregiver feels like their relationship with the care recipient is changing, drained or becoming distant (Ursula & Holley 2007).

#### 2.2.4 Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people may be at risk of social isolation or increased perceptions of social isolation (loneliness) (Biordi & Nicholson 2013; Masoom 2016) due to reduced access and/or willingness to connect with services and other resources. This greater exclusion and self-exclusion from larger societal structures (Hunter 2000) is because of the historical disenfranchisement and inhumane policies of state and national governments.

Social isolation or loneliness when being off country or away from community may arise in some Aboriginal and Torres Strait Islander people due to policies of forcibly removing children from their families and culture (Samuel et. al. 2014), as well as when moving areas for education or employment. Further, the health and wellbeing of Aboriginal and Torres Strait Islander people can be affected by direct or intergenerational experiences of marginalisation, stemming from continued discrimination, unemployment, mental health problems and/or drug and alcohol issues (McMillen & Donnelly 2008).

#### 2.2.5 LGBT+ peoples

Lesbian, gay, bisexual and transgender (LGBT+) people are at a greater risk of social isolation. In some degree, this is due to them being less likely to have children or more likely to be estranged from family (Klinenberg 2016)—objectively reducing the number of strong ties in their social circle (Aspen Institute Round table on Community Change 2006). LGBT+ individuals often rely on friend-centred social networks and have historically experienced discrimination from service providers (Brennan-Ing et. al. 2014).

HIV is a significant health issue in the LGBT+ community, and older adults with HIV experience the onset of illnesses that are normally associated with the very old (Havlik et al. 2011), requiring care earlier on. Of those living with HIV, older men and older adults of colour are the most at risk of social isolation, but this risk can be mediated by having a confidante and receiving instrumental support (Emlet 2006).

#### 2.2.6 Refugees and people from culturally and linguistically diverse backgrounds

While there is very limited information on how people from culturally and linguistically diverse backgrounds experience social isolation, there is some evidence that they, specifically refugees (Simich et. al. 2003), international students and newly arrived men, are at risk (Fine & Spencer 2009). The community service sector has limited capacity to address specific cultural, religious, social and linguistic needs of people from culturally and linguistically diverse communities (Dimitriadis & Freidin 2004). They may be socially isolated at the organisational and/or societal level (Table 15) due to language and cultural barriers, racism and discrimination and/or a lack of services that are culturally appropriate (Fine & Spencer 2009). These factors may be confounded by age (Fine & Spencer 2009), past trauma (in the case of refugees) and gender (Casimiro et. al. 2007).

## 3. Effects of social isolation

Most of the literature surrounding the effects of social isolation explores the detrimental effects to the individual, both to their physical and mental wellbeing (Smith & Victor 2019), though there are implications at the community-level in terms of costs to the economy.

The section below describes the negative physical and mental health effects of social isolation to the individual; and the following section scales these effects up to a community level and frames the issue as monetary costs to society.

### 3.1 The individual

The literature suggests three ways in which social isolation can impact an individual:

1. reducing their mental health
2. reducing their physical health
3. increasing their engagement in health-risk behaviours, such as smoking.

Social isolation may act as a pathway to poorer health status. One study (Chatters et. al. 2018) posits that being socially isolated limits access to informal social support systems—adult children, spouses, other family members and friends—that are important for providing health relevant information and other assistance, such as:

* general health maintenance activities
* direct in-home care (e.g. meal preparation, personal care)
* chronic disease and medication management
* rehabilitative efforts
* health decision-making
* assistance in accessing and navigating formal health resources (e.g. transportation, medical appointment scheduling).

A national study in the US found that health professionals rarely if ever ask people questions about social isolation (Anderson & Thayer 2018), which may mean that people are not getting referred to services as expediently as possible, potentially leaving health effects unaccounted for.

A person’s increased engagement in health-risk behaviours is undeniably linked to their physical and mental health. For example, a socially isolated person has a higher chance of taking up smoking (Shankar et. al. 2013), which has a suite of well-known effects on one’s physical health. Social isolation is also associated with engaging in less-than-ideal physical activity (Kobayashi & Steptoe 2018), which may impact their mental health by increasing depressive or anxious symptoms (Booth et. al. 2012).

However, it is also important to consider that social isolation often involves a vicious cycle, whereby the factors that constitute consequences are also causes (Pettigrew et. al. 2014). For example, in a society where smoking has become less normative, it may be that smoking contributes to the perceived or actual social isolation of a long-term smoker (Kobayashi & Steptoe 2018).

#### 3.1.1 Mental health

Social isolation can impact on mental health. Many studies show significant associations between social isolation and psychological distress (Taylor et. al. 2018), depressive symptoms (Choi & McDougall 2007; Leigh-Hunt et. al. 2017), anxiety symptoms (Xiang & Brooks 2017), suicidal ideations (Calati et. al. 2019) and possibly even dementia (Qiu et. al. 2010).

Some studies suggest that loneliness (otherwise called ‘subjective social isolation’) has a greater negative effect on an individual’s mental health than objective social isolation (Ge et. al. 2017; Taylor et. al. 2018). A person with few social connections may not experience loneliness, yet a person with relatively more social connections (and therefore less socially isolated) may still feel alone. There is a reverse causality between loneliness (and possibly social isolation) and depression (Rohde et. al. 2015); that one’s perception of loneliness may be causing and/or caused by depressive symptoms.

In dealing with major life events, people who are socially isolated often use coping strategies such as denial, avoidance or withdrawal (Meeuwesen 2006), which often leads to other problems such as addiction or depression (Åkerlind & Hörnquist 1992).

Studies have also found associations between social isolation and a reduction in sleep quality (Yu et. al. 2018), which has flow-on consequences on mental (Del Rio Joao et. al. 2018) and physical (Fatima et. al. 2016) health.

#### 3.1.2 Physical health

Our research describes studies that outline associations between social isolation and a range of physical ailments. We came across no studies that describe positive changes to *mortality or morbidity* based on interventions that definitively reduced social isolation.

There is a breadth of literature relating social isolation and, at times, loneliness to increased all-cause mortality (Beer et. al. 2016; Holt-Lunstad et. al. 2015; Leigh-Hunt et. al. 2017; Steptoe et. al. 2013), excluding suicide (though the relationship between social isolation, depressive symptoms and suicidal thoughts may impact suicide-related mortality).

Other studies have found relationships between social isolation and increased disease-related morbidity and mortality (Friedler et. al. 2015), and a suggested association between social isolation and cancer-related mortality (Beer et. al. 2016). One study claimed that the effect of social isolation on the risk of mortality exceeds that of smoking up to fifteen cigarettes a day, obesity and air pollution (Khosravi et. al. 2016).

A study conducted in Lebanon found that social isolation and loneliness were both risk factors for malnutrition in older people (Boulos et. al. 2016). As such, the effects of social isolation on physical health may reflect the negative health effects of smoking, inactivity or a poor diet—in that, for example, an individual who is socially isolated takes up smoking and then develops heart disease. Other studies found that a high degree of social isolation is associated with increased risk of becoming physically frail (Gale et. al. 2018; Shankar et. al. 2017).

Social isolation has also been found to predict coronary artery disease, chronic heart failure and congestive heart failure (Courtin & Knapp 2015), inflammatory pathogenesis (Kovaleva et. al. 2018), cardiovascular disease (Leigh-Hunt et. al. 2017; Shankar et. al. 2011), and other diseases including atherosclerosis, myocardial infarction, ischemic stroke and Alzheimer’s disease (Friedler et. al. 2015).

Some studies have described the physiological pathways that cascade from social isolation to negative physical outcomes. Such pathways include increasing blood pressure, disrupting neuroendocrine and neuroimmunological regulation (Kovaleva et. al. 2018), promoting pro-inflammatory gene expression leading to increased levels of fibrinogen (a clotting protein) or C-reactive protein (involved in the inflammation response) (Shankar et. al. 2011).

### 3.2 Costs to the community

There is very little information on the costs of social isolation to the community. A systematic review of systematic reviews (systematic overview) found no reviews that examined wider socio-economic or developmental outcomes of social isolation but concluded that social isolation and loneliness are important upstream factors impacting morbidity, mortality and later public health, (Leigh-Hunt et. al. 2017).

