

MASTER THESIS

The Role of Local Government, Informal Networks and Professionals in Loneliness Interventions amongst Elderly Citizens on a Local Level: The Netherlands and Denmark compared



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6th November 2015
Word Count: 31.021

Abstract

With the rising costs of spending in elderly care, both Dutch and Danish governments have sought alternative methods of solving health and social problems. An increased focus in both countries has emerged on greater self-sufficiency of people through informal networks. Another trend in both countries has been an increased focus of health prevention to delay the decline of social, physical and mental health. For a social problem such as loneliness among the elderly, a widely occurring problem in the Netherlands and Denmark, both national governments appeal to informal networks for preventive interventions. However, quantitatively, the effectiveness of preventive interventions through informal networks has been contested in the academic literature. Qualitatively, insufficient research has been conducted to demonstrate its effectiveness. Furthermore, previous research shows that professionals and local governments do play a valuable role in these interventions.

By drawing on data from 12 semi-structured interviews, this thesis sheds light on the effectiveness of current preventive interventions, particularly activating informal networks as perceived by Dutch and Danish social care professionals. Moreover, the role that local governments can play in facilitating these interventions, as perceived by social care professionals and policy advisors in both countries, has been researched.

The findings demonstrate that informal networks can indeed be effective in loneliness interventions in both countries. They lead to higher well-being because of the creation of meaningful relationships. This is possible because informal networks have access to more time than professionals to build relationships and are less target-oriented. In terms of self-sufficiency, Dutch social care professionals pointed out that self-sufficiency in different areas improved simultaneously. The Danish social care professionals indicated that either physical or social self-sufficiency increased due to social networks. The findings furthermore demonstrate that professionals remain important in loneliness interventions amongst elderly citizens, particularly in the initial stage and because of their expertise. Lastly, the findings show that local authorities play a salient role in facilitating local informal network formation and play an important role in terms of financing, coordinating, measuring, and monitoring results and bringing different groups together. In conclusion, informal networks, professionals, and local authorities, all play important and unique roles in preventive loneliness interventions.

Acknowledgements

In one of the last meetings with my first reader, Kees van Paridon, I asked him why all students had to write a thesis in order to graduate. This was out of curiosity and a little bit out of frustration. He simply told me that you learn a lot from writing a thesis, from the very beginning till the end. After 7 months of laughter, stress, writer's block, challenges, and ambitious time planning, I can definitely confirm this. After all, I am very happy that I came to this final piece. I would like to thank Kees for all the time he took to challenge my thinking and to try to guide me in the right direction and bring my thinking to a higher level. I also want to thank him for his feedback, his flexibility and the good laughs. Last, but not least I want to apologise again and be publicly ashamed for being late for our appointment that one day in the huiskamer and really for the fact that he has been so flexible in the final two weeks of this process. I also would like to thank my second reader, Menno Fenger, for taking time to read my thesis and provide me with feedback. I furthermore would like to thank all the respondents that have given their valuable time to me, to talk to me and help me and for sharing their experiences with me. My colleagues, Marly Kiewik and Jason Jie, at Deloitte that have given me the opportunity and trust to perform this research. I also want to thank municipality A for trusting me to take part in their working environment and providing me with access to respondents. Additionally I would like to thank my husband George. You are an inspiration to me, the love of my life and my support every day. Thanks for always pushing me and thank you for proofreading this monster work and always push me to work harder. Also, to my best friend Anny Ho—thank you for cheering me up and helping me getting through this process with food packages and weird dwarf candles. Thanks also to my parents for the endless support and “gezelligheid” always. You two are my heroes and my biggest examples in life. Thanks to my siblings, nieces and nephew for making me laugh and forgetting about time when I needed it. Also a thank you to my IMP-shizzle group of girls that helped me through the first half of the year with endless coffees, wine, advice and fun. Lastly, my sister Sarah, friends Ines and Emina—thank you especially for your help. After a 7-month process, that was challenging at times, I can say that I am quite satisfied with the result, and I hope that this research can modestly contribute to the academic field and to finding solutions for this important social issue.

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List of Abbreviations

DHMA – Danish Health and Medicine Authority [Sundhesstyrelsen]

DMHP – Danish Ministry of Health and Prevention [Sundhedsministeriet]

DNBH - Danish National Board of Health [Sundhesstyrelsen]

GWl – Groningen Well-Being Indicator

LGDK – Local Government Denmark

OECD – Organisation for Economic Co-operation and Development

PA – Policy Advisor

RIVM – Rijksinstituut voor Volksgezondheid en Milieu [National Institute for Public Health and the Environment (NIPHE)]

SP – Social Care Professional

SSM – Self-Sufficiency Matrix

VSW – Ministerie van Volksgezondheid, Welzijn en Sport [Ministry of Health, Welfare and Sport (HWS)] (Netherlands)

WHO – World Health Organisation

Wpg – Wet Publieke Gezondheid [Law on Public Health] (Netherlands)

Wmo – Wet Maatschappelijke Ondersteuning [Social Support Act (SSA)] (Netherlands)

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Chapter 1 - Introduction

1.1 Problem statement

Loneliness: The Hidden Killer Among the Elderly?

A tragic event hit the municipality in Rotterdam in 2013 (NOS 2013). The body of a woman, who had died 10 years earlier, was discovered in her own home (NOS 2013). The woman was 74 years old when she died, and, for those 10 years, nobody had noticed (NOS 2013). Assuming that loneliness caused this tragic event, the minister of Health, Welfare and Sport (VWS), Edith Schippers, commented that “social control” in neighbourhoods should be reintroduced to prevent these occurrences from happening (NOS 2013). The ministry of VWS also made an appeal for informal networks such as one’s family, one’s friends and volunteers to support the aged instead of the formal care sector fulfilling this role (VWS 2013). But can informal networks mitigate loneliness? How should this be organised? Is it effective? Was this senior citizen alone or did she suffer from loneliness? Is there a difference? Is it a problem? How do other countries deal with this social issue?

According to the Dutch national health monitor 2012, 50% of people over 65 years and older in the Netherlands felt lonely at that time (Zantinge 2014).¹ Severe loneliness was experienced by 10.4% of this age group (Zantinge 2014). Severe loneliness can cause poor mental and physical health. Elderly people experiencing loneliness also often experience symptoms of depression (correlation rate 87.8%) (Van Beljouw et al. 2014: 1541). Their risk is not limited to depression, though. Extensive research demonstrates that loneliness and social isolation cause a potential risk for emotional and physical disorders such as anxiety, fatigue, alcohol abuse, self-reported increase of memory loss, increased frequency of seeking medical advice and suicide (Eil, 1984; Rook 1984a in Andersson 1998: 268).² Loneliness amongst the elderly can be so severe that when intervention is not undertaken in a timely manner, complex care

¹ See appendix 1 for table.

² More health issues correlational to loneliness will be elaborated upon in chapter 3, paragraph 3.3.

(admission to a nursing home), with its associated high costs, can be needed (Aartsen and Jylha 2011: 31).

High costs associated with elderly care are a rising concern for the Dutch government. Costs of public spending on healthcare for this group need to be reduced to ensure affordability of and accessibility to future elderly care. The second biggest public expenditure on health care, within the total amount of 93 € billion in 2013, is elderly care, amounting to 18,2 € billion in 2013 (CBS Statline 2015).³ This has more than doubled since 2001 (CBS Statline 2015).⁴ With the current elderly population (65 years or older) in the Netherlands amounting to 16,53% of the total population and the projected growth to 25% for 2040, this is a sound concern (OECD 2013: 140). Moreover, people live longer. In the Netherlands, the life expectancy of a Dutch citizen was 71 years old in 1965, 60 years later this amounted to 82 years old (De Vries en Kossen 2014 : 22). Thus, the group of people older than 65 years will not only become larger but will also live for longer. Furthermore, 50% in this age group experience a multimorbidity of chronic diseases and this percentage is expected to grow in the future (Lopez-Hartmann et al. 2012: 2; Spoorenberg et al. 2013: 1). Consequently, a continuous struggle exist “to find a balance between the provision of support for increasing numbers of care-dependent older people and effective use of scarce public resources” (Grootegoed & van Dijk 2012 in van Dijk 2015: 9).

With this realisation, an increased focus on self-sufficiency emerged in Dutch public policy rhetoric. With the introduction of the ‘participation state’ [*participatiesamenleving*] by King Willem Alexander, the focus on this concept has only strengthened. He stated the following in his first address to the nation in September 2013:

“It cannot be denied that people in our current network and information society are more empowered and more independent than in the past. Combined with the fact that the government’s deficit needs to be reduced, the classical welfare state is gradually

³ Part of the increase in costs over the last 10 years (50 %) is due to an increase in utilisation of services (in turn partly due to demographic changes), another part is due to increase of prices and wages (RIVM 2011: 26).

⁴ Total spending in healthcare represents a 110% increase in 15 years -, costing a Dutch citizen 5600 € annually and amounting to 14,6% of the Netherlands’ GDP in 2013 (CBS Statline 2015). Hospital care is the first biggest spending area, elderly care the second biggest area of spending.

changing into a participation state. Everyone that can is expected to be responsible for their own life and their own environment (Koninklijk Huis 2013).”⁵

The emphasis on the participation state has significantly influenced the course of public policy changes for healthcare in the Netherlands. Citizens are expected to be responsible for their own well-being and health, to be less dependent on government services, and to be increasingly self-sufficient [*zelfredzaamheid*] (Van der Linde & Frieswijk 2014: 129). In the case of the elderly, self-sufficiency implies ensuring that the elderly can live at home for as long as possible while simultaneously participating actively in society and using their own networks as much as possible when in need of care (Harbers 2009). This expectation also holds true for the lonely elderly.

With the coming of the participation state, social policies were decentralised – including elderly care. The transfer of tasks however, also came with a reduced budget. Municipalities receive about 25% of the budget that was previously available for extramural care and, consequently, municipalities are not only facing the challenge of adapting to these new responsibilities with limited capacity but also face the challenge of executing their new responsibilities well with such a reduced budget (Movisie 2015). Alternative approaches are sought to be able to still cater to the elderly’s needs with reduced financial means. One of the approaches to reduce public spending on healthcare is through trying to prevent these costs from occurring initially. This involves changing the way healthcare is organised – rather than curing the sick, the focus should be on preventing illnesses – and, where possible, to prevent them through informal networks. Prevention in this case is one more cost-effective manner to cover rising healthcare costs. Moreover, prevention is possible through social networks it is even a more cost-effective manner to do so.

Loneliness is one of the six main issues in elderly care, on which the Dutch government has been focusing, because, as mentioned above, the number of the elderly experiencing (severe) loneliness is high (Harbers 2009). Through the

⁵ Original quote: [“Het is onmiskenbaar dat mensen in onze huidige netwerk- en informatiesamenleving mondiger en zelfstandiger zijn dan vroeger. Gecombineerd met de noodzaak om het tekort van de overheid terug te dringen, leidt dit ertoe dat de klassieke verzorgingsstaat langzaam maar zeker verandert in een participatiesamenleving. Van iedereen die dat kan, wordt gevraagd verantwoordelijkheid te nemen voor zijn of haar eigen leven en omgeving” (Koninklijk huis 2013)].

emergence of the participation state, it is expected that lonely elderly people too will have to rely initially and mainly on their informal networks and be more self-sufficient. Nevertheless, in the 21st century, increasing geographical distances between members of one family and more females employed than ever are only two factors that constrain the extent of informal support citizens can provide (Timmermans and Pommer 2008: 138). Moreover, social networks decline as people age. However, if loneliness amongst the elderly could be prevented through informal networks, it would benefit both Dutch society and senior citizens. The question is, though, how this should be organised. Qualitative research in this area is scarce and, where data (quantitatively) is available, the effectiveness of both formal and informal interventions to prevent or reduce loneliness among elderly citizens has been contested.⁶ It is therefore important that more qualitative research into this area be conducted.

The Netherlands is not the only country facing the challenge of an increasing elderly population and of a significant proportion of this group experiencing loneliness. Many Western countries face the challenge of meeting the needs of increasing numbers of care-dependent older people using limited health and social care budgets, inter alia because of the “Baby Boom” generation entering the 65 years and above category and this quantity will only further increase in the near future (RIVM 2011a: 15). Denmark is perceived as an example to Dutch policymakers in terms of dealing with this challenge and their elderly health and social care policy.

Denmark experiences similar demographic developments and public policy changes in healthcare as the Netherlands does. In Denmark the elderly population amounted to 17,60% in 2012 (OECD 2015) and is expected to grow to 25% in 2035 (DHMA 2010: 5). In anticipating this demographic change and the associated financial pressures, a new approach towards elderly care was emerging because the state could not afford to pay for the increasing amount of institutional care and nursing homes (Lindstrom 1997: 1). “Staying home as long as possible” was guiding elderly health policy development, with an emphasis on prevention (Lindstrom 1997: 1). When, in 2007,

⁶ When it comes to healthcare interventions and treatments the effectiveness of many is unknown (Clinical Evidence 2015). The clinical evidence database of the British Medical Journal analysed 3000 Random Controlled Trials (RCT's) and concluded that of half of the treatments applied in healthcare, their effectiveness has not been proven (BMJ Clinical Evidence 2015). For the remaining half, only one in three interventions are proven to be effective (BMJ Clinical Evidence 2015).

with a major decentralisation process, the municipalities received the primary responsibility for prevention and health promotion, they needed time to adapt to this new responsibility guidelines of how to organise effective preventive interventions. Several studies in Denmark have been conducted to measure the effectiveness of prevention to reduce loneliness and social isolation amongst the elderly citizens and to identify best practices of municipalities in caring for their elderly residents. Denmark's approach to elderly care is seen as an example for Dutch policymakers (Harbers 2009). When looking at the numbers, Denmark indeed has a lower rate on loneliness amongst their elderly than the Netherlands does 25% (Denmark) versus 50% (Netherlands) (Zantinge 2014; Marselisborg 2015: 7).⁷ Denmark substantially focuses on preventive interventions in elderly care as an important part of public healthcare policy for the elderly (Harbers 2009). Do these interventions contribute to a lower rate of loneliness? And, how they organise their preventive interventions? Can the Netherlands learn from Denmark?

1.2 Zooming in: research focus and goal

This thesis will focus on what approach is needed to make for an effective intervention to prevent or reduce the psychosocial issue of loneliness among the elderly citizens through strengthening their informal networks. Since, according to the Dutch government, Denmark is perceived as an example in this, Denmark's approach and implementations of interventions will be explored. It will also examine to what extent these interventions in both countries can contribute to one's well-being and self-sufficiency. These outcome indicators are to be found important by both countries.

The aim of this thesis is therefore to investigate to what extent preventive interventions through informal networks on loneliness are effective in elderly care in Denmark and the Netherlands and how these should be organised on a local level. This thesis will look at the "social care" [*welzijn*] side of the healthcare sector and will include the experiences of the social care professionals that are performing the interventions in both countries. As the Dutch Public Health Status and Foresight Report claims "(i)n order to explore and design specific solutions to specific problems, strategic and

⁷ See appendix 1 for table.

multidisciplinary research is needed, in which professionals on the ground are also contributing to the research” (2010: 10). In addition to social care professionals views on this issue, policy advisors in both countries were interviewed for getting a clearer view on the role local governments could play. Thus, I hope to contribute to provide municipalities with feedback on the effectiveness of their current interventions and more concrete guidelines of how these could be facilitated by them. The central research question of this thesis is, therefore:

“Are activating informal networks in loneliness interventions effective on a local level in the Netherlands and Denmark, and if so, how should this be organised?”

In order to answer the central research question, the following sub questions have been formulated to structure the study, divided into three categories.

The sub questions guiding the analysis of the policy and legal framework are:

- 1. What preventive social care policy do the Dutch and Danish governments have in place to tackle loneliness among the elderly and what is the role the municipalities can play in this?*
- 2. When are preventive interventions of loneliness among the elderly effective, from both Dutch and Danish public policy perspectives?*

Sub questions that will be answered by the literature review are:

- 3. What are the causes and consequences of loneliness among aged citizens?*
- 4. What is known about the types of preventive interventions (focusing on increasing one’s informal network) and its effectiveness that are in place to reduce or prevent loneliness amongst elderly citizens?*
- 5. What is known about the role local municipalities can play in this?*

The sub questions leading the qualitative data collection is:

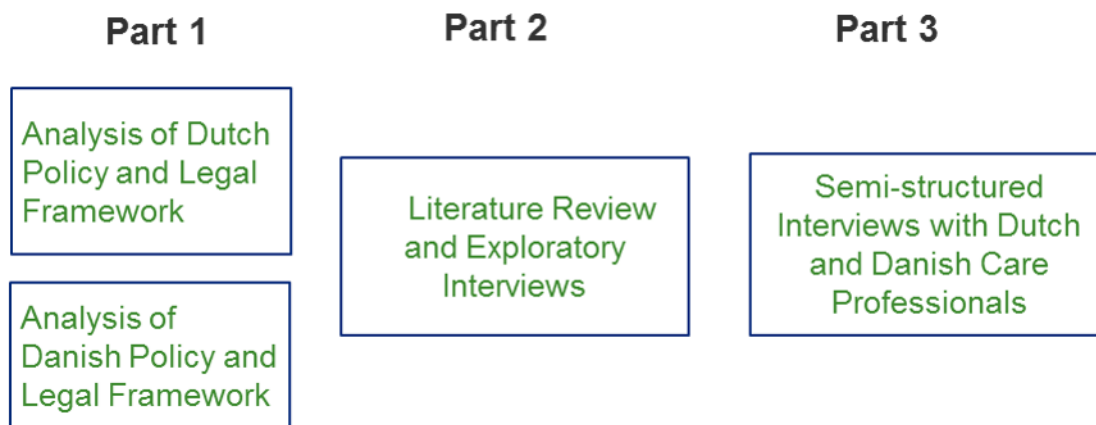
- 6. Are preventive interventions of loneliness that strengthen the informal networks of the elderly effective, from both Dutch and Danish social care professionals’ perspectives and what are the prerequisites?*

7. According to Dutch and Danish policy advisors how should preventive interventions of loneliness that strengthen informal networks of elderly citizens be organised on a local level?

1.3 How to answer this question

This paragraph will briefly describe the methodological approach of this thesis and its structure. In order to enhance the rigour of the proposed study I am using more than one method of data collection (triangulation) and different types of data, both primarily and secondary data. The structure of this thesis is in accordance with a deductive approach and it is qualitative in nature. This research consist of three components. The first component comprises an analysis of the judicial and policy frameworks of both the Netherlands and Denmark. The second part constitutes a theoretical review that is built upon an academic literature review and exploratory interviews with experts in the field. The third includes qualitative semi-structured interviews with both, Dutch and Danish social care professionals and Dutch and Danish policy advisors.

Figure 1.1 - Main Research Components Thesis*



*Please note that a complete research model will be provided in chapter 4

In order to achieve the aim of clarifying effective approaches of preventing loneliness amongst elderly citizens in the Netherlands and Denmark through informal networks and examining what role local authorities should take the following steps have been taken.

Firstly, an analysis was made of the judicial and policy frameworks of both countries. Policy documents and statements regarding prevention policy of loneliness amongst the elderly in both countries were explored to do so. Desired indicator outcomes of both Dutch and Danish prevention policy were extracted from this chapter to test if these are achieved with current practices as experienced by social care professionals in both countries.

Secondly, six exploratory interviews with experts in the field in both countries and desk research of academic literature were conducted to constitute the current state and scope on this topic. The interviews focused on prevention policies in each country, preventive interventions in place, and why loneliness experienced amongst the elderly was perceived as a problem.⁸ The literature review helped in clarifying salient concepts, examining the effectiveness of informal networks in loneliness interventions and in finding out what role local authorities could play.

Thirdly, the assumptions learned from the literature review and the outcome indicators learned through the policy frameworks of both Denmark and the Netherlands were tested through 12 semi-structured interviews with social care professionals and policy advisors in the Netherlands and Denmark. The main aims of this data collection were to observe if the professionals had found interventions with a focus on informal networks to be effective, what they feel constitute effective interventions and the role of the local government in this.

The actors playing salient roles in this paper are the Dutch and Danish national health ministries, the municipalities in both countries, social care professionals and policy advisors. It is regretful to say that the people undergoing the interventions are not

included in this paper, but due to practical reasons and time constraints this was not feasible.

The research of my master thesis has been combined with a traineeship at Deloitte Consulting, Human Capital. Deloitte is piloting a project in one of the municipalities in Rotterdam where preventing loneliness among the elderly (among others) has been labeled as a focus area by the municipal council. Its access to various relevant actors in the field of my research have been used for conducting the empirical part of my research.

The main region that is focused upon in the Netherlands is “Regio Rijnmond-Rotterdam”, in which loneliness is experienced most (Deuning 2014).⁹ The main region that is focused upon in Denmark is Copenhagen and its surrounding municipalities because Copenhagen has long been involved with addressing the issue of loneliness amongst the elderly (EGV Foundation 2015) and because in this area loneliness numbers amongst senior citizens are higher than in other parts in Denmark (LGDK 2010). For the sake of clarity, figure 1.2 summarises the complete structure of the research process.

Figure 1.2 Flow Chart Complete Thesis Research Process



⁹ Regio Rijnmond includes: Albrandswaard, Barendrecht, Brielle, Capelle aan den IJssel, Hellevoetsluis, Krimpen aan den IJssel, Lansingerland, Maassluis, Nissewaard, Goeree-Oostflakkee, Ridderkerk, Rotterdam, Schiedam, Vlaardingen, Westvoorne (GGD 2015).

1.4 Relevance

In this paragraph I will explain the academic and societal relevance in accordance with the university's requirements.

In terms of the relevancy to the IMP (International Public Management and Policy) master, the choice for a comparative study of public policy focused on healthcare grasped my interest by taking the elective course titled "The Development of the EU Welfare State(s)". I have also enjoyed observing how public policy is developed and how this translates into practice by taking "International Public Management." I wanted to apply an approach similar to the approach used in those two subjects in my thesis.

1.4.1 Academic relevance

Already in 1984, Rook claimed in her research on loneliness that this topic has been a neglected subject of research and even less research was done on the prevention or alleviation of loneliness (1984: 1390). In 1998, Andersson claimed that the interventions that existed to reduce loneliness amongst the elderly had not been "acceptably evaluated" and therefore academic knowledge on what constitutes an effective preventive intervention for loneliness among the elderly was still lacking (272). In 2009, the Dutch National Institute for Public Health and the Environment (NIPHE) noted that the effectiveness, the reach and the offerings of preventive interventions to the elderly remain unknown, that the target groups they aim for remain unknown, and that only a few interventions have been scientifically researched (Harbers 2009). During the literature review and the exploratory interviews these claims were made repeatedly (DNBH 2007: 3; Machielse 2011; Expert 2). Therefore, this thesis will modestly contribute to the academic field where information in the field of preventive interventions addressing loneliness among the elderly is greatly lacking. With the outcomes of the research, I hope to contribute, more specifically, to addressing what prerequisites in an approach are needed to increase an elderly person's well-being and self-sufficiency and the role local authorities could play in facilitating this.

1.4.2 Societal relevance

In light of the study of public administration it is important that the thesis has societal relevance (van Thiel 2007: 22). This implies that the research should contribute to the solution of societal and policy issues (van Thiel 2007: 22). The knowledge produced through this study has societal value in several ways. It has policy relevance since its findings modestly contribute to the political and societal discussion of how to solve loneliness among the elderly in the Netherlands and Denmark and may allow for policy changes on a municipal level. Due to the recent decentralisation in the Netherlands and the impact the decentralisation of 2007 in Denmark had on a municipal level, municipalities in both countries are still facing challenges of how to deal with this problem and how to constitute an effective approach. The outcomes of this thesis will provide Dutch and Danish policy-makers an insight into the practical factors for the decisions they will take and local policy they make. The aim of policy improvement is the overarching goal. Secondly, since the research is practice applied, Deloitte (where the researcher completed her internship) and its client, a municipality in Rotterdam (where the researcher conducted part of her empirical research) will benefit from the results as their approach is part of a joint pilot project. Based on the outcomes of this thesis, the researcher hopes to provide advice of how to better structure their approach for improved outcomes.