Conclusions about the costs of social isolation to communities and societies often hinge on (logical) assumptions about cause and effect; costs considered are the cost of treating ill health (mental and physical) related to social isolation. It is important to keep this in mind when reading the following section.

Affluent nations, such as Australia, have the highest proportions of people living alone (Holt-Lunstad et. al. 2015) and some predict that, in such countries, loneliness will reach epidemic proportions by 2030 (Linehan et. al. 2014). As populations continue to age and more people live alone, nations will have to invest in innovative elderly care solutions and supportive housing programs to combat the causes and symptoms of social isolation (Klinenberg, 2016). As it stands, very few countries have recognised the growing threat of social isolation nor have they made concrete steps to combat it (Klinenberg, 2016).

The costs of social isolation to society can be viewed in terms of dollars—but the lack of primary evidence regarding cost-benefits reduces the certainty of conclusions (Mihalopoulos et. al. 2019). In a 2013 technical review, Medibank estimated that the Australian government spent roughly $28.6 billion on support for individuals with mental illness in 2012 (Medibank Private 2013), including direct spending on public and private mental health services, medication, and related drug and alcohol services. A separate study used this figure to claim that a nationwide 10 per cent reduction in loneliness (by reducing social isolation, assumed therein) would reduce annual expenditure on mental illness in Australia by approximately $3 billion (Rohde et. al. 2015). This assumes a causal relationship between social isolation (and loneliness) and mental illness. We have to keep in mind that, depending on the circumstances, social isolation can be the cause, process or response (Biordi & Nicholson 2013). Also, as better mental health often has positive effects such as greater physical health and improved general wellbeing, it is expected that medical, social and economic costs would reduce even further (Dean 2019).

Costs to society don’t stop at treating mental health. Social isolation is also a risk factor associated with elder abuse in community settings, as these populations have less access to social support, fewer opportunities for abuse to be noticed and reported, and their caregivers face increased demands (Dean 2019). In the United States, elder abuse poses financial costs of approximately $12 million annually (Lubben et. al. 2015), a cost that could potentially be mediated by reducing social isolation. These costs can be assuaged by increased social supports and better quality of relationships between caregivers and older adults, which act as protective factors (Acierno et. al. 2010) and risk moderators (Dean 2019) against elder abuse respectively.

Furthermore, studies have found that, independent of chronic illness, loneliness is a predictor of hospital emergency department use (Geller et. al. 1999) and social isolation is a significant predictor of delayed hospital discharge for older hip fracture patients (Landeiro et. al. 2016), which poses more costs to society. Recent research suggests that social isolation interventions can reduce these hospitalisations of older individuals (Abel et. al. 2018; Liotta et. al. 2018).

A multidimensional intervention called Compassionate Communities was implemented in the UK and helped reduce the number of unplanned hospital admissions in the area (Abel et. al. 2018). This complex intervention identified at risk people, including those in residential care, who may be socially isolated, and helped them enhance and build supportive networks, signposted them to services (such as housing, health, education etc), allowed them to make their own choices about the level of support they wanted, and helped them set health goals (Abel et. al. 2018). Long Live the Elderly (LLE) is a social isolation intervention in Italy that runs awareness campaigns, phone monitoring, strengthening of personal social networks and home visits (Liotta et. al. 2018). A recent study compared a cohort of LLE to matched Rome citizens over 80 and found that after 6 months in the program, the LLE cohort had a significantly lower risk of hospital admission (Liotta et. al. 2018).

We also know that people who are socially isolated are more likely to engage in health-risk behaviours such as smoking (Shankar et al. 2011), inactivity (Kobayashi & Steptoe 2018) and a poor diet; and are at risk of a suite of (potentially related) physical ailments. Some claim that the effects of social isolation on morbidity and mortality exceed that of heavy smoking and obesity, yet the latter risk factors receive substantially more attention and resources (Khosravi et. al. 2016). It follows then that reducing social isolation may help combat smoking, obesity and their related public health costs.

One study argues that social isolation is an intrinsic dimension to poverty, an instrumental component in a feedback loop that reinforces marginalisation (Samuel et. al. 2014). In this loop, those who are isolated learn to not take part in society, and others learn to exclude them, which may result in adverse consequences such as being excluded from employment or having reduced access to services.

## 4. Responding to social isolation

Social isolation is clearly a pervasive issue with a range of individual and community-level consequences. A 2018 proposal suggested a loneliness minister be appointed to combat the issue in Australia, which is supported by the Australian Coalition to End Loneliness (Wahlquist 2018). In 2018 the United Kingdom launched its first loneliness strategy and appointed a Minister for Loneliness.

In a review highlighting gaps in the social isolation evidence base, only 9 of 128 mostly US studies explored social isolation interventions (Courtin & Knapp 2015). There is also very little clear evidence available on the effectiveness of social isolation interventions, and it is difficult to identify particular strengths and weaknesses of individual models due to a lack of publicly available evaluation data (Australian Healthcare Associates 2017).

### 4.1 Types of interventions

There are many approaches to combatting social isolation, and ways of categorising and differentiating interventions vary widely between studies. Some studies classify interventions by the activities they provide (Gardiner et. al. 2016; Ursula & Holley 2007), which may include the following:

* **Social facilitation interventions**, such as charity-funded friendship clubs, shared interest topic groups, day care centres for frail older people and friendship enrichment programs. There is very limited information specifically on the effects of therapeutic relationships on social isolation.
* **Psychological therapies**, such as humour therapy, mindfulness and stress reduction, reminiscence group therapy, and cognitive and social support interventions.
* **Health and social care provision**,including transport services.
* **Animal interventions**
* **Befriending/ companionship interventions** typically involve formulating new friendships, usually one-to-one and often involving volunteers – the Visit Program falls under this category.
* **Leisure/ skill development** may include group-based exercise programs, or solitary computer-based interventions.

When categorising interventions by activity type, technology-based interventions appear to be the most common, with exercise programs and befriending programs also common.

Other ways of categorising interventions are by the nature of their delivery, namely whether they are group-based or one-to-one (Landeiro et. al. 2017), or by using a combination of both the nature of delivery and the activities provided (Dickens et. al. 2011; Shvedko et. al. 2018), for example a one-to-one befriending intervention such as the Visit Program.

A scoping review found that one-to-one interventions are relatively common (O’Rourke et. al. 2018). Yet a more recent review found that, of the interventions included in their review, nearly two-thirds used a group-based design while only one in ten interventions were one-to-one (Bessaha et. al. 2019).

#### 4.1.1 Befriending interventions

Open Support’s Visit Program is a one-to-one befriending intervention that aims to significantly improve the health and wellbeing of people who are socially isolated. Trained volunteers and staff (‘visitors’) visit clients in Sydney’s eastern and south western suburbs on a fortnightly basis. The client base is comprised predominantly of clients who are elderly, and who have existing health issues, sometimes multiple health issues.

Visitors and volunteers in befriending interventions

Providing high quality training to facilitators appears to be an enabler of any successful intervention to combat social isolation (Findlay 2003; Landeiro et al. 2017). An enabler for befriending interventions is recruiting and retaining appropriate visitors (Australian Healthcare Associates 2017). Visitor appropriateness may encompass age, common interests and activities, expectations regarding visits, background and life history and personality (Chal 2004). However, compatibility may be hard to define and measure, with some even suggesting that intergenerational contact may help address loneliness (Windle et al. 2011).

From our search of the literature, we conclude that many befriending programs are delivered wholly or partially by volunteers (see section *4.3 Other social isolation interventions* for examples). This may be because using staff visitors, and especially having user pays for the service, may undermine the concept of befriending (Australian Healthcare Associates 2017), or may be due to limitations in funding.

A recent review found that one-to-one interventions are less common than group-based interventions (Bessaha et. al. 2019), and a different review of social isolation interventions for older people found that only five of the 32 interventions they reviewed were one-to-one interventions specifically taking place in peoples’ homes (Dickens et. al. 2011). This indicates that the Visit Program appears to be relatively unique.

In terms of the effectiveness of befriending interventions, there are many factors that may contribute or determine an intervention’s effectiveness. Even very similar models can have vastly different outcomes.

A systemic review of randomised control trials indicates mixed success for one-to-one home visit interventions in improving participant outcomes, such as mental and physical wellbeing, functional and structural social support, loneliness and objective social isolation (Dickens et. al. 2011). For example, a one-to-one home visit befriending intervention that specifically targeted older people who are socially isolated or have chronic mental health problems found no significant increase in structural[[53]](#footnote-54) or functional social support[[54]](#footnote-55) (O’Loughlin et. al. 1989), while a different intervention with a very similar model (weekly home visits, explicit targeting of people in the community on the waiting list for the Friendly Visitor Programme) showed significant increase in structural social support (Bogat & Jason 1983). A different one-to-one home visit befriending intervention, with fortnightly home visits of very isolated older people in the community, showed no significant effect on social isolation or mental wellbeing (Mulligan & Bennett 1977). Conversely, a similar program involving weekly visits in retirement homes with no explicit targeting, yet in which participants could control the frequency and duration of the visits, led to significant increases in participant mental wellbeing and physical health (Schulz 1976).

Another review found no statistically significant effects of one-to-one interventions on loneliness or social isolation (Wilson & Bickerdike 2014), while another study found that befriending interventions had a modest effect on depression in a range of population groups (Mead et. al. 2010).

It is clear that it is difficult to determine the sorts of befriending initiatives that are effective at alleviating social isolation and improving outcomes for socially isolated people. This may be due to a range of factors, such as not having a theoretical basis underpinning the program, the program’s choice of outcome measurements, which cohorts the program targets (if it targets populations at all). Determining the effectiveness of interventions is discussed in more detail in section *4.2 Effectiveness of interventions.*

Despite the lack of robust evidence that befriending interventions successfully address social isolation, consumers of the programs are generally satisfied with the intervention. For befriending interventions, service staff are often told by service users that they really value the social contact they get from the program (Age Concern New Zealand 2015), and the quality of social support appears to play a large part in an older person’s perception of life satisfaction (Chal 2004).

#### 4.1.2 Technology-based interventions

Technology-based interventions range from web- or telephone-based exercise programs (Shvedko et. al. 2018) to online social networking, to reverse mentoring of older people to increase their digital competency (Breck et. al. 2018). Many reviews have explored the different types of technology-based interventions (Baker et. al. 2018; Khosravi et. al. 2016), which include but are not limited to:

* general Information and communication technologies (ICT)
* telecare
* reverse mentoring for digital competency
* social network sites
* peer support chat rooms
* personal reminder information and social management systems
* 3D virtual environments
* video games
* robotics, such as robopets (see Abbot et. al. 2019).

Technology-based interventions appear to be the most common type of social isolation intervention; and also appear to be the most well evaluated and effective interventions (Bessaha et. al. 2019; Gardiner et. al. 2016). Among technology-based interventions, telephone services allow frequent contact between staff/ volunteers and socially isolated consumers even where geographical barriers exist, or where people may not feel comfortable about having people come to their homes or meet face-to-face (Devine 2014). Telephone-based interventions are also cost-effective and may make it easier to recruit volunteers (Jopling 2015).

The Australian Red Cross offers the [Telecross service](https://www.redcross.org.au/get-help/community-services/telecross). This involves volunteers making daily calls to isolated older people to check on their wellbeing and contact emergency services if there is no response (Bond et al. 2014).

### 4.2 Effectiveness of interventions

There is very little clear evidence about the effectiveness of social isolation interventions. Often, review and meta-analyses have conflicting conclusions on the effectiveness of different interventions, and it is often difficult to determine the ‘active ingredient’ responsible for the success of a social isolation initiative. Furthermore, there is a diversity of outcome measurements used across social isolation interventions, so it can be hard to determine which intervention is more reliably measuring and affecting social isolation. Such measurement outcomes include:

* the [de Jong Gierveld Loneliness Scale](https://mvda.info/sites/default/files/field/resources/De%20Jong%20Gierveld%20Lonliness%20Scale.pdf)
* the [Personal Resource Questionnaire](http://www.ncacbsa.org/wp-content/uploads/2015/10/Personal-Resource-Questionnaire.pdf)
* the Wohlford Hope Scale (see also, the [Adult Hope Scale](https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/PURPOSE_MEANING-AdultHopeScale.pdf); Snyder et. al. 1991)
* the Friendship Scale (Hawthorne 2006)
* current/ desired networks
* number of visitors/ visits/ phone calls per week.

Many studies have shown that most interventions that aim to combat social isolation are not particularly effective (Bartlett et. al. 2013; Dickens et. al. 2011; Findlay 2003; Shankar et. al. 2011). This may reflect how benefits from social isolation interventions tend to accrue in the long-term, at least such is the case with supported socialisation programs (Sheridan et. al. 2014).

Most interventions target older people (Lubben et. al. 2015), and do not account for the diverse experiences and demographics of those experiencing social isolation, even among the elderly (Machielse 2015), i.e. programs follow a one-size fits all approach. Interventions targeting particular populations of people who are socially isolated generally have better outcomes than interventions with no explicit targeting (Cattan et. al. 2005; Dickens et. al. 2011). In a systematic review of social isolation interventions, researchers found that most studies only targeted people for whom social isolation and loneliness was implied or assumed based on personal circumstance, such as being a resident in a nursing home, rather than explicitly targeting people who are confirmed to be socially isolated or lonely through a self- or professional-assessment (Dickens et. al. 2011).

While technology-based interventions appear to generally be the most effective and well evaluated types of interventions (Bessaha et. al. 2019; Gardiner et. al. 2016), it is still difficult to tease apart the specific components—the ‘active ingredient’—that make them effective (Khosravi et. al. 2016). One review attributed this difficulty to inadequacies in methodology between individual studies and insufﬁcient attention to key social concepts between interventions (Baker et. al. 2018). For example, ICT use increases social connectedness and reduces social isolation, but these positive effects do not appear to last after six months (Chen & Schulz 2016).

A meta-analysis of loneliness interventions concluded that group-based interventions were no more effective than individual-based interventions (Masi et. al. 2011). However, a more recent review found that, despite group-based interventions being more common, only one-third of all group-based interventions had significant reductions in loneliness, whereas over two-thirds of all individual-based interventions yielded significant positive results (Bessaha et. al. 2019). While loneliness and social isolation are invariably related, note that these two reviews only investigated interventions to combat the former.

There is some evidence that befriending initiatives, such as the Visit Program, can reduce the effects of social isolation and improve self-perceived health status and social integration (Chal 2004), as well as reduce depressive symptoms and emotional distress (Mead et al. 2010). However, other studies have found that one-to-one interventions conducted in people’s homes are ineffective in combatting social isolation (Pate 2014), are only moderately successful in improving participant outcomes (Dickens et. al. 2011; Wilson & Bickerdike 2014), or that social isolation outcomes are still unclear (Montclaire 2011). For example, another befriending intervention with one-to-one home visits from volunteers, that specifically targeted older people who are socially isolated or have chronic mental health problems, found no significant increase in structural or functional social support (O’Loughlin et. al. 1989). This may be because the program did not have a theoretical basis or due to the choice of outcome measurements (Dickens et. al. 2011).

In conclusion, it is difficult to compare the effectiveness of different types of social isolation interventions because:

* there is very little publicly available data, and available evidence is often conflicting.
* benefits from social isolation interventions tend to accrue in the long-term.
* methods and measurements differ between studies measuring the effectiveness of social isolation interventions.
* studies measuring the effectiveness of social isolation interventions pay insufficient attention to key social concepts.
* most interventions do not account for the diverse experiences and demographics of those experiencing social isolation.

Instead of trying to determine what type of intervention is better than others, it may be more useful to look at success factors, i.e. what are the elements that make social isolation interventions (be they group-based or one-to-one, befriending or technology-based, or any combination) successful.

#### 4.2.1 Success factors

There is a lack of publicly available evaluation data that identifies the success factors of individual models (Australian Healthcare Associates 2017). Because there are very few evidence-based theories of what predicts social isolation and what can be done to alleviate or intercept it, social isolation interventions are diverse and often have no theory-based logic of cause and effect.

Regardless, social isolation interventions appear to be successful when they are built around theory; include active input from service users; and target specific groups of people (Dickens et. al. 2011; Dobbins 2019). One researcher said the most promising social isolation interventions are those that are framed positively, i.e. focus on ‘connecting people’ (Rural Health Voices 2020).

Other success factors have been compiled below.