1.5 Research outline

The first chapter provides the problem statement, the research objective and questions, and the relevance of this study. In the following chapter, an analysis of the Dutch and Danish public health and policy approaches and judiciary frameworks to prevention of loneliness among the elderly is demonstrated. In chapter three, a review of the literature and some of the data collected during the exploratory data collection with experts is provided on the phenomenon of loneliness among the elderly. It furthermore goes into the effectiveness of interventions in this field and the role local governments can play. Chapter three will conclude with two hypotheses. In chapter four, the design of the research is elaborated on and the reliability and validity of the research are examined. Chapter five presents and discusses the empirical research

findings and makes a comparative analysis of these findings. Lastly, chapter six, concludes the research and provides an answer to the central research question by summarising the main findings based on the sub questions. It furthermore reflects on the formulated hypotheses and limitations of the research and provides policy recommendations and suggestions for further research.

Chapter 2 – Analysis of Policy and Legal Framework

This chapter constitutes part 1 of my research and introduces an analysis of the judicial and policy frameworks of prevention in elderly care in the Netherlands and Denmark. Within that context, the aim is to answer the following two sub questions:

1. What preventive health care policy do the Dutch and Danish governments have in place to tackle loneliness among the elderly? And, 2. When are preventive interventions of loneliness among the elderly effective, from both Dutch and Danish public policy perspectives?

In order to do so, one must first examine why governments should invest and care about public health and prevention (paragraph 2.1). Subsequently the judicial framework, mechanism for execution and the policy framework of the Netherlands for prevention in elderly care are illustrated (paragraph 2.2). The same will follow for Denmark (paragraph 2.3). Finally, a concluding remark (paragraph 2.4) is provided that sheds light on the similarities and differences between the Netherlands and Denmark based on the answers provided to the aforementioned sub questions.

2.1 Why invest in public health and prevention?

2.1.1 The case for investing in public health

Public health is essential to the wellbeing of society and defined as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals” (Larsen et al. 2013: 778). The Dutch government perceives investing in public health as paramount to a healthy society and a healthy economy (RIVM 2010: 7). The Danish government sees investing in public health as contributing to prolonging life, better quality of life and closing the gap of inequalities of groups within society (DMHP 2015a).

Several institutions on multiple levels (international, national, regional, and local) are involved in prioritising public health issues and defining public policy in order to tackle public health problems with the ultimate aim of improving public health (Larsen et al. 2013:778). Institutions do not bear this responsibility alone, but communities and individuals are also responsible for their own health and wellbeing. An increased focus on this responsibility has emerged in both the Netherlands and Denmark in the last decade (RIVM 2010: 42; Vallgarda 2011: 2). Since, in both countries, the ageing population is growing while the working population is declining, people need to be actively engaged in society for longer. This has had as consequences that the retirement age has increased so people work longer and the request of government on citizens to volunteer or give care for longer and being able to function with limitations or disabilities (RIVM 2010: 11; RIVM 2011a: 26). In these ways, senior citizens can still contribute positively to society and the economy.

In the case of loneliness amongst elderly citizens, the salience of overcoming social isolation and loneliness to improve older people's wellbeing and quality of life is increasingly recognised in international policy and in some national health strategies (Cattan et al. 2005: 41). Both the Netherlands and Denmark are examples of recognising this issue in their national health strategies. Due to the negative health consequences of loneliness, such as increased depression (Cacioppo et al 2006 in Aartsen en Jylha 2011: 31) or increased likelihood of nursing home admissions (Russell et al. 1997 in Aartsen and Jylha 2011: 31) and the higher associated costs with it, loneliness is an important public health issue (Aartsen and Jylha 2011: 31).¹⁰

2.1.2 The importance of caring about prevention from a public health point of view

Keeping citizens healthy for as long as possible can lead to lower (public) healthcare costs (Spoorenberg et al 2013:2; RIVM 2014b: 37-38). One of the means to achieve this is prevention. Preventing the need for long-term and more expensive care can reduce the utilisation of healthcare services in the long term (Spoorenberg et al. 2013:

¹⁰ Loneliness and social isolation also cause a potential risk for emotional and physical disorders such as anxiety, fatigue, alcohol use, self-reported increase of memory loss, increased frequency of seeking medical advice and suicide (Eli, 1984; Rook 1984a in Andersson 1998: 268). See also chapter 3, paragraph 3.3.

2). The Embrace Triangle of Spoorenberg et al. illustrates the different types of elderly people that exist in terms of their needs and corresponding interventions (2013: 2). It illustrates three levels with risks for healthcare needs that exist amongst the elderly population with corresponding intervention strategies (Spoorenberg et al. 2013: 2). The three different types are: (A) seniors with complex care needs; (B) frail elderly at risk of complex care needs; and (C) elderly citizens without complex care needs and with a relatively low frailty level (Spoorenberg et al. 2013: 3). Different interventions exist for each level. For group A, is helped by professionals and case management (Spoorenberg et al. 2013: 3). Group B is helped by professionals and semi-professionals, and for group C, self-management or intervention by their network can be effective (Spoorenberg et al 2013: 3).

Preventive care has to be provided at all three levels according to Spoorenberg et al. (2013: 3). There are three different levels of disease prevention:

- Primary prevention: seeking to avoid the development of a disease or health problem (focus on determinants and risk factors and causes). This type of prevention is aimed at the first layer of the pyramid (layer A).
- Secondary prevention: aiming at early disease detection. This type of prevention is focused on preventing progression of the disease through treatment and preventing the emergence of other symptoms of the disease or health problem. This type of prevention occurs in the second layer of the pyramid (layer B).
- Tertiary prevention: reducing the negative impacts and long-term impairments of an already established disease by restoring function and reducing disease-related complications, once the diseases has stabilised attempting to maintain optimal functioning (focus on disease).¹¹

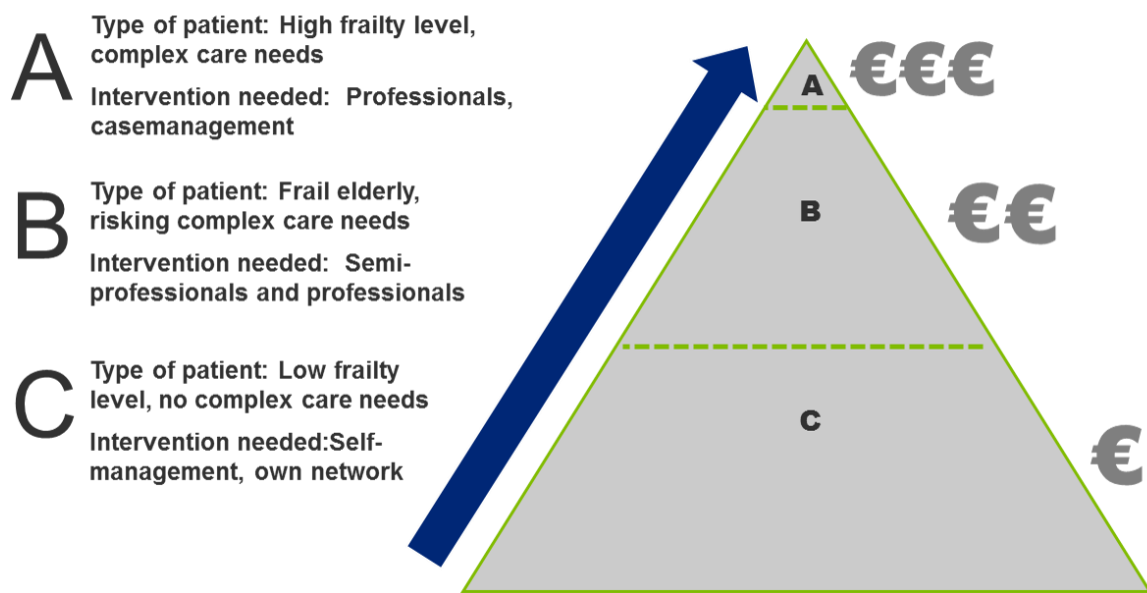
When looking at figure 2.1, from an economic and public perspective, it is important to focus on groups B and C, aiming to prevent them from moving up higher in the pyramid. Group C is the group representing the majority of the elderly population, followed by group B and, lastly, group A.¹² The assumption in terms of costs is that if you start at the lowest level in the triangle with prevention, preferably through one's

¹¹ Description of different types of prevention based in RIVM 2010: 66 and Tulchinsky & Varavikova, 2000: 64.

¹² This triangle is based on the Dutch elderly population.

informal networks or limited professional help, delaying or completely preventing movement up to the second or third tiers will lead to lower costs. From a public health point of view, an increased focus on prevention of disease and health problems and health systems are “essential for assuring healthy ageing populations” (Jusot 2012: 15).

Figure 2.1 Embrace Triangle Elderly Care



Based on Spoorenberg et al. 2013

2.1.3 Comparing the Netherlands and Denmark

As mentioned in chapter 1, Denmark’s approach to elderly care and preventive interventions are seen as an example for Dutch policymakers (Harbers 2009). Therefore, this thesis will also examine what occurs in practice in Denmark. The Netherlands and Denmark are both changing welfare states and appear to have similar healthcare systems in terms of organisational structure and financing. In terms of the societal context, both countries face the same demographic challenges with a large and increasing ageing population that is more chronically ill than ever. Both countries are also working on organising their national health policies in such ways that the provision of healthcare will remain fiscally sustainable. This implies that the “division of responsibilities among the state, market and community” have been

restructured (Daly & Lewis 2000, Pavolini & Ranci 2008, Triantafillou et al. 2010 in van Dijk 2015: 9). “Instead of the state serving as the main provider of (social) care such burdens have been allocated to communities (Daly & Lewis 2000, Tonkens 2011, Grootegoed & van Dijk 2012, Verhoeven & Tonkens 2013 in van Dijk 2015: 9). In this framework, public protection is provided only when the community cannot provide care for objective reasons, such as the absence of informal caregivers and/or insufficient economic means (Pavolini & Ranci 2008 in van Dijk 2015: 9)”. Nevertheless, taking into account that public health interventions occur in different societal contexts country heterogeneity exists (Larsen et al. 2013: 778). This is determined by the way public and private sectors in countries are organised (Larsen et al. 2013: 778). Therefore, it is important to draw the policy and judicial framework against which prevention policy and intervention of loneliness amongst the elderly has been designed in both countries. In this manner, execution of the preventive interventions and the context in which care professionals are working can be better understood (Jusot 2012: 15).

2.2 Judicial and Policy framework for prevention in the Netherlands

2.2.1 Law and mechanisms - Netherlands

Prevention in the Netherlands is regulated by law. The most salient law for protecting or improving the health of the Dutch population is the law on public health [Wet publieke gezondheid (Wpg)].¹³ The Wpg describes public healthcare as “protecting and promoting health of the population or specific groups within the population, implying the prevention and early detection of illnesses” (Meijer and Hamberg-van Reenen 2011). Prevention is thus an inherent part of this law. Based on the Wpg, prevention is a shared responsibility of the national government and the municipalities (Meijer and Hamberg-van Reenen 2011). The national government is administratively responsible for prevention (Meijer and Hamberg-van Reenen 2011). Based on the constitution (article 22), this means it has to take the initiative to advance public health and the necessary measures to achieve this (Meijer and Hamberg-van Reenen 2011). The Ministry of VWS is responsible for setting policy goals and implementing

¹³ Original quote: “De Wpg omschrijft publieke gezondheidszorg als “gezondheidsbeschermende en gezondheidsbevorderende maatregelen voor de bevolking of specifieke groepen daaruit, waaronder begrepen het voorkomen en het vroegtijdig opsporen van ziekten” (RIVM 2011).

instruments and actors to achieve these goals (Meijer and Hamberg-van Reenen 2011). The Ministry of VWS moreover needs to ensure that the execution is target-oriented and efficient (Meijer and Hamberg-van Reenen 2011). Based on the Wpg, municipalities in the Netherlands are responsible for elderly healthcare (65 years and above).

Another law stressing prevention, specifically applying to municipalities is the Wmo (Social Support Act hereafter SSA).¹⁴ Generally, municipalities, based on the Wmo, are responsible for executing promotion of active participation of their citizens (Harbers 2009). More specifically, based on this law, municipalities are responsible for optimally promoting active elderly in society in order to prevent them from having social, mental or physical problems and the overall aim of living at home independently, being self-sufficient, and participating in society (Harbers 2009; Transitiebureau Wmo 2015). They are also responsible for execution of elderly wellness/wellbeing or social care [welzijnzorg] (Harbers 2009). Initially, this responsibility lies with people themselves, through their own network (volunteers, family, friends, and acquaintances), but the municipality should help facilitate the realisation of these interactions (Transitiebureau Wmo 2015). This implies, inter alia, that municipalities ensure that facilities and basic care are available in the neighbourhood, with an emphasis on facilities that stimulate elderly citizens to live healthy and independent lives (Hamberg-van-Reenen 2011). This includes activities that tackle loneliness, provide information on health problems of this population, promote providing social support or providing caretaker support, and provide facilities for the elderly to move around if they are unable to use public transport (Meijer and Hamberg-van-Reenen 2011; Transitiebureau Wmo 2015).

¹⁴ The Social Support Act (SSA) was firstly introduced in 2007 when its overarching aim was participation, meaning that people can live at home for as long as possible and are able to participate in society (Transitiebureau Wmo 2015). With the decentralization of 2015, municipalities received additional and more specified tasks under this law, mainly in the area of providing support to people with functional disabilities (Transitiebureau Wmo 2015). An increased focus in the SSA 2015 is on the help of citizens in municipalities (volunteering work, citizen participation) and thus further developing the participation state (Movisie 2015).

2.2.2 Policy framework - Netherlands

Since the beginning of the '90's, prevention has been emphasized by the Dutch Ministry of VWS in policy documents [beleidsnota's] (RIVM 2014b: 19). The prevention cycle forms the basis for the Dutch public healthcare policy (Meijer and Hamberg-van Reenen 2011). This policy cycle is revised every four years and constituted in the Wpg (Meijer and Hamberg-van Reenen 2011). The first step in this cycle consists of the National Institute for Public Health and the Environment (PHE) [Rijksinstituut voor Volksgezondheid en Milieu (RIVM)] producing its publication, Dutch Public Health and Foresight Report (PHSF) [Volksgezondheid Toekomst Verkenning (VTV)] (Meijer and Hamberg-van Reenen 2011). This report drafts a future image of the public health situation in the Netherlands by using epidemiological data (Meijer and Hamberg-van Reenen 2011). Based on this report, the Minister of VWS produces a national public health policy document solidifying national public health priorities (Meijer and Hamberg-van Reenen 2011). Municipalities will receive advice from the national government on priority issues for the Dutch government, however they have policy discretion of what themes they want to prioritise (Meijer and Hamberg-van Reenen 2011). This thesis examines the PHE's PHSF 2010 and 2014 and corresponding national elderly care policy documents.

The PHSF 2010 focuses on lifestyle changes and health promotion in public health policy as this can prevent problems such as smoking, alcohol abuse, obesity, diabetes, and depression (RIVM 2010: 9). Public health policy focusing specifically on elderly citizens aimed at keeping them healthy, independent and autonomous (Harbers 2009; National Public Health Policy 2011). "Healthy ageing and successfully ageing is not about preventing and delaying illness and death but it is also about prevention of limiting functioning, preventing reduction of self-sufficiency [zelfredzaamheid] and reducing being dependent on care" (Harbers 2009). The Dutch government also focused on keeping elderly living at home for as long as possible and having them participate in society and still enjoy life (Harbers 2009; RIVM 2014a: 20). In terms of administrative advice, the PHSF 2010 recommended that municipalities should become more responsible for issues as functional abilities of citizens, loneliness, participation and other social aspects of health, based on the duty it has under the

Wpg and the Wmo (RIVM 2010: 79). This occurred under the new Wmo 2015, effective from January 2015 onwards.

Where, in the PHSF 2010 and the corresponding public health elderly policy, the emphasis was on the health benefits that prevention could result in, in the PHSF 2014 the focus is on stimulating participation of the (frail) elderly and the benefits this participation can lead to, for example, providing caretaker support, performing volunteer work, or engaging in other forms of social participation (RIVM 2011a: 20). Having elderly citizens living at home for as long as possible remained an important pillar of Dutch elderly policy (Post and Van der Lucht 2012 in RIVM 2014b: 110). This policy document formalized a shift in the role from being a citizen and healthcare consumer (and, thus, a passive actor) to becoming an active citizen [“van zorgconsument naar actieve burger”] (RIVM 2014b: 21). This means that one has to an increased responsibility for one’s own social and mental health and also an increased role in the decision-making process of what form this care takes (RIVM 2014b: 23). It is important though that the municipality facilitates services that can help the elderly be more active and teach them about self-management and prevention. Moreover, the facilities need to be easily accessible to senior citizens and that they know where to find them (RIVM 2014b: 20).

The PHSF 2014 outlines some of the challenges that prevention in elderly care is subject to. For example it is hard to find the frail elderly.¹⁵ Thus, even though health gains can be achieved, as frail elderly have an increased chance of more functional limitations, death, and admission to nursing homes (Daniels et al. 2008 in RIVM 2014b: 110), when these people cannot be identified, the health gains can also not be made. One of the solutions the PHSF supports for finding frail elderly is cooperation between different parties in the healthcare sector, including home visits by volunteers (thus, an integrated approach) (RIVM 2014b: 113). The General Practitioner (GP) is seen here as an important player in the field as he or she is in contact with 80% of these patients in his or her practice (Van Campen 2011 in RIVM 2014b: 113). Another challenge the PHSF 2014 mentions is the lack of data about how many elderly people

¹⁵Frail elderly people as defined in the PHSF 2014 are elderly citizen that experience physical, social or psychological problems (Van Campen 2011 in PHSF 2014b: 110). This also includes social loneliness as this negatively affecting one’s health.

are reached by interventions and their effectiveness (RIVM 2014b: 112). Not much is known about the “participation effects” of the interventions that are in place for elderly (RIVM 2014b: 116). Since this concept has only been recently introduced at the time of writing this thesis, this is not surprising.

2.2.3 Financing - Netherlands

Numbers on spending specifically for preventive care and loneliness are scarce, suggesting that the sector has only recently prioritized these policies. Spending on prevention increases with age according to the Dutch government. People aged 65 and older costs three times as much as people between 0-19 years old and twice as much as people between 20-64 years old (Harbers 2009). Spending here refers to research about breast cancer, the use of anti-hypertensive medication and the use of cholesterol-lowering medication (Harbers 2009). What is known about the total amount of spending of preventive care, according to the PHSF 2014, is that in 2012, a total of 3% of public healthcare spending was spent on prevention. In the last couple of years, spending on public health has been growing faster than spending on prevention (RIVM 2014c). Moreover, in 2011 and 2012, spending on prevention decreased. Spending on prevention of issues linked to wellbeing such as loneliness and depression are even harder to find. The only numbers available on spending on prevention of wellbeing related issues in elderly care was 0,4% of the total spending of public health in 2011 (Kommer and Poos 2013) and that in 2007, 500 million (=0.06%) was spent to non-disease related prevention for the whole population (RIVM 2010: 71). In this sense, words used to emphasize the importance of prevention in policy documents and national rhetoric do not appear to translate into practice in terms of spending. The PHSF definition report outlined that the scarcity of numbers available on spending and the reason for low spending on prevention is partly because it remains unclear from which source preventive activities should be financed (2011: 27). Moreover, policymakers want to get a clearer picture on what is spent on prevention in the healthcare sector (PHSF 2014b: 39) and the financial and social gains that can be achieved.

2.3 Judicial and policy framework for prevention - Denmark

2.3.1 Law and mechanisms - Denmark

In Denmark, prevention is set out as an aim of the Health Act of 2007. The health objectives of the Danish healthcare system, as claimed by this act, are generally to improve the health of the population and individually to prevent and treat diseases and “alleviate suffering and functional restrictions” (Pedersen et al. 2001: 15). The national government is responsible for the formal framework (and, thus, the national guidelines), legislation, supervision, monitoring and funding (Pedersen et al. 2011: 47). The national government’s duty is “to initiate, coordinate and advise” and set goals for national health policy (DMHP 2008: 9). Through the Department of the Ministry of Health and Prevention, it is responsible for setting up guidelines through the National Board of Health.

The municipalities are in charge of most public health and long term care services (home nursing), rehabilitation and a broad range of welfare services (Strandberg-Larsen 2006:8; DMHP 2008: 8; Pedersen et al. 2011: 47). With the reorganisation of the healthcare sector in 2007, municipalities also have the primary responsibility for preventive health and health promotion (Pedersen et al. 2011: 47).¹⁶ As is the case in the Netherlands, the reason for the decentralisation of these tasks to a municipal level was to ensure that “services (...) are provided as close to the users as possible” (DHMP 2008: 7) and to meet future demands, by creating structures that would be more sustainable. In terms of elderly care and prevention, this implies support for frail citizens, wellness promotion at senior centres and informing elderly citizens about these possibilities (Danish National Health Council 2012: 10).¹⁷

Furthermore, it is important to mention, that based on national law in place since 1996, municipalities have to offer two home visits yearly to all citizens over 75 years of age

¹⁶ The local government changes became effective on January 2007, “the old system of 15 counties (including the metropolitan area) and 271 municipalities was replaced by five regions primarily focused on the healthcare sector and 98 municipalities responsible for a broad range of welfare services and healthcare services” (DHMP 2008: 2). New local health care tasks included (preventive treatment, care and rehabilitation) and with this have received a more important role within healthcare (DHMP 2008: 12).

¹⁷ Prior to the reforms, elderly care was already a responsibility of the municipalities, but with the reforms, healthcare and welfare related issues became a responsibility of the municipalities (DHMP 2008: 9).

(Campbell and Wagner 2009: 8); Garasen and Hendriksen 2009: 223) The aims of the visits are “to support older people’s self-caring and to aid them in utilising their own resources optimally” (Garasen and Hendriksen 2009: 223). “Home visits may detect and solve the need for help and support at an early stage, which may reduce or preclude the need for more comprehensive help and support from the public sector” (Garasen and Hendriksen 2009: 224). Furthermore, during home visits, information on counselling, support options and activities are communicated to the elderly citizens, with the ultimate aim of postponing functional decline and maintaining social relations (Garasen and Hendriksen 2009: 224). GPs play an important role in this and since 2006 have a contract with the health authorities through which they receive payments for making one preventive home visit per frail elderly citizen per year (Garasen and Hendriksen 2009: 224).

2.3.2 Policy Framework - Denmark¹⁸

In 2011, the Danish government decided on national public health targets for the Danish population that are meant to be achieved by 2021. In 2014 the goals were formulated as seven national health goals in the publication “healthier life for all” [“sundere liv for alle”] (DMHP 2015b). Goal three, “More adults should thrive and have great mental health” specifically concerns mental health among the adult population including elderly citizens (DMHP 2015b). Within this goal, tackling loneliness is emphasized as one of the priorities for the Danish government, with their goal being to reduce loneliness amongst the adult population by 10% in the next 10 years (DMHP 2015b).

To promote public health by systematic high quality health promotion and to ensure effective preventive interventions in the municipalities, the Danish Health and Medicines Authority (DHMA) develops health promotion guidelines on different subjects (DMHP 2015b). These health promotion guidelines are based on current best knowledge in creating systematic and effective interventions at the local level and they

¹⁸ A limitation in the research was that information on Danish public health policies (prevention policy, elderly care) was often only available in Danish. A request for an interview with the Ministry of Health and Prevention was declined, but relevant documents for my research were referred to. These documents however also were only available in Danish. Translate machines and contacts in Denmark were used to verify information from the documents. Moreover, some academic articles were used to get a grasp of their policy approach in the matter.

provide technical recommendations to the municipalities (DMHP 2015b). The health promotion guidelines target all citizens in the municipality by dealing with alcohol, physical activity, mental health, sexual health, tobacco, hygiene, indoor climate in schools, sun safety, food and meals, overweight and drug abuse (DMHP 2015b). Furthermore, the DHMA also regularly publishes different material in the field that municipalities can use in their daily work among the elderly population, for example in the fields of physical and mental health (DMHP 2015b).