* Recruitment and retention of appropriate service provider staff (Australian Healthcare Associates 2017), including the provision of high-quality training (Findlay 2003; Landeiro et. al. 2017).
* Referral of appropriate service users (Australian Healthcare Associates 2017).
* Explicit targeting of service users (Cattan et. al. 2005; Dickens et. al. 2011).
* The presence of a clear theoretical base (Dickens et. al. 2011).
* For befriending interventions, clear friendship boundaries between the service user and the service provider staff or volunteer (Australian Healthcare Associates 2017).
* A community development approach, where service users are involved in the design, implementation and evaluation of interventions (Cattan et. al. 2005; Gardiner et. al. 2016; Landeiro et. al. 2017).
* Productive engagement, where service users are actively engaged in their improvement and have explicit goals (Gardiner et. al. 2016; Landeiro et. al. 2017).
* Multidimensional interventions that include not only the core component of the intervention, but also aspects such as educational activities and addressing personal and situational factors contributing to loneliness and isolation (Cattan et. al. 2005; Courtin & Knapp 2015).
* Adaptability of programs to local contexts (Gardiner et. al. 2016).

More investment into research is required to tease out what types of interventions are most effective and for whom these interventions are most effective.

A successful yet complex and multidimensional intervention called [Compassionate Communities](https://www.compassionate-communitiesuk.co.uk/projects) was implemented in Frome in the UK and helped reduce the number of unplanned hospital admissions in the area (Abel et. al. 2018). This complex intervention identified at risk people, including those in residential care, who may be socially isolated and helped them enhance and build supportive networks, signposted them to services (such as housing, health, education etc), allowed them to make their own choices about the level of support they wanted, and helped them set health goals (Abel et. al. 2018). This program was successful because it had most of the above success factors.

Table 16 outlines the extent to which Open Support’s Visit Program addresses the above success factors, highlighting areas where the program could improve to better support/ address social isolation in the community.

1. The Visit Program’s model - success factors

| Success factor | The Visit Program |
| --- | --- |
| Recruitment and retention of appropriate service provider staff, and high-quality training | At the recruitment stage, potential visitors are screened against set criteria. Staff and volunteer visitors attend training before their first visit with their client, including sitting in on visits with an experienced staff member. Training has been refined over the years to more appropriately target the skills required for the position. |
| Referral of appropriate service users | Most referrals to the Visit Program are considered appropriate for the program; this indicates referral agencies are aware of the program and of the criteria for referral to the program. |
| Explicit targeting of service users | Currently the Visit Program does not target specific cohorts to receive the service. |
| The presence of a clear theoretical base | The Visit Program evolved organically and as such does not have a theoretical evidence base. |
| Clear friendship boundaries | Visit Program staff and volunteers have spoken about the importance of maintaining appropriate boundaries between client and visitor; staff have made efforts to make this boundary clearer to visitors (including ensuring that clients know the boundaries), including substantial training in this area and support to visitors if they feel the boundary has been or is getting close to being crossed. |
| A community development approach | Participants were not involved in the design of the Visit Program, but to a limited extent are involved in the implementation of the Visit Program through providing feedback via surveys and annual reviews; they are providing feedback on the program in this evaluation. |
| Productive engagement | To differentiate it from other supports the clients may be receiving and to diminish expectations, the Visit Program was designed to not be goal-focused. It provides support in the form of unconditional positive regard. Participants do not have explicit goals they work towards. |
| Multidimensional interventions | The Visit Program provides one-on-one visits, but there are opportunities for participants to attend organised social events with their visitor.  There may be instances where visitors suggest other appropriate services to clients.  By providing a trusted, supportive relationship, visitors may help support clients to address health factors that contribute to their isolation, such as agoraphobia in one case, but this is likely situational. |
| Adaptability of programs to local contexts | The Visit Program is offered in the eastern suburbs of Sydney and the south western suburbs of Sydney. One potential issue in the south western suburbs site is the lack of visitors who speak another language, given the diversity of cultural backgrounds of residents in the south western suburbs, thus limiting the program to those who speak good English. |

### 4.3 Other social isolation interventions

There are a number of programs and studies in Australia and internationally that aim to address social isolation and loneliness.

In Australia, [The Compeer Friendship Program](https://www.vinnies.org.au/page/Get_Involved/Become_a_volunteer/ACT/Compeer/), offered through the St Vincent de Paul Society, and the [Red Cross’ Companionship Social Support Programs](https://www.redcross.org.au/get-help/community-services/companionship-social-support), such as MATES, link volunteers to those in the community who are socially isolated. [The Brightwater Group](https://brightwatergroup.com/) offers a range of aged care programs, which includes providing people in aged care with volunteer visitors. Only the Compeer Friendship Program has been evaluated, and this reported positive social and wellbeing outcomes for participants (Montclaire 2011), although it is still mostly unclear how it has impacted social isolation for its consumers.

The [Community Visitor Scheme](https://ableaustralia.org.au/wp-content/uploads/2019/02/Community-Visitor-Friends_Brochure_CVFQLD051802_v2.pdf) (CVS) also provides paid and volunteer visitors to residents of aged care homes (Irlam 2016). Similar to the Visit Program, visits occur on average fortnightly but may be one-to-one or in a group setting, depending on the contract with the residential aged care facility. Visitors are provided with training, although training is not compulsory for volunteers. In a review of the CVS, stakeholders (but not socially isolated people themselves) said that consumers of the scheme ‘*experience significant benefit from the CVS, including decreased sense of loneliness and improved quality of life.*’ (Australian Healthcare Associates 2017).

Mt Gravatt Community Centre and the University of Queensland launched the [Ways to Wellness Social Isolation Project](https://waystowellness.org.au/) in June 2019, which provides people who are socially isolated with ‘link workers’, who help them to identify goals and link them to community groups or activities. The Sutherland Shire Loneliness Project connects socially isolated people with social contact through home visits, phone calls and linking them to other services, groups or events (Sutherland Shire Council 2018). Neither of the projects have been evaluated.

Three other Queensland-based social isolation interventions, including the now discontinued Connecting Points-Connecting People (CPCP) program that implemented a buddy system, have been evaluated. Two of the three interventions, including the CPCP program, had no significant differences in loneliness or number of social supports between the start and end of the programs (Bartlett et. al. 2013).

The Queensland government [has a website](https://www.qld.gov.au/seniors/recreation-staying-connected/social-connection-leisure/staying-connected-your-community) that compiles programs and services (mostly group activities) across the state to help seniors stay connected, while [Connections Matter](https://www.beyondblue.org.au/who-does-it-affect/older-people/connections-matter) is an online resource that provides tips on boosting social connectivity.

There are numerous other programs and services in Australia and overseas, including those listed below.

* [Age UK](https://www.ageuk.org.uk/)
* Anglicare
* [Befriend](https://befriend.org.au/)
* [Blue Care](https://www.bluecare.org.au/)
* Catholic Community Services
* [CHSP programs](https://www.health.gov.au/initiatives-and-programs/commonwealth-home-support-programme-chsp) (including Legacy, Neighbourhood Visitors)
* City of Boroondara Community Recreation Outreach Program (CROP) activities
* [Community Circles](https://www.community-circles.co.uk/) (UK)
* [Community Navigators](http://bristolageingbetter.org.uk/community-navigators-bris/) (UK)
* Companionship for disability through [WA Blue Sky](https://wabluesky.com.au/)
* [Contact the Elderly](https://www.together-uk.org/southwark-wellbeing-hub/the-directory/9507/contact-the-elderly/) tea parties (UK)
* [The Campaign to End Loneliness](https://www.campaigntoendloneliness.org/) (UK)
* [Men’s Sheds](https://mensshed.org/)
* Telecross, Telechat and Mates programs (Red Cross)
* Uniting Church outreach programs
* [Val’s Cafe](https://www.latrobe.edu.au/arcshs/health-and-wellbeing/lgbti-ageing-and-aged-care/what-we-offer)

## References

1. Abbot, R., Orr, N., McGill, P., Whear, R., Bethel, A., Garside, R., Stein, K., Thompson-Coon, J. (2019) How do "robopets" impact the health and well-being of residents in care homes? A systematic review of qualitative and quantitative evidence, International Journal of Older People Nursing, 14(3): DOI: 0.1111/opn.12239
2. Abel, J., Kingston, H., Scally, A., Hartnoll, J., Hannam, G., Thomson-Moore, A., Kellehear, A. (2018) Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities, British Journal of General Practice, 68(676): 803-810
3. Acierno, R., Hernandez, M.A., Amstadter, A.B., Resnick, H.S., Steve, K., Muzzy, W., Kilpatrick, D.G. (2010) Prevalence and correlates of emotional, physical, sexual and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study, American Journal of Public Health, 100(2): 292–297
4. Age Concern New Zealand (2015) Do you have time for older people?, Accredited Visiting Service: http://www.ageconcern.org.nz/files/AVSVisitorbrochure.pdf
5. Åkerlind, I., Hörnquist, J.O. (1992) Loneliness and alcohol abuse: A review of evidences of an interplay, Social Science & Medicine, 34: 405–414
6. Anderson, G.O., Thayer, C.E. (2018) Loneliness and Social Connections: A National Survey of Adults 45 and Older, AARP Research, AARP Foundation: doi.org/10.26419/res.00246.001
7. Aspen Institute Round table on Community Change (2006). Community Change: Theories, Practice and Evidence. Edited by Karen Fulbright-Anderson and Patricia Auspos. Washington, DC: Aspen Institute
8. Au, T.N., Mays, A.M., Rosales, K., Saliba, D., Rosen, S. (2019) Leveraging Exercise to Age in Place (LEAP): Engaging Older Adults in Community-Based Exercise to Combat Social Isolation, Journal of the American Geriatrics Society, 67: 141
9. Australian Healthcare Associates (2017) Review of the Community Visitors Scheme: Final Report, Department of Health: https://www.health.gov.au/sites/default/files/documents/2019/12/final-report-of-the-community-visitors-scheme-cvs-review\_0.pdf
10. Baker, S., Warburton, J., Waycott, J., Batchelor, F., Hoang, T., Dow, B., Ozanne, E., Vetere, F. (2018) Combatting social isolation and increasing social participation of older adults through the use of technology: A systematic review of existing evidence, Australasian Journal on Ageing, 37(3), 184-193
11. Baltes, M., Freund, A., Horgas, A. (1999) Men and Women in the Berlin Aging Study, The Berlin Aging Study: Aging from 70 to 100: 259-281
12. Bartlett, H., Warburton, J., Lui, C.W., Peach, L., Carroll, M. (2013) Preventing social isolation in later life: findings and insights from a pilot Queensland intervention study, Ageing & Society, 33(7): 1167-1189
13. Beer, A., Faulkner, D., Law, J., Lewin, G., Tinker, A., Buys, L., Bentley, R., Watt, A., McKechnie, S., Chessman, S. (2016) Regional variation in social isolation amongst older Australians, Regional Studies, Regional Science, 3(1): 170-184
14. Bessaha, M.L., Sabbath, E.L., Morris, Z., Malik, S., Scheinfield, L., Sargossi, J. (2019) A Systematic Review of Loneliness Interventions Among Non-Elderly Adults, Clinical Social Work Journal, https://doi.org/10.1007/s10615-019-00724-0
15. Biordi, D.L., Nicholson, N.R. (2013) Social isolation, Chronic illness: Impact and intervention: 85-115
16. Bogat, G., Jason, L. (1933) An evaluation of two visiting programs for elderly community residents. International Journal of Aging and Human Development, 17: 267-280. 10.2190/6AQX-1TDM-DEL4-3T6L.
17. Bond, M., Howden, P., Ralston, N. (2014) Connections matter: Social connectedness research project final report prepared for beyondblue, Roberts Evaluation, https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0286-social-connectedness-final-report.pdf?sfvrsn=2
18. Booth, F.W., Roberts, C.K., Laye, M.J. (2012) Lack of exercise is a major cause of chronic disease, Comparative Physiology, 2(2): 1143-1211
19. Boulos, C., Salameh, P., Barberger-Gateau, P. (2016) Social isolation and risk for malnutrition among older people, Geriatrics Gerontology International, 17: DOI 10.1111
20. Breck, B.M., Dennis, C.B., Leedahl, S.N. (2018) Implementing Reverse Mentoring to Address Social Isolation Among Older Adults, Journal of Gerontological Social Work, DOI: 10.1080/01634372.2018.1448030
21. Brennan-Ing, M., Seidel, L., Larson, B., Karpiak, S.E. (2014) Social Care Networks and Older LGBT Adults: Challenges for the Future, Journal of Homosexuality, 61:1, 21-52
22. Cacioppo, J. T., Fowler, J. H., Christakis, N. A. (2009) Alone in a crowd: The structure and spread of loneliness in a large social network, Journal of Personality and Social Psychology, 97: 977-991
23. Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho Philippe Courteta, A. F. (2019) Suicidal thoughts and behaviours and social isolation: A narrative review of the literature, Journal of Affective Disorders, 245: 653-667
24. Casimiro, S., Hancock, P., Northcote, J. (2007) Isolation and Insecurity: Resettlement Issues Among Muslim Refugee Women in Perth, Western Australia, Australian Journal of Social Issues, 42(1): 55-69
25. Cattan, M., White, M., Bond, J., Learmouth, A. (2005) Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions, Ageing & Society, 25: 41–67
26. Chal, J (2004) An evaluation of befriending services in New Zealand: Final Report, Ministry of Health, Auckland
27. Chatters, L.M., Taylor, H.O, Nicklett, E.J., Taylor, R.J. (2018) Correlates of Objective Social Isolation from Family and Friends among Older Adults, Healthcare, 6(24): doi:10.3390/healthcare6010024
28. Chen, Y.R.R., Schulz, P.J. (2016) The effect of information communication technology interventions on reducing social isolation in the elderly: a systematic review, Journal of medical Internet research, 18(1): e18
29. Choi, N.G., McDougall, G.J. (2007) Comparison of depressive symptoms between homebound older adults and ambulatory older adults, Aging and Mental Health, 11(3): 310-322
30. Courtin, E., Knapp, M. (2015) Social Isolation, Loneliness and Health in Old Age: A Scoping Review, Personal Social Services Research Unit
31. Coyle, C.E. (2016) How age-friendly communities can reduce social isolation and why it matters, Center for Social & Demographic Research on Aging, https://www.mwhealth.org/Portals/0/Uploads/Documents/Understanding\_Social\_isolation\_Age\_Friendly\_%20Communities.pdf
32. Dean, A. (2019) Elder abuse: Key issues and emerging evidence, Child Family Community Australia – information exchange, CFCA Paper No. 51
33. Del Rio Joao, K.A., de Jesus, S.N., Carmo, C., Pinto, P. (2018) The impact of sleep quality on the mental health of a non-clinical population, Sleep Medicine, 46: 69-73
34. de Jong Gierveld, J., van Tilburg, T.G., Dykstra, P.A. (2006) Loneliness and Social Isolation, The Cambridge Handbook of Personal Relationships, 2: 485-500
35. Devine, P. (2014) One-to-one befriending programmes for older people, ARK Ageing Programme, https://www.ark.ac.uk/publications/occasional/Befriending.pdf
36. Dickens, A.P., Richards, S.H., Greaves, C.J., Campbell, J.L. (2011) Interventions targeting social isolation in older people: a systematic review, BMC Public Health, 33, 647-669
37. Dimitriadis, L. and Freidin, J. (2004) Ten Year Aged Care Plan 2004-2014, Melbourne, Australian Croatian Community Services