For my thesis I have examined the health promotion guidelines on mental health (including wellness care of citizens and psychosocial problems) of the DHMA for the municipalities, guidelines on activities for promoting mental health amongst the elderly of the DHMA, and recommendations of the Danish National Board of Health (DNBH) for municipalities on “evidence in health promotion and disease prevention”.

The aim of preventive work according to the DNBH, is to “hinder the emergence and development of diseases and thereby promote well-being through such means as strengthening the individual, socio-economic and physical determinants of health and health-related behaviours” (2007: 6).¹⁹ The DHMA encourages municipalities to promote social activities for elderly citizens in senior centres focusing on one’s well-being, activities to build upon a network and physical activity (DHMA 2012: 21). Having sufficient social relationships is perceived by the DHMA to have a great influence on one’s mental health (2010: 5). Furthermore, physical activity amongst the elderly is important to target because it has a correlation with one’s mental health (DHMA 2010: 5).

Municipalities bear a great responsibility for creating an awareness amongst citizens about what the municipality has to offer (DHMA 2012: 27). This should be done through group sessions targeted to citizens of 65 years and older in which the focus lies on health behaviour, social relationships, finances and being in charge of their own lives (DHMA 2010: 8). It simultaneously serves as a moment to provide information about transportation, healthcare needs, nutrition, personal care and safety

¹⁹ Preventive activities are described by the DNHB as follows: “preventive and health promoting interventions are target (group) directed activities that are applied in an attempt to prevent the emergence and development of disease, psychosocial problems, or accidents with the aim of promoting public health” (DMHP 2008: 5). Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factors reductions, but also to arrest its progress and reduce its consequences once established. (DMHP 2008: 5).

in the home (DHMA 2010: 8). In addition to the fact that the municipalities play an important role in Denmark for the prevention of psychosocial problems such as loneliness amongst the elderly, the Danish government also puts an emphasis on one's individual behaviour. "The government wishes that we each take responsibility for our own health and the health of our closest relatives. With the responsibility comes the freedom to make our own choices – while respecting those of others" (Vallgarda 2011: 2). Health is thus seen as a shared responsibility between the government and its citizens where the role of the government is to provide its citizens with the correct information to keep healthy, and the role of citizens is to be free to decide what they want to do with that information. Overarching goals of policy targeted to elderly citizens are self-sufficiency, a good quality of life and strengthening social networks (Campbell and Wagner 2009: 3; DHMA 2012: 26)

The DNBH emphasizes the need for different groups to work together within the public health sector when it comes to prevention (2007: 5). "P[ublic health work is still a fairly new area of responsibility for municipalities in Denmark". This is probably the reason why most municipalities lack a complete overview of their interventions and total effort. It is necessary to provide such an overview to be able to implement the most effective interventions and to obtain optimal value (health) from the limited resources (financial and human) allocated. Furthermore, it is beneficial to develop a common language in relation to public health work in municipalities because of the fact that most public health problems should be solved in collaboration between sectors" (Larsen et al. 2013: 782). A more integrated approach is thus preferred. Furthermore, preventive home visits are encouraged by the DHMA to be continued but this does imply municipalities should educate their staff of how to detect issues as depression, dementia and loneliness.

2.3.3 Financing - Denmark

The local government in Denmark has a major responsibility in terms of raising taxes to finance healthcare provisions (WHO 2007: 58). Municipalities have the right to set and raise their own taxes (WHO 2007: 58). With the reforms in 2007, and thus considering the new local health tasks (preventive treatment, care and rehabilitation), the municipalities have acquired a more important role within healthcare (DHMP 2008:

12). The purpose of local contributions is to encourage the municipalities to initiate efficient preventive measures for their citizens with regard to health issues” (DHMP 2008: 12). “Local authorities are responsible for home nursing offered to citizens free of charge, and social service to older people in form of personal or practical assistance, transport to rehabilitation appointments and meals on wheels” (Campbell and Wagner 2009: 21). Although no precise numbers could be found regarding spending on welfare related issues, in terms of elderly care related issues, Denmark spends four times as much as the Netherlands does (OECD Stat 2015).

2.4 Concluding remark - similarities and differences

Both the Netherlands and Denmark are welfare states transiting into states in which an increased responsibility of good health fall to the individual. In terms of their judicial and policy frameworks, they have similar structures, only that Denmark has started earlier with its decentralisation process and has a law enforcing municipalities to carry out home visits to citizens of 75 years and older.

In both countries there is a focus on ensuring self-sufficiency of elderly citizens, in the hopes that implying they can perform their daily activities and live at home for as long as possible. Both countries also emphasise the importance of social relationships for elderly citizens. In the Netherlands this appears to be for both humanitarian and financial reasons; in Denmark, the focus on the importance of social relationships appears more to be because they genuinely contribute to good health overall. In Danish policy there is a stronger focus on the quality of life and the importance of physical movement of the elderly than there is in the Dutch policy documents. They furthermore have as overall aim in their policies that health inequalities that exist in their population should be decreased. Also, although there is an individual responsibility to prevent bad (mental) health from occurring, the Danish government does emphasize the importance of the municipalities in providing information to their

elderly citizens about what options are available to them that can help them maintain good health. In the Netherlands there is less of emphasis on this, but also less of an emphasis on the individual's one responsibility (although, this is emerging). Regarding preventive home visits, in Denmark these are required by law, while in the Netherlands only a few municipalities are experimenting with them. In the Netherlands there is a stronger focus on being able as an elderly citizen to participate in society. Lastly, the Danish government is more advanced in providing their municipalities with concrete tools of how to structure their services and interventions targeted at the (frail) elderly.

Chapter 3 - Theoretical Review

This chapter constitutes the second part of my research and provides an overview of the academic literature on loneliness amongst the elderly and effective preventive interventions focusing on increasing one's informal networks. Moreover, it will examine the role local authorities can play in the successful organisation of these interventions. Academic literature has been examined for this chapter because it is important to connect with the already existing theories and literature on loneliness amongst the elderly and type of preventive interventions that work for this psychosocial problem. It also includes qualitative data collected from the exploratory interviews with several experts in the field.²⁰ This was completed in order to get speedily up to date with where the research on this topic stands and what to look for during the data collection.

It aims to provide answers to the following sub questions:

- 1) *What are the causes and consequences of loneliness among aged citizens?*
- 2) *What is known about the types of preventive interventions (focusing on increasing one's informal network) and its effectiveness that are in place to reduce or prevent loneliness amongst elderly citizens?*
- 3) *What is known about the role local municipalities can play in this?*

For clarity it is necessary to describe and define the central concepts that are used throughout this thesis. In order to do so, firstly the concept of loneliness will be further introduced and the use of different definitions will be discussed (paragraph 3.1). Accordingly, an overview will be provided about the causes of loneliness amongst

²⁰ See appendix 3 for list with experts spoken to during exploratory interviewing process. Experts were selected based on their expertise in the field and job position. A selection of researchers of different disciplines was chosen to give a complete picture of the situation. This included researchers in the field of interventions and social policy and mental health amongst the elderly in the Netherlands and Denmark. They have been useful because they have done research in this domain and have had more experience than the author of this thesis with this topic.

² This definition as used by Aartsen and Jylha comes closest to the definition of loneliness as used by the Dutch National Institute for Public Health and the Environment (NIPHE) (Savelkoul and Tilburg 2010). They also differentiate between social and emotional loneliness and perceive loneliness as a subjective experience.

aged citizens and the consequences this can have (paragraph 3.2 and paragraph 3.3). Consequently, the role informal networks can play in prevention will be discussed and a summary will be provided of essential preconditions (paragraph 3.4). Lastly, the role municipalities can play in stimulating informal networks on a local level will be examined (paragraph 3.5).

3.1 Loneliness – Defining the concept

Since the 70's of the last century loneliness has been a research subject in the academic world. It is a complex phenomenon as it is challenging to measure because it entails a subjective feeling people's experience. Different definitions of loneliness exist in the literature.²¹ Cattani uses the definition of Townsend (1957) and Weis (1982): "the subjective, unwelcome, feeling of lack or loss of companionship (2005: 43). Andersson refer to loneliness as "the generalised lack of satisfying personal, social or community relationships" (Andersson 1993c in Andersson 1998: 265)". These two definitions do not completely describe loneliness that I am targeting in my thesis as the problematic loneliness elderly people experience or have a high risk factor of experiencing do not appear to be included in these definitions. Aartsen en Jylha use "the unpleasant feeling due to a perceived discrepancy between the desired and the achieved level of social and personal resources" to define loneliness (2011: 31).^{22 23} This definition comes closer to not feeling well because of the perceived loneliness one might experience. However, the definition describing most completely what loneliness consist of in case of this thesis, considering different definitions in the literature and after talking to several professionals, researchers and practitioners working with elderly experiencing loneliness in the field, is the definition used by Rook:

²² This definition as used by Aartsen and Jylha comes closest to the definition of loneliness as used by the Dutch National Institute for Public Health and the Environment (NIPHE) (2010). They also differentiate between social and emotional loneliness and perceive loneliness as a subjective experience.

²³ I did not succeed in finding a definition that is officially used by the Danish government to describe loneliness. The Danish Ministry of Health and Prevention could also not provide an officially used definition. From the documentation I gathered, used in chapter 2, it appears that Denmark focuses more on social loneliness than emotional loneliness. However, the numbers used in chapter 1, to describe the extent of the issue, were measured by Marselisborg (advisory business) that included both emotional and social loneliness.

“an enduring condition of emotional distress that arises when a person feels estranged from, misunderstood, or rejected by others and/or lack appropriate social partners for desired activities, particularly activities that provide a sense of social integration and (or) opportunities for emotional intimacy” (Rook 1984: 1391).

The loneliness elderly in my research experience or are risking to experience is so severe that they will experience or must have a high risk factor of experiencing emotional distress because of it. This means that it will eventually negatively affect their mental and or physical health. This does imply that those who do not experience emotional distress or are not at the risk of experiencing emotional distress because of an absence of social ties would not be considered lonely in this thesis and thus not be considered for interventions.^{24 25}

An important distinction to consider when conducting research on loneliness is to distinguish between “the objective manifestation of being alone and the subjective manifestation of experiencing loneliness” (Andersson 1998: 264; Expert 1; Expert 2). This implies that a person who is alone or lives alone may not experience loneliness and a person that lives with others or has a big network can experience loneliness. The latter can be explained by the fact that one can feel the lack of having any meaningful relationships (socially or emotionally). It can also mean that one has expectations that are not sufficiently fulfilled by the contact she or he has. It is important to be aware of this distinction of the phenomenon of loneliness and of salience of the perception of someone because if either subjective or objective loneliness does not bother one, the person does not have to be considered for an intervention (Expert 1; Expert 2; Expert 3; Expert 4)

The definition of loneliness used in this paper respects those people that choose not to engage in interventions for loneliness by increasing their social network because of personal choice and preference.²⁶ Another important distinction in the loneliness

²⁴ For example, the author of this thesis, attended a regional conference on loneliness (27-03-2015 in Schiedam at the Lentiz Life College) which was also attended by citizens. An elderly man, admitted to feel lonely and knew people in his environment that felt lonely too, however he saw it as part of that life stage and did not perceive it as problematic. He did not wish for any interference of anyone.

²⁵ Also during the exploratory interview process this was mentioned so claimed one expert “you should do something about it what the person wants to be helped” (Expert 4).

²⁶ Even though, as Rook acknowledges in her research, some people will not admit the emotional distress because they are reluctant to discuss their experience and might perceive themselves as a failure (1994: 1391).

literature is between social loneliness and emotional loneliness. Weiss (1973, in Andersson 264) explains this as the following; “emotional isolation can be seen as the absence of an attachment figure in one’s life, whereas social isolation may be regarded as the absence of a place in an accepting community” (Weiss, 1973) in Andersson 264). This distinction is important to make when developing policy towards preventing loneliness or wanting to intervene or designing interventions. Social loneliness can be solved by interventions targeting to get a person involved with a community again, whereas emotional loneliness might be better helped to be reduced by a one-on-one intervention. By ensuring the cause of one’s loneliness, more targeted interventions can be conducted. Loneliness can be most severe when people experience both emotional and social isolation. This group needs help most. In this thesis, both emotional and social loneliness are included.