38. Dobbins, M. (2019) Tackling a silent beast : Strategies for reducing loneliness and social isolation, McMaster University, McMaster Optimal Aging Portal, https://www.mcmasteroptimalaging.org/blog/detail/blog/2019/02/06/tackling-a-silent-beast-strategies-for-reducing-loneliness-and-social-isolation
39. Emlet, C.A. (2006) An Examination of the Social Networks and Social Isolation in Older and Younger Adults Living with HIV/AIDS, Health and Social Work, 31(4): 299-308
40. Fatima, Y., Doi, S.A.R., Mamun, A.A. (2016) Sleep quality and obesity in young subjects: a meta-analysis, Obesity Reviews, 17(11): 1154-1166
41. Fields, J., Cemballi, A., Michalec, C., Uchida, D., DeSmidt, H., Cuella, J., Chodos, A., Lyles, C.R. (2019) In-Home Technology Training to Reduce Social Isolation Among Older Adults: Preliminary Findings from the Tech Allies Program, Journal of the American Geriatrics Society, 67: 226
42. Findlay, R.A. (2003) Interventions to reduce social isolation amongst older people: where is the evidence? Ageing & Society, 23(5): 647-658
43. Fine, M., Spencer, R. (2009) Social Isolation: Development of an Assessment Tool for HACC Services, Centre for Research on Social Inclusion
44. Friedler, B., Crapser, J., McCullough, L. (2015) One is the Deadliest Number: The Detrimental Effects of Social Isolation on Cerebrovascular Diseases and Cognition, Acta Neuropathalogica, 129(4): 493-509
45. Gale, C.R., Westbury, L., Cooper, C. (2018) Social isolation and loneliness as risk factors for the progression of frailty: the English Longitudinal Study of Ageing, Age and Ageing, 47: 392-397
46. Gardiner, C., Geldenhuys, G., Gott, M. (2016) Interventions to reduce social isolation and loneliness among older people: an integrative review, Health & Social Care in the Community: ISSN https://doi.org/10.1111/hsc.12367
47. Ge, L., Yap, C.W., Ong, R., Heng, B.H. (2017) Social isolation, loneliness and their relationships with depressive symptoms: A population-based study, PLoS ONE, 12(8): https://doi.org/10.1371/journal.pone.0182145
48. Geller, J., Janson, P., McGovern, E., Valdini, A. (1999) Loneliness as a Predictor of Hospital Emergency Department Use, Journal of Family Practice, 48(10): 801
49. Havlik, R.J., Brennan, M., Karpiak, S. E. (2011) Comorbidities and depression in older adults with HIV, Sexual Health, 8: 551–559
50. Hawthorne, G. (2006) Measuring Social Isolation in Older Adults: Development and Initial Validation of the Friendship Scale, Social Indicators Research, 77: 521-548
51. Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., Stephenson, D. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, Perspectives on Psychological Science, 10: 227-237
52. Hunter, B.H. (2000) Social exclusion, social capital, and Indigenous Australians: measuring the social costs of unemployment, Centre for Aboriginal Economic Policy Research, Discussion paper No. 204
53. Irlam, C. (2016) Consultation on the Review of the Community Visitors Scheme, COTA Victoria, https://www.cota.org.au/wp-content/uploads/2017/11/cota-submission-to-community-visitors-scheme-review-december-2016.pdf
54. Jopling, K. (2015) Promising approaches to reducing loneliness and isolation in later life, AgeUK, https://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life-1.pdf
55. Khosravi, P., Rezvani, A., Wiewiora, A. (2016) The impact of technology on older adults’ social isolation, Computers in Human Behaviour, 63: 594-603
56. Kobayashi, L.C., Steptoe, A. (2018) Social Isolation, Loneliness, and Health Behaviors at Older Ages: Longitudinal Cohort Study, Annals of Behavioural Medicine, 52: 582-593
57. Kovaleva, M., Spangler, S., Clevenger, C., Hepburn, K. (2018) Chronic Stress, Social Isolation, and Perceived Loneliness in Dementia Caregivers, Journal of Psychosocial Nursing and Mental Health Service, 56(10): 36-43
58. Klinenberg, E. (2016) Social isolation, loneliness, and living alone: identifying the risks for public health, American Journal of Public Health, 106(5), 786
59. Landeiro, F., Barrows, P., Musson, E.N., Gray A.M., Leal, J. (2017) Reducing social isolation and loneliness in older people: a systematic review protocol, BMJ Open, 7: doi:10.1136/ bmjopen-2016-013778
60. Landeiro, F., Leal, J., Gray, A.M. (2016) The impact of social isolation on delayed hospital discharges of older hip fracture patients and associated costs, Osteoporosis International, 27(2): 737-745
61. Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., Caan, W. (2017) An overview of systemic reviews on the public health consequences of social isolation and loneliness, Public Health, 152: 157-171
62. Liotta, G., Madaro, O., Inzerilli, M.C., Scarcella, P., Marazzi, M.C. (2018) Impact of social interventions on older adults’ mortality and hospitalization, European Journal of Public Health, 28(4): 213-504
63. Linehan, T., Bottery, S., Kaye, A., Millar, L., Sinclair, D., Watson, J. (2014) Vision: The best and worst futures for older people in the UK, Independent Age and Longevity Centre-UK
64. Lopez, M.J., Lapena, C., Sanchez, A., Continente, X., Fernandez, A. (2019) Community intervention to reduce social isolation in older adults in disadvantaged urban areas: study protocol for a mixed methods multi-approach evaluation, BMC Geriatrics, 19(44): https://doi.org/10.1186/s12877-019-1055-9
65. Lubben, J., Gironda, M., Sabbath, E., Kong, J., Johnson, C. (2015) Social Isolation Presents a Grand Challenge for Social Work, American Academy of Social Work & Social Welfare, Working Paper No. 7
66. Machielse, A. (2015) The heterogeneity of socially isolated older adults: A social isolation typology, Journal of Gerontological Social Work, 58(4): 338-356
67. Mance, P. (2018) Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey, Working paper, Relationships Australia: https://www.relationships.org.au/what-we-do/research/an-epidemic-of-loneliness-2001-2017
68. Masi, C.M., Chen, H., Hawkley, L.C., Cacioppa, J.T. (2011) A Meta-Analysis of Interventions to Reduce Loneliness, Personality and Social Psychology Review, 15(3): 219-266
69. Masoom, M.R. (2016) Social Isolation: A Conceptual Analysis, Research Journal of Humanities and Social Sciences, 7(4): 241-249
70. McHugh, J.E., Kenny, R.A., Lawlor, B.A., Steptoe, A., Kee, F. (2017) The Discrepancy between Social Isolation and Loneliness as a Clinically Meaningful Metric: Findings from the Irish and English Longitudinal Studies of Ageing (TTILDA & ELSA), International Journal of Geriatric Psychiatry, 32(6): 664-674
71. McMillen, J., Donnelly, K. (2008) Gambling in Australian Indigenous communities: the state of play, Australian Journal of Social Issues, 43(3): 397-426
72. Mead, N., Lester, H., Chew-Graham, C., Gask, L., Bower, P. (2010) Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis, British Journal of Psychiatry, 196(2): 96–101
73. Medibank Private (2013) The case for mental health reform in Australia: A review of expenditure and system design (Technical Report)
74. Meeuwesen, L. (2006) Personal competences and social isolation. In Social isolation in modern society: 99-117