3.2 Causes of loneliness amongst the elderly

Elderly people are at an increased risk of loneliness. Loneliness increases the older a person becomes with the incidence of emotional loneliness being higher than social loneliness (see figure 3.1) (Zantinge 2014). In order to better comprehend the phenomenon of loneliness and execute the right interventions to reduce or prevent loneliness, it is important to consider the factors that are causing or have an increased risk of elderly people experiencing loneliness. Different causes resulting in loneliness amongst elderly citizens exist. One person might be more sensitive than another person to becoming lonely. Victor et al. emphasize the importance of acknowledging “different subgroups for the theoretical and conceptual understanding of loneliness as well as for the development of intervention strategies” (2004 in Aartsen & Jylhä 2011: 37). Generally speaking, causes of loneliness can be divided in three overarching categories. Firstly, personal traits (from here on intra-individual) such as a lack of social skills and low self-esteem. Secondly, dramatic life events (from here one inter-individual), such as divorce or passing of a partner can influence the ongoing negative feeling of loneliness (Movisie 2010: 10). Thirdly, societal causes can influence the extent of the ability that people have to connect with one another (Movisie 2010: 10).

Figure 3.1 – Loneliness per Age Group

Percentage of people that indicate to be lonely or indicate to experience severe loneliness per age group*

Age	Lonely	Severe Loneliness
19-34	33,8%	7,4%
35-49	37,4%	8,4%
50-64	40,3%	9,0%
65-74	40,9%	7,3%
75-84	49,5%	9,9%
85+	59,2%	13,8%

Source: RIVM – Measurement represents the Dutch population in the year 2012

*Please note that for each age group, the categories (thus lonely or severe loneliness) have been each calculated separately over the corresponding age group.

Intra-individually, personal characteristic may create obstacles for a person to establish satisfactory relationships) due to a lack of social skills or a low self-esteem (Rook 1984: 1390; Movisie 2013: 1; Honigh-de Vlaming 2013: 990). One of the experts gave the example of an 82 year old friend that often replies negatively when she enquires about how he is doing (“everyone moves and dies”). Whilst in her eyes, he has quite an active social life (eating out with friends, having cups of coffee with friends, going out with friends). Nevertheless, he perceives it differently and feels lonely. “Nothing can be done about that type of loneliness through informal networks” according to her. An intense (formal) intervention such as cognitive behavioural therapy is needed for this (Movisie 2013:2; Expert 2; Expert 3; Expert 4). As this thesis is focusing on interventions through informal networks this cause of loneliness will not be further looked at.²⁷

Contemporary societal developments, thus societal causes of loneliness, such as the decrease of families, spreading of families throughout the country and more women

²⁷ Factors that are mostly contributing to elderly experiencing loneliness are occurrences such as the death of one’s spouse or friends, declining mobility and self-sufficiency because of increasing limitations on physic and mental abilities (Van Tilburg, 2007c; Jylhä, 2004 in Zantinge 2014).

entering the labour force are of influence on causing loneliness amongst elderly (Rook 1984:1390; Lindstrom 1997: 2). Fewer family members are available to take care of elderly family members. Furthermore, there has been an increased focus on oneself (career, privacy and achievements) (Rook 1984: 1390). As a consequence there are less people available to take care of the elderly and there is less social contact between people. Furthermore, Gordon and Slater claim that “the growing rate of divorce, increases in the number of people who are living alone, and the magnitude of the singles industry are frequently cited as evidence of the failure of traditional institutions to foster the development of enduring social bonds” (Gordon, 1976; Slater, 1970 in Rook 1984: 1390). Fokkema et al. also claim that “(t)he integrative functioning of the family seems to be at risk as a consequence of the trends towards increasing rates of divorce and remarriage after marital breakup, in combination with the forming of complex new forms of stepfamilies” (2012: 204). However, as claimed by Rook (already back in 1984) it is “prudent to question nostalgic beliefs in a more socially cohesive past” (1984: 1390). Nevertheless, elderly citizens (of any generation) can feel disconnected from society because it has transformed severely of how they knew it.

Inter-individually, the loss of social and personal resources lead to increased levels of loneliness such as losing a partner, friends or relatives and having increased physical disabilities (Aartsen and Jylha 2011: 32; Honigh-de Vlaming et al. 2013: 990). The former can reduce one’s social network and social activities (Fokkema et al. 2012: 204). It can also influence the social support needs of elderly people (Honigh-de Vlaming et al. 2013: 990). In particularly, the passing of a partner has an influence on causing emotional loneliness, as marriage in general protects against loneliness (Dykstra & De Jong Gierveld 2004; Stack 1998 in Fokkema et al. 2012: 220). Increased physical disabilities challenges the ability to be physically involved or get to social activities (more challenging to go outside and meet people) which might also result in reduced social activities and decreasing social integration (Aartsen and Jylha 2011: 3).

The societal and inter-individual causes are most applicable to the majority of older people experiencing loneliness. This thesis focuses on these two causes, as the government can influence these causes through some extent namely by facilitating

the recently relative new idea of extending one's informal network to mitigate loneliness.

3.3 Consequences of loneliness amongst elderly

Prior to going into interventions governments can support it is important to elaborate on the health consequences, both physical and mental health, loneliness is correlated to. Previous research has pointed towards the correlational relationships between loneliness and health related problems such as depression (Rook 1984: 1389; Andersson 1998: 268; Djernes 2006:1), increased alcohol use (Rook 1984: 1398; Andersson 1998: 268), aggressiveness (Sermat: 1980 in Rook 1984: 1389), "(a)nxiety (Schultz & Moore, 1984), fatigue (Berg et al.1981), mental disorder (Freeman, 1988; Hovaguimian et al., 1988), backache, headache, dizziness, palpitations and breathlessness (Miller & Ingham, 1976), psychosomatic complaints (Stephan et al., 1988), neuroticism (Stephan et al., 1988), high consumption of hypnotics and sedatives (Berg et al., 1981), more vigorous decline of immunoglobulin levels, higher urinary cortisol levels, lower levels of natural killer cell activity, poorer T-lymphocyte response to phytohemagglutinin (Kiecolt-Glaser et al., 1984a; 1984b), high frequency of seeking medical advice (Berg et al., 1981), self-reported memory problems (Bazargen & Barbre, 1992), suicide (Diamant & Windholz, 1981; Trout, 1980), schizophrenia (Jaco, 1954; Kohn & Clausen, 1955), and mortality (Berkman & Syme, 1979; House et al., 1982)" (all in Andersson 1998: 268). These studies include various populations and situations. It is important to note that these studies are correlational in nature and not causal. The only causal relationship that was found was the "causally prior role" of a lack of social relations in "the etiology of mental health problems" (Pearlin, Lieberman, Menaghan, & Mullan 1981; Turner 1981; Williams, Ware & Donald 1981 in Rook 1984: 1390).

In light of one of the outcome measurements stressed by the Dutch and Danish government of loneliness interventions, namely to increase one's well-being, loneliness is associated with lowered well-being (Andersson 1998: 267).²⁸Improving

²⁸ Using Cramm et al.'s definition: "an individual's appraisal of his or her life situation as a whole; the totality of pleasures and pains, or quality of life (Bradburn 1969; Diener 1984; Watson 1988; Omodei & Wearing 1990), which is broader than health (Cramm et al. 2013: 143).

one's well-being through social resources can mitigate loneliness (Aartsen & Jylhä 2011: 2) and is an important outcome measure. In a recent study by Cramm et al. the importance of social capital (support through indirect ties) was of influence on the well-being of home-dwelling elderly people (2013: 142). It can buffer against being single for example (Cramm et al. 2013: 143) "and adverse life events" (Egolf et al. 1992 in van Dijk et al. 2013a: 9) that elderly people are likely to experience. Another outcome measurement, namely self-sufficiency, can decrease when an older person experiences severe loneliness (Movisie 2013:1). One's ability to remain self-sufficient decreases, when one is vulnerable to the potential above outlined risks. More on these outcome measurements will be elaborated upon in chapter 4.

3.4 Preventive interventions through informal networks

"Preventive and health promoting interventions are target (group) directed activities that are applied in an attempt to prevent the emergence and development of disease, psychosocial problems, or accidents with the aim of promoting public health" (DNBH 2007: 5).²⁹ The Dutch and Danish ministries both emphasize the importance of informal networks in preventing, solving and reducing loneliness (informal networks being family, friends and volunteers, hereafter referred to as "informal networks" or "social networks"). Several experts, both in the Netherlands and Denmark, mentioned that increasingly so in the social domain, prevention is also becoming a task of people themselves and volunteers (mainly because of financial restraints) (Expert 2; Expert 4; Expert 7). This is not necessarily a bad development as for care related issues like loneliness, informal sources such as volunteers with an intrinsic value, might be more able to contribute to reducing loneliness than professionals that lay a bigger emphasize on medical issues (Expert 2). Also in the literature, an informal network or

²⁹ As became apparent during the literature review and as Larsen notes in his research about assessing criteria of a model to measure public health interventions in a Danish municipality, "[d]isease prevention was perceived as interventions aiming at reducing risk factors and preventing disease. However, most informants did not differentiate health promotions and disease prevention interventions" (Larsen 2013: 782). Therefore both, health promotions and diseases prevention interventions will be included when preventive interventions are discussed and hereafter referred to as preventive interventions or prevention.

In the literature review I have mainly focused on preventive interventions focused on alleviating loneliness but also on social emotional isolation as loneliness and social emotional isolation are used interchangeably in the literature. Therefore articles that included preventive interventions targeted to alleviate social emotional isolation have also been included. Loneliness and social emotional isolation are defined as "the subjective, unwelcome, feeling of lack or loss of companionship, while social isolation was considered to be the objective absence or paucity of contacts and interactions between an older person and a social network (Townsend 1957; Weiss 1982).

the development of such is a sound and by some even claimed the best means to prevent loneliness from occurring (Rook 1984: 1391; Movisie 2013:2; Honigh- de Vlaming et al. 2013: 990). Informal networks are valuable in mitigating loneliness because social networks can provide one social support Rook 1984: 1390; Andersson 1998: 3) and they are the second most important factor for one's well-being after one's health (Expert 2).³⁰ They furthermore can stimulate social participation so that one feels more socially integrated in society, which is a feeling that senior citizens experiencing loneliness might lack (Fokkema et al. 2012: 202). That feeling of loneliness however can be countered by social participation (Victor et al. 2005) and benefits people's health (Avlund et al. 2004, Glass et al. 2006) and quality of life (Bowling et al. 2002, Gabriel & Bowling 2004 all in van Dijk 2015: 20-21). Nevertheless, factors such as accessibility, affordability and the presence of sites for social interaction are of influence here (Baum & Palmer 2002; Bowling & Stafford 2007; WHO 2007 in van Dijk 2015: 20-21).³¹

Although informal helpers are the preferred source of support by the Danish and Dutch government, professionals can play an important role in helping to set up such a network when this informal network is absent or small - which is often the case amongst (lonely) elderly citizens. One of the experts mentioned that "the government expects that if they cut back on responsibilities people will sort it out amongst themselves, I wonder what the empirical basis is for this assumption? Research has shown that people are more inclined to volunteer if formal services are sufficient (Expert 4)."³²

Van Dijk et al. came to the conclusion in her research on an integrated neighbourhood, focusing on informal support of the community that "(p)rofessionals have an indispensable role in providing back-up and accountable, specialised support" (2013c: 68). A professional can act as a contact between individuals and social networks and

³⁰ Social support can be defined as "the degree to which a person's basic social needs are gratified through interaction with other" (Thoits, 1982), or as "any material, informational, or emotional resource that, when exchanged among individuals, is perceived by the recipient as beneficial" (Weinberg & Marlowe 1983 in Andersson 1998: 3).