75. Menec, V.H., Newall, N.E., Mackenzie, C.S., Shooshtari, S., Nowicki, S. (2019) Examining individual and geographic factors associated with social isolation and loneliness using Canadian Longitudinal Study on Ageing (CLSA) data, PLoS ONE, 14(2): e0211143 https://doi.org/10.1371/journal.pone.0211143
76. Mihalopoulos, C., Le, L.K., Chatterton, M.L., Bucholc, J., Holt-Lunstad, J., Lim, M.H., Engel, L. (2019) The economic costs of loneliness: a review of cost‑of‑illness, Social Psychiatry and Psychiatric Epidemiology, https://doi.org/10.1007/s00127-019-01733-7
77. Montclaire, A (2011) Friendship Really Matters: Exploring effects of Compeer friendships for people experiencing mental illness, St Vincent de Paul Society
78. Mulligan, M., Bennett, R. (1977) Assessment of mental health and social problems during multiple friendly visits: the development and evaluation of a friendly visiting program for isolated elderly, International Journal of Aging and Human Development, 8: 43-65. 10.2190/6F9D-2FT9-JFQB-M8R2.
79. O'Loughlin, J., Laurendeau, M.C., Gagnon, G. (1989) An evaluation of a volunteer visitor program for socially isolated adults with chronic mental-health problems, Canadian Journal of Community Mental Health, 8: 31-52
80. O’Rourke, H.M., Collins, L., Sidani, S. (2018) Interventions to address social connectedness and loneliness for older adults: a scoping review, BMC Geriatrics, 18(1): 214 https://doi.org/10.1186/s12877-018-0897-x
81. Pate, A. (2014) Social isolation: its impact on the mental health and wellbeing of older Australians, COTA Victoria Working Paper No. 1
82. Pettigrew, S., Donovan, R., Boldy, D., Newton, R. (2014) Older people’s perceived causes of and strategies for dealing with social isolation, Aging and Mental Health, 18(7): 914-920
83. Pirhonen, J., Tiilikainen, E., Pietila, I. (2018) Ruptures of affiliation: social isolation in assisted living for older people, Ageing and Society, 38(9): 1868-1886
84. Qiu, W.Q., Dean, M., Liu, T., George, L., Gann, M., Cohen, J., Bruce, M.L. (2010) Physical and mental health of homebound older adults: an overlooked population, Journal of the American Geriatric Society, 58(12): 2423-2428
85. Rohde, N., D’Ambrosio, C., Tang, K.K., Rao, P. (2015) Estimating the Mental Health Effects of Social Isolation, Applied Research in Quality of Life, DOI 10.1007/s11482-015-9401-3
86. Rural Health Voices (2020) Approaching the issue of rural social isolation, Rural Health Voices, https://www.ruralhealthweb.org/blogs/ruralhealthvoices/january-2020/approaching-the-issue-of-rural-social-isolation
87. Samuel, K., Alkire, S., Hammock, J., Mills, C., Zavaleta, D. (2014) Social isolation and its relationship to multidimensional poverty, OPHI Working Paper No. 80, Oxford University
88. Shankar, A., Hamer, M., McMunn, A., & Steptoe, A. (2013) Social isolation and loneliness: Relationships with cognitive function during 4 years of follow-up in the English Longitudinal Study of Ageing, Health Psychology, 75, 161–170
89. Shankar, A., McMunn, A., Banks, J., Steptoe, A. (2011) Loneliness, Social Isolation, and Behavioral and Biological Health Indicators in Older Adults, Health Psychology, 30(4): 377-385
90. Shankar, A., McMunn, A., Demakakos, P., Hamer, M., Steptoe, A. (2017) Social isolation and loneliness: prospective associations with functional status in older adults, Health Psychology, 36(2): 179-187
91. Shaw, P., Mikusz, M., Davies, N., Bull, C.N., Harding, M., Hayes, N. (2019) Demo: Helping to Tackle Social Isolation and Loneliness of Older Adults Using Mobile Applications, Proceedings of the 20th International Workshop on Mobile Computing Systems and Applications: 185
92. Sheridan, A.J., Drennan, J., Coughlan, B., O’Keefe, D., Frazer, K., Kemple, M., Alexander, D., Howlin, F., Fahy. A., Kow, V., O’Callaghan, E. (2014) Improving social functioning and reducing social isolation and loneliness among people with enduring mental illness: Report of a randomised controlled trial of supported socialisation, International Journal of Social Psychiatry: 1-10
93. Schulz, R. (1976) Effects of control and predictability on the physical and psychological well-being of the institutionalized aged, Journal of Personality and Social Psychology, 33: 563-573
94. Shvedko, A., Whittaker, A.C., Thompson, J.L., Greig, C.A. (2018) Physical activity interventions for treatment of social isolation, loneliness or low social support in older adults: A systematic review and meta-analysis of randomised controlled trials, Psychology of Sport & Exercise, 34: 128-137
95. Simich, L., Beiser, M., Mawani, F.N. (2003) Social Support and the Significance of Shared Experience in Refugee Migration and Resettlement, Western Journal of Nursing Research, 25(7): 872-891
96. Smith, K.J., Victor, C. (2019) Typologies of loneliness, living alone and social isolation, and their associations with physical and mental health, Ageing and Society, 39: 1709-1730
97. Snyder, C.R., Harris, C., Anderson, J.R., Holleran, S.A., Irving, L.M., Sigmon, S.T., Yoshinobu, L., Gibb, J., Langelle, C., Harney P. (1991) The will and the ways: Development and validation of an individual-differences measure of hope, Journal of Personality and Social Psychology, 60: 570-585, https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/PURPOSE\_MEANING-AdultHopeScale.pdf
98. Steptoe, A., Shankar, A., Demakakos, P., Wardle, J. (2013) Social isolation, loneliness, and all-cause mortality in older men and women, Proceedings of the National Academy of Sciences of the United States of America, 110(15): 5797-5801
99. Sutherland Shire Council (2018) Council Combats Loneliness, Sutherland Shire Council News and Publications, https://www.sutherlandshire.nsw.gov.au/Council/News-and-Publications/News/Council-Combats-Loneliness
100. Taylor, H.O., Taylor, R.J., Nguyen, A.W., Chatters, L. (2018) Social Isolation, Depression, and Psychological Distress among Older Adults, Journal of Ageing and Health, 30(2): 229-246
101. Ursula, A., Holley, R.N. (2007) Social Isolation: A Practical Guide for Nurses Assisting Clients with Chronic Illness, Rehabilitation Nursing, 32(2): 51-56
102. Valkorta, N.K., Kanaan, M., Gilbody, S., Hanratty, B. (2016) Loneliness, social isolation and social relationships: what are we measuring? A novel framework for classifying and comparing tools, BMJ Open, 6: e010799. doi:10.1136/bmjopen-2015-010799
103. Wahlquist, C. (2018) ‘Loneliness minister' proposed to tackle Australian social isolation, the Guardian, Australian edition: https://www.theguardian.com/society/2018/oct/19/loneliness-minister-proposed-to-tackle-australian-social-isolation
104. Windle, K., Francis, J., Coomber, C. (2011) Preventing loneliness and social isolation: interventions and outcomes, Social Care Institute for Excellence, Research Briefing 39: 1-16
105. Xiang, X., Brooks, J. (2017) Correlates of Depressive Symptoms among Homebound and Semi-Homebound Older Adults, Journal of Gerontological Social Work, 60(3): 201-214
106. Yu, B., Steptoe, A., Niu, K., Ku, P.W., Chen, L.J. (2018) Prospective associations of social isolation and loneliness with poor sleep quality in older adults, Quality of Life Research, 27(3): 683-691
107. Zavaleta, D., Samuel, K., Mills, C.T. (2017) Measures of social isolation, Social Indicators Research, 131(1): 367-391