³¹A cross-national study of loneliness conducted by (Fokkema et al. 2012: 201) shows that regular contact with family, social participation and providing support to others were also important factors in reducing and preventing loneliness in the majority of the countries studied (Fokkema et al. 2012: 202). Countries encompassing Austria, Belgium, the Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, the Netherlands, Poland, Spain, Sweden and Switzerland (Fokkema et al. 2012: 201).

³² For more see Steyaert and Winsemius 2011.

thus as a social network activator (Andersson 1998: 268). Andersson describes this as “a planned activity by a professional that aims to influence the functioning of an existing informal network or to bring about the creation of a social network where one did not previously exist due to absence or inaccessibility” (1998: 268). A Danish expert on loneliness of a medium-sized consultancy firm, having advised several municipalities, furthermore noted that elderly citizens often need a push in the right direction (Expert 6). In this manner, professionals also have a valuable role to play, particularly in the setting-up phase. Furthermore, professionals can play an important role in discovering loneliness or signs of loneliness amongst senior citizens as well as training others to do so (Expert 5).

Although loneliness interventions have been quantitatively studied in the literature not much is known about the effectiveness of these interventions. This was also noted by several experts (Expert 2; Expert 5). Qualitative research into loneliness interventions even less so. Several experts found that qualitative research in the social domain should be increased (Expert 2; Expert 4). Moreover, one of the experts noted that “in the social domain there is not a tradition of research into the essential requirements of how to design and organise your intervention and the effectiveness of interventions used. This could be a financial issue. I mean until now, money is much more easily provided for medical research. There is hardly any money for the study of social interventions (Expert 4).”

With the significant research gap that exists in this area, making systematic comparisons of effective interventions amongst lonely elderly was challenging. Moreover, as Sorensen et al. suggested in their paper on interventions for caregivers suffering from loneliness and expert 2 mentioned as well a “one-size-fits-all approach” with interventions is not useful because lonely senior citizens have different needs (2002: 357; Expert 2), as also explained above. It is therefore hard to make generalisations about types of interventions and policy makers should be aware of this (Expert 2).

Instead, I have looked at generalisations of prerequisites that are needed for interventions focusing on elderly citizens experiencing loneliness. Effective interventions as gathered from the literature shared several characteristics:

- They enabled some level of participant and facilitator control or consulted with the intended target group prior to the intervention (Cattan et al. 2005: 57; Movisie 2013: 3; DNBH 2007: 5; Trine Rosdahl; Expert 4). This included involvement during planning, implementation and evaluation.
- The studies included some form of process evaluation and their quality was judged to be high. (Cattan et al. 2005; Andersson 1998)
- The interventions focused on extending one's social network not only by focusing on recreational activities but also by focusing on societal participation. This refers to making a selfless effort in an organised context so that people feel they can be meaningful to others (Broese van Groenou 2007 in Movisie 2013: 3).
- They were characterised by continuity and structure. This implies keeping in touch with the client to build on a relationship to structurally improve one's situation (Movisie 2013:3; Expert 4).
- They were characterised by trust or a trusting relationship. This flows from the former point and time is needed to develop this (Movisie 2013: 3).

3.5 The role of local government

While the above literature supports that informal networks can help in mitigating loneliness to a certain extent, and the importance of the involvement of professionals, it is also important to look into how local governments can organise the involvement of professionals and informal networks and the role that local governments can play. This paragraph will examine this.

As already touched upon in the introductory chapter of this research, both the Netherlands and Denmark are transitioning from traditional welfare states to "activating welfare states" (Sirotkina and van Ewijk 2010: 75). An activating welfare state is one with an increased emphasis on "activation, participation and individual responsibility for dealing with living and working conditions and the (economics) risks in life" (Sirotkina and van Ewijk 2010: 75). There are two relevant strategies for achieving this goal: promoting active citizens and localisation (Sirotkina and van Ewijk 2010: 75). The former is relevant, because it caused both the Dutch and Danish

governments to encourage higher self-sufficiency of their elderly citizens as outcomes of any loneliness interventions and to encourage more citizens (thus activating informal networks) to be involved in solving social issues (as a citizen's responsibility to the community and society). The latter is relevant because it is believed that problems such as loneliness can be better addressed at local levels since these social problems differ by municipality and the causes and best approaches to take can also differ by municipality (Sirotkina and van Ewijk 2010: 76). Localisation, has already been carried out in both the Netherlands and Denmark through the decentralisation of social care task to the municipalities.

Localising policy provides for a better focus on social issues, but giving substance to local policy goals is another salient aspect into successful realisation of involving informal networks in loneliness prevention. One manner in which the local government plays a role, is through subsidising social care organisations on a local level that take care of informal network activation amongst elderly citizens experiencing loneliness (Boivard et al. 2002: 425). The role of the creation of informal networks can thus be outsourced. However, the involvement of the municipality in the planning and implementation thereof is paramount (Larsen et al. 2013: 778). This requires initiating and overseeing contact with social care professionals (Craig and Manthorpe 1999: 60) and setting common goals between the municipality and these actors (Sirotkina and van Ewijk: 84, Larsen et al. 2013: 778). This, in turn, ensures that local authorities have some control and influence over what occurs in practice but also that they can respond to the needs of the social care professionals. In this situation, the role of local authorities is not so much of a service provider but a service enabler (Craig and Manthorpe 1999: 58).

This is central to the idea of local governance as defined by Craig and Manthorpe: "enabling local authorities at the centre of a network of agencies engaged in mapping and responding to local needs collaboratively" (1999: 60). Bovaird et al. 2002 take it one step further and find that other local stakeholders such as businesses, organisations and voluntary organisations should also be a part of such a collaborative network (2002: 415). In research carried out in the Netherlands and Estonia amongst social care providers, local governments were expected to take leadership positions in identifying main objectives and an overall strategy to the main social problems

(Sirotkina and van Ewijk 2010: 83). Larsen notes the role of the municipality in assessing the public health interventions available in municipalities through “priority setting, planning, implementation and evaluation” (Larsen et al. 2013: 783). Thus, the local government does not play a direct role in informal network creation. Although, through indirect coordination of services of other actors, it can still achieve its policy objectives.

As the role of the local authorities moves towards enabling the services of social care professionals, its facilitative role should be apparent to its citizens. In the Netherlands, policy prescribes that local authorities to facilitate the interactions of informal networks (Transitiebureau Wmo 2015). In Denmark the focus is more on providing correct and sufficient information to citizens about the options available to them (see also chapter 2). Larsen et al. refers to having a complete overview of the interventions offered on a municipal level in order to have “optimal value (health) from the limited resources (financial and human) allocated” (2013: 782) and inform their citizens about this. In this manner, the local authority extends its role as community developer. This can be achieved by, for example, establishing local information centres and their funding, and making citizens aware of volunteering options (Boivard et al. 2002: 425). Especially in light of citizens needing to be more active themselves and of the limited capacity of social care budgets, this minimal investment into providing correct information that reaches citizens is paramount.

3.6 Concluding remark and hypotheses

This chapter has defined the concept of loneliness and examined the main cause of loneliness amongst the elderly. It has also outlined the health consequences loneliness can have. There has been explored if informal networks can mitigate loneliness amongst senior citizens as an increased focus by the Dutch and Danish government have emerged on this in the last five years. The academic literature has shown that informal networks can contribute to mitigating loneliness as meaningful relationships can be created, social support can be provided and social participation can be stimulated. Nevertheless, the role of social care professionals remains important in the initial stage as a matchmaker between an elderly person and the

informal network. Furthermore, their expertise is useful in teaching others about how to engage in this issue or providing guidance and support to informal networks. Quantitative research in the areas of effectiveness of loneliness interventions activating informal networks amongst senior citizens has been conducted, but no intervention have proven to be effective so far. Qualitative research in this area is scarce. It is therefore impossible to draw conclusions on what form or substance interventions should take even though it is known that informal networks can help in mitigating loneliness. Moreover, the question remains if a one-size-fits-all approach is applicable in this area and might declare why effectiveness in previous studies has not been found yet. It might also have to do with the fact that insufficient qualitative research in this area has been conducted till this present day. Prerequisites for loneliness interventions targeted to senior citizens involving informal networks were found in the literature review. These were factors such as participant involvement, process evaluation, creating a sense of meaningfulness for the senior citizen undergoing the intervention and trust. Based on the foregoing and with the wish to see for a richer answer as to why informal networks are effective in loneliness interventions the following hypothesis has been created:

H1 “Activating informal networks in loneliness interventions among elderly people on a local level positively contributes to the effectiveness of these interventions.”

Local governments encourage informal network stimulation through social care professionals and are thus partly outsourcing these tasks. They can play an important role however in terms of a service enabler. This implies that they bring social care professionals and other non-traditional parties together, set common goals and coordinate and oversee the planning and implementation. Involvement of local authorities to some extent ensures control over the process, so they have an overview and can align their policy goals with the outcomes of interventions. Moreover, they can respond to needs of social care professionals accordingly. Towards citizens the role of local authorities is more facilitative such as enabling interactions amongst informal networks and providing correct and up to date information to citizens about activities and support available in the municipality (Larsen et al. 2013: 778). Based on this the following expectation is hypothesised:

H2 “Local government’s role as a service enabler for loneliness interventions focusing on activating informal networks amongst elderly citizens positively contributes to these interventions.”

Figure 3.2 Hypotheses

Hypothesis 1
<i>H1: “Activating informal networks in loneliness interventions among elderly people on a local level positively contributes to the effectiveness of these interventions.”</i>
Hypothesis 2
<i>H2 “Local government’s role as a service enabler for loneliness interventions focusing on activating informal networks amongst elderly citizens positively contributes to these interventions.”</i>

Chapter 4 - Research Design and Methods

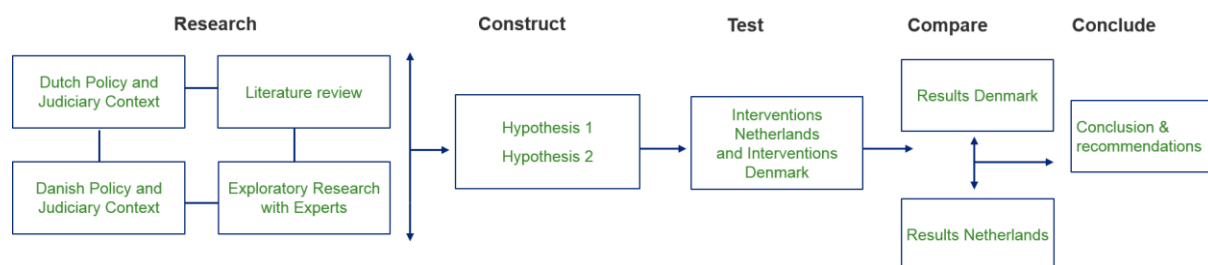
This chapter describes the research design and methodological approach used in this thesis. It will explain why choices for certain research techniques and data collection have been made and is divided in five parts. The first part will briefly introduce the types of research this thesis constitutes and will portray and provide the model of research design (paragraph 4.1). The second part will go into the author's research stance and the method of data collection (paragraph 4.2). The third part will provide outcome indicators and the operationalisation (paragraph 4.3). The fourth part will explain the methods of analysis (paragraph 4.4). In the final part, limitations of the data collection will be portrayed (paragraph 4.5). This chapter describes what strategy has been followed in order to answer sub question 6: *Are preventive interventions of loneliness that strengthen the informal networks of the elderly effective, from both Dutch and Danish social care professionals' perspectives and what are the prerequisites?* And sub question 7: *According to Dutch and Danish policy advisors how should preventive interventions of loneliness that strengthen informal networks of elderly citizens be organised on a local level?*

4.1 Types of research and research design

This thesis is a mix between evaluation research and practical design research. The former compares a current practice to the desired situation (Verschuren 2007: 59). An important aspect of this kind of research is that a set of criteria is developed through which reality will be tested (Verschuren 2007: 61). This has been done by taking two commonly desired goals of both the Dutch and Danish government as outcome indicators. These outcome indicators are increased self-sufficiency and increased well-being as learned from chapter two. With these indicators, existing interventions focusing on strengthening elderly citizens' informal networks could be examined on contributing to to these goals. The operationalisation of these outcome indicators will be elaborated upon in paragraph 3 of this chapter.