1. Survey data includes all surveys received before the end of April 2020. [↑](#footnote-ref-1)
2. Geldhof, G. J., Warner, D. A., Finders, J. K., Thogmartin, A. A., Clark, A., & Longway, K. A. (2018). Revisiting the utility of retrospective pre-post designs: the need for mixed-method pilot data. Evaluation and program planning, 70, 83-89. [↑](#footnote-ref-2)
3. Steptoe, A., Shankar, A., Demakakos, P., Wardle, J. (2013) Social isolation, loneliness, and all-cause mortality in older men and women, *Proceedings of the National Academy of Sciences of the United States of America*, 110(15): 5797-5801 [↑](#footnote-ref-3)
4. Biordi, D.L., Nicholson, N.R. (2013) Social isolation, *Chronic illness: Impact and intervention*: 85-115 [↑](#footnote-ref-4)
5. Steptoe, A., Shankar, A., Demakakos, P., Wardle, J. (2013). [↑](#footnote-ref-5)
6. Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., Stephenson, D. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, *Perspectives on Psychological Science*, 10: 227-237. [↑](#footnote-ref-6)
7. <https://www.endloneliness.com.au/about/> [↑](#footnote-ref-7)
8. <https://www.gov.uk/government/news/pm-launches-governments-first-loneliness-strategy> [↑](#footnote-ref-8)
9. Rohde, N., D’Ambrosio, C., Tang, K.K., Rao, P. (2015) Estimating the Mental Health Effects of Social Isolation, Applied Research in Quality of Life, DOI 10.1007/s11482-015-9401-3. [↑](#footnote-ref-9)
10. Steptoe, A., Shankar, A., Demakakos, P., Wardle, J. (2013) Social isolation, loneliness, and all-cause mortality in older men and women, Proceedings of the National Academy of Sciences of the United States of America, 110(15): 5797-5801. [↑](#footnote-ref-10)
11. Fine, M., Spencer, R. (2009) Social Isolation: Development of an Assessment Tool for HACC Services, Centre for Research on Social Inclusion. [↑](#footnote-ref-11)
12. Taylor, H.O., Taylor, R.J., Nguyen, A.W., Chatters, L. (2018) Social Isolation, Depression, and Psychological Distress among Older Adults, Journal of Ageing and Health, 30(2): 229-246. [↑](#footnote-ref-12)
13. Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., Caan, W. (2017) An overview of systemic reviews on the public health consequences of social isolation and loneliness, Public Health, 152: 157-171. [↑](#footnote-ref-13)
14. Xiang, X., Brooks, J. (2017) Correlates of Depressive Symptoms among Homebound and Semi-Homebound Older Adults, Journal of Gerontological Social Work, 60(3): 201-214. [↑](#footnote-ref-14)
15. Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho Philippe Courteta, A. F. (2019) Suicidal thoughts and behaviours and social isolation: A narrative review of the literature, Journal of Affective Disorders, 245: 653-667. [↑](#footnote-ref-15)
16. Qiu, W.Q., Dean, M., Liu, T., George, L., Gann, M., Cohen, J., Bruce, M.L. (2010) Physical and mental health of homebound older adults: an overlooked population, Journal of the American Geriatric Society, 58(12): 2423-2428. [↑](#footnote-ref-16)
17. Meeuwesen, L. (2006) Personal competences and social isolation. In Social isolation in modern society: 99-117. [↑](#footnote-ref-17)
18. Some clients may have received assistance from the Visit Program in their applications but this data was not available for this report. [↑](#footnote-ref-18)
19. Fine, M., Spencer, R. (2009) Social Isolation: Development of an Assessment Tool for HACC Services, Centre for Research on Social Inclusion. [↑](#footnote-ref-19)
20. Gardiner, C., Geldenhuys, G., Gott, M. (2016) Interventions to reduce social isolation and loneliness among older people: an integrative review, Health & Social Care in the Community: ISSN https://doi.org/10.1111/hsc.12367 [↑](#footnote-ref-20)
21. Landeiro, F., Barrows, P., Musson, E.N., Gray A.M., Leal, J. (2017) Reducing social isolation and loneliness in older people: a systematic review protocol, BMJ Open, 7: doi:10.1136/ bmjopen-2016-013778 [↑](#footnote-ref-21)
22. Age Concern New Zealand (2015) Do you have time for older people?, Accredited Visiting Service: http://www.ageconcern.org.nz/files/AVSVisitorbrochure.pdf [↑](#footnote-ref-22)
23. Chal, J (2004) An evaluation of befriending services in New Zealand: Final Report, Ministry of Health, Auckland [↑](#footnote-ref-23)
24. Landeiro, F., Barrows, P., Musson, E.N., Gray A.M., Leal, J. (2017) Reducing social isolation and loneliness in older people: a systematic review protocol, BMJ Open, 7: doi:10.1136/ bmjopen-2016-013778. [↑](#footnote-ref-24)
25. Bessaha, M.L., Sabbath, E.L., Morris, Z., Malik, S., Scheinfield, L., Sargossi, J. (2019) A Systematic Review of Loneliness Interventions Among Non-Elderly Adults, Clinical Social Work Journal, <https://doi.org/10.1007/s10615-019-00724-0>. [↑](#footnote-ref-25)
26. Australian Healthcare Associates (2017) Review of the Community Visitors Scheme: Final Report, Department of Health: https://www.health.gov.au/sites/default/files/documents/2019/12/final-report-of-the-community-visitors-scheme-cvs-review\_0.pdf [↑](#footnote-ref-26)
27. Chal, J (2004) An evaluation of befriending services in New Zealand: Final Report, Ministry of Health, Auckland [↑](#footnote-ref-27)
28. Department of Social Services; Melbourne Institute of Applied Economic and Social Research (2019) The Household, Income and Labour Dynamics in Australia (HILDA) Survey, GENERAL RELEASE 18 (Waves 1-18). DOI: http://dx.doi.org/10.26193/IYBXHM, ADA Dataverse, V5. [↑](#footnote-ref-28)
29. The SF-12 was first published in 1995 as part of the Medical Outcomes Study. [↑](#footnote-ref-29)
30. The United States population standard deviation is 10 points. Therefore, each increment of 10 points above or below 50, corresponds to one standard deviation away from the average. [↑](#footnote-ref-30)
31. Ware JE, Kosinski M, Keller SD. SF-12 How to Score the SF-12 Physical and Mental Summary Scales. Boston, MA: The Health Institute, New England Medical Centre, Second Edition, 1995. [↑](#footnote-ref-31)
32. Sanderson, Kristy & Andrews, Gavin. (2002). The SF-12 in the Australian population: Cross-validation of item selection. Australian and New Zealand journal of public health. 26. 343-5. 10.1111/j.1467-842X.2002.tb00182.x. [↑](#footnote-ref-32)
33. Program participants had significantly higher MCS-12 scores following their involvement with the Visit Program, t(48) = -6.62, p <.01. [↑](#footnote-ref-33)
34. There was no significant difference between PCS-12 scores for participants after being involved in the Visit Program, t(48) = .02, p >.05. [↑](#footnote-ref-34)
35. Shankar, A., Rafnsson, S. B., & Steptoe, A. (2015). Longitudinal associations between social connections and subjective wellbeing in the English Longitudinal Study of Ageing. Psychology & health, 30(6), 686-698. [↑](#footnote-ref-35)
36. The derived mental health and physical health scores use different transformations of Client Survey results to the PCS and MCS scores calculated in the cost-analysis. This was done so that a legitimate comparison with HILDA data was possible. [↑](#footnote-ref-36)
37. Longman, J., Passey, M., Singer, J., & Morgan, G. (2013). The role of social isolation in frequent and/or avoidable hospitalisation: rural community-based service providers’ perspectives. Australian Health Review, 37(2), 223-231. [↑](#footnote-ref-37)
38. Preference-Based Measures [online]. (2016). York; York Health Economics Consortium; 2016. https://yhec.co.uk/glossary/preference-based-measures/ [↑](#footnote-ref-38)
39. Brazier, J. E., & Roberts, J. (2004). The estimation of a preference-based measure of health from the SF-12. Medical care, 851-859. [↑](#footnote-ref-39)
40. Hanmer, J. (2009). Predicting an SF‐6D preference‐based score using MCS and PCS scores from the SF‐12 or SF‐36. Value in Health, 12(6), 958-966. [↑](#footnote-ref-40)
41. Office of Best Practice Regulation, Department of Prime Minister and Cabinet (August, 2019). *Best Practice Regulation Guidance Note: Value of statistical life*. [↑](#footnote-ref-42)
42. <https://www.sciencedirect.com/science/article/pii/S1098301513000168#bib4> and <https://www.sciencedirect.com/science/article/abs/pii/S0165178106003672> [↑](#footnote-ref-43)
43. <https://journals.sagepub.com/doi/pdf/10.1177/0004867417710730> [↑](#footnote-ref-44)
44. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386514/> [↑](#footnote-ref-45)
45. Ibid. [↑](#footnote-ref-46)
46. Ibid. [↑](#footnote-ref-47)
47. <https://www.publish.csiro.au/ah/Fulltext/ah12152> [↑](#footnote-ref-48)
48. Cost acute admitted patients multilevel data sourced from the Australian Institute of Health and Welfare’s MyHospitals site (<https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients>) and adjusted into 2020 Australian dollars. [↑](#footnote-ref-49)
49. Admitted patient care 2014–15: Australian hospital statistics (2016) from AIHW - <https://www.aihw.gov.au/reports/hospitals/ahs-2014-15-admitted-patient-care/data> [↑](#footnote-ref-50)
50. Note that as not all clients are women over 65 years this is an estimate. [↑](#footnote-ref-51)
51. Landeiro, F., Leal, J., Gray, A.M. (2016) The impact of social isolation on delayed hospital discharges of older hip fracture patients and associated costs, Osteoporosis International, 27(2): 737-745 [↑](#footnote-ref-52)
52. Geller, J., Janson, P., McGovern, E., Valdini, A. (1999) Loneliness as a Predictor of Hospital Emergency Department Use, Journal of Family Practice, 48(10): 801 [↑](#footnote-ref-53)
53. the extent to which a recipient is connected within a social network, like the number of social ties or how integrated a person is within his or her social network. [↑](#footnote-ref-54)
54. the perception that support resources, such as material aid, emotional support, companionship or information, would be available from one's social network if needed. [↑](#footnote-ref-55)