Practical design research looks at the (pre)conditions that constitute an effective intervention (Verschuren 2007: 61). This has been explored in part through testing conditions extracted from the literature review through qualitative interviews with social care professionals. Since qualitative research in this area is scarce, it was expected that this research might offer insight into new conditions constituting effective interventions. For the sake of clarity, the complete research design model can be found in figure 4.1. As can be seen in this figure, an analysis of both the Danish and the Dutch policy and legal framework was conducted in order to construct outcome indicators for hypothesis one, but also to get a sound grasp of the operating environment of social care professionals were operating in. Accordingly, a review of the literature on informal networks and the role of local government was performed to help complete the operationalisation of hypothesis one and was used for the operationalisation of hypothesis two. These hypotheses were then tested through the semi-structured interviews with the social care professionals, policy advisors and policy officers in both countries. The results were in turn compared with each other and following from that the conclusion and recommendations were made.

Figure 4.1 Model of Research Design



4.2 Research approach, data collection and sample

Research Approach

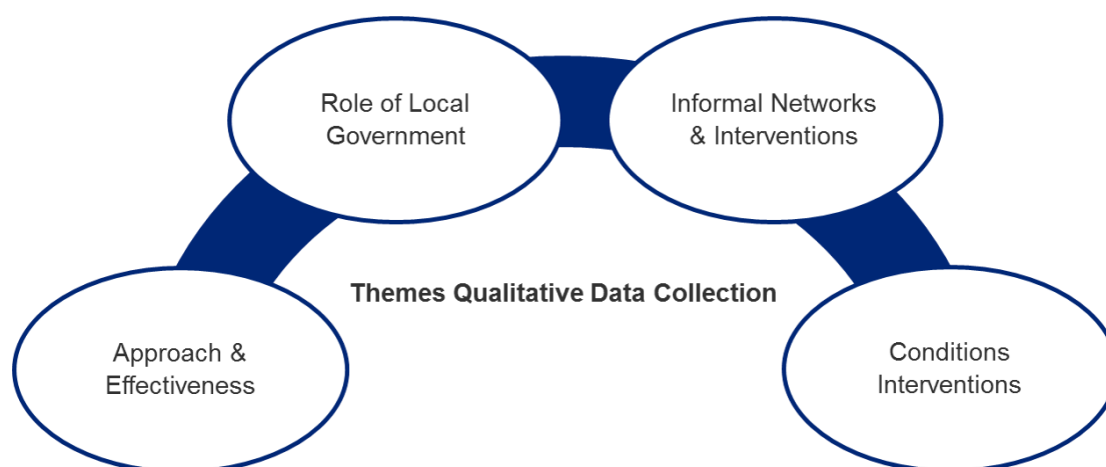
In terms of the author's research stance in this thesis, she took the ontological stance that reality is subjective and the epistemological stance that knowledge is interpretive (Van Thiel 2007: 43). This supports the assumption that there are many different realities and truths. Loneliness is a subjective experience and therefore, it only seemed logical that, in this case, qualitative data collection was necessary to provide room to collect people's experiences and their interpretation regarding this phenomenon. This research paradigm, according to McNabb, reifies reality or truths so they can be constructed by several individuals and organisations that participate in the studied situation (2008: 251). It provides for a more in-depth understanding of this complex phenomenon and can provide richer data than quantitative data (Collis and Hussey 2003: 55). Results therefore will be interpretive and descriptive.

Additionally, as becomes clear from the literature review presented in chapter 2, qualitative insight is scarce about effective interventions mitigating loneliness amongst the elderly and the organisation of such interventions on a local level. Various actors important to this issue have suggested that more qualitative research should be done or have stressed the importance of qualitative research in this field. Rychetnick et al. (2002) for example, suggested that for "the transferability of evidence to be meaningful, then qualitative, observational and multilevel evaluations need to be drawn upon in addition to the traditional trial" (in Cattan et al. 2005: 62). Moreover, the minister of HWS noted during a recent conference about the newest healthcare report released by the Care Institute, that she would like to consult with the practitioners in the health and care industry that will be influenced by new policies, structures and rules, know how they perceive it and "how they will give substance to it" (Schipper 2015). Also, the DNBH noted that it is important to seek insight systematically from different professionals in ways that produce useable qualitative data from those in the field (DNBH 2007: 5). For these reasons, in the empirical part of this thesis, qualitative data collection through semi-structured interviews was chosen for data collection.

Data Collection

A semi-structured interview is a formal interview between an interviewer and respondent (Cohen and Crabtree 2006). The interviewer develops an interview guide with questions and topics that need to be covered during the interview (Cohen and Crabtree 2006). For this reason, comparable and reliable qualitative data can be gathered (Cohen and Crabtree 2006). Nevertheless, because of the *semi*-structured nature of the interviews, they also allow for new themes to arise (Cohen and Crabtree 2006). Since qualitative research in this area is scarce, this seemed to be an appropriate manner to seek for new knowledge. Additionally, using a semi-structured interview technique allowed for deeper research of the material. The topics and questions for the interview were developed by the author of this thesis and guided by the literature study, the analysis of the legal and policy frameworks of both countries, the hypotheses, and the exploratory interviews with experts in the field. The main topics discussed during the empirical part of the study were approach and effectiveness (the latter in terms of well-being and self-sufficiency), policy and role of the local government, informal networks and interventions and preconditions for interventions (see also figure 4.2). The questionnaire can be found in appendix 4.

Figure 4.2 Themes Data Collection



The interviews had an average length of 1.5 hours. All interviews were fully recorded with an iPhone with the consent of the respondents under the conditions that results would be anonymous. Accordingly, they were transcribed by the author of this thesis as transcription is considered the most accurate and complete representation of the interview itself (Van Thiel 2007: 112). Interviews with the Dutch social care professionals were conducted in Dutch and transcribed in English. The interviews with the Danish social care professionals were conducted in English and transcribed in English.

Sample

There were two groups of respondents. The first group of respondents were based on the following criteria; they had to be working on primary and/or secondary prevention of loneliness amongst the elderly, and with a focus in their work of increasing informal networks of lonely or at risk-of becoming lonely elderly citizens. The majority of the Dutch respondents were recruited through the prevention pilot project with Deloitte through snowball sampling.³³ In one of the meetings with the social care organisations involved in this project, a presentation of the research was provided by the author of this thesis. The author asked if social care professionals were willing to participate in an interview. The author also asked, where possible, if senior citizens they knew undergoing an intervention were willing to cooperate they could let her know. The latter was declined, the former was successful. Three respondents from the working group agreed to an interview and one respondent was found through people involved in the working group. The Danish respondents were recruited with the initial assistance of Deloitte Denmark by connecting the researcher to relevant parties. Through snowball sampling, the researcher found four suitable candidates for the interviews. The interviews with the Dutch respondents were conducted in the Netherlands in April, May and June 2015. The author conducted the interviews with the Danish respondents in Denmark from June 22-26. The respondents from here on will be referred to as “social care professionals”.

³³ Snowball sampling refers to the method of the creation of a study sample through “referrals made among people who share or know of others who possess some characteristics that are of research interest” (Biernacki and Waldorf 1981: 141). For more on snowball sampling see Biernacki and Waldorf 1981.

In order to obtain a more complete picture of the role that municipalities (hypothesis two) can play in facilitating the emergence of informal networks amongst the elderly, an additional group of respondents were interviewed. The criteria to be included were to have experience in advising in social care policy and also to be familiar with the topic loneliness. The respondents included two Dutch policy advisors in the social domain. One played a major advisory role in the design of a program for loneliness amongst the elderly in the biggest municipality of the Rijnmond-region), the other one had more of 8 years of experience as an advisor of social care in municipality A. The Danish respondents had both been involved with designing policy targeting loneliness amongst elderly citizens in 25 municipalities in Denmark.

Figure 4.3 Dutch Respondents

Respondent	Job function	Municipality	Abbreviation
1	Generalist with specialisation in senior advising	Municipality A	SP1
2	Elderly advisor	Municipality A	SP2
3	Consultant informal caretakers	Municipality A	SP3
4	Director social care	Municipality B	SP4
5	Policy advisor	Municipality C	PA1
6	Policy officer	Municipality A	PA2

Figure 4.4 Danish Respondents

Respondent	Job function	Municipality	Abbreviation
7	Director social care institution	Municipality D	SP5
8	Occupational therapist senior citizens and registered nurse senior citizens	Municipality E	SP6
9	Quality consultant healthcare and training	Municipality F	SP7
10	Prevention consultant and chairman of national organisation of employees working in health promotion and health prevention	Municipality G	SP8
11	Policy advisor	25 municipalities	PA3
12	Policy advisor	25 municipalities	PA4

4.3 Outcome indicators and operationalisation

The following section will describe the process of defining the themes and outcome indicators that shape the research. The themes and outcome indicators are based on the insights from the analysis of the policy and legal framework, the literature review, the exploratory interviews with the experts and the hypotheses. By ensuring the operationalisation of concepts (derived from the hypotheses) important to this study, structure and order were ensured prior to collecting the data (McNabb 2008: 227).

Hypotheses 1 Theme - Approach and Effectiveness

As became clear from the Dutch and Danish policy frameworks presented in chapter 2, desired outcomes of interventions targeting loneliness are increased self-sufficiency and improved well-being. Both self-sufficiency and well-being have therefore been chosen as outcome indicators in order to accept or reject hypothesis one: *“Activating informal networks (in loneliness interventions) on a local level reduces loneliness among elderly people”*. Effectiveness in this hypothesis thus refers to improved self-sufficiency and increased well-being.

Self-sufficiency has been measured through the Self Sufficiency Matrix (SSM) [zelfredzaamheidsmatrix]. The SSM is a validated tool that is used in the Netherlands by several municipalities to measure one’s self-sufficiency in 11 different domains (housing, physical health, mental health, daily life activities, day-time activities, income, domestic relations, social networks, community participation, addiction, judiciary). Social care professionals together with their clients go through the matrix to decide their levels of self-sufficiency in each domain. Accordingly, together with the clients, social care professionals design plans to increase levels of self-sufficiency if needed. The matrix is revised regularly to observe if any progress has occurred. The social care professionals were asked in what area(s) their clients improve most in contributing to their self-sufficiency. All social care professionals interviewed in the Netherlands have previous experience with this tool. The Danish social care providers had some knowledge about the American variant (Utah SSM) but had it explained to

them during the interviewing process (the tool was translated into English by the author of this thesis). The SSM can be found in appendix 4.

Well-being has been measured through the Groningen Well-being Indicator (GWI) of J. Slaets. This tool measures eight domains of well-being regarding daily experiences: enjoying eating and drinking, sleeping and resting well, having good relationships and contacts, being active, managing yourself, being yourself, feeling healthy in body and mind and living pleasantly. The social care professionals were asked in what areas their clients improved most that contributes to a higher well-being. The GWI can also be found appendix 4.

In addition to these questions, social care professionals were also asked questions about the approach (advantages and disadvantages, substance of approach) and social care professionals' satisfaction with the approach in terms of contributing to one's self-sufficiency and well-being (see also appendix 4).

Hypothesis 1 Theme - Informal Networks and Interventions

In addition to using the theme "approach and effectiveness" to accept or reject hypothesis 1, data collected for the theme "informal networks and interventions" was also used in order to accept or reject this hypothesis. The operationalisation of this theme is illustrated in figure 4.3. As learned during the literature review, activating or constructing informal networks for elderly citizens experiencing loneliness can be effective since informal networks can provide one social support or lead to social participation (Fokkema et al. 2012: 202) (Rook 1984: 1390; Andersson 1998: 3). The first two questions in figure 4.3 attempt to discover whether social care professionals provide the same reasons or if other reasons can explain the value of informal networks. The second question in figure 4.3 makes the link between informal networks and the outcome indicators of self-sufficiency and well-being. In the literature review, it was also noted that professionals do play an important role in establishing (social network activator) informal networks (Andersson 1998: 268) and providing back up and accountable specialised support (van Dijk et al. 2013b: 68). This role was tested through questions three and four in figure 4.3.

Figure 4.5 – Operationalisation Theme “Informal Networks and Interventions”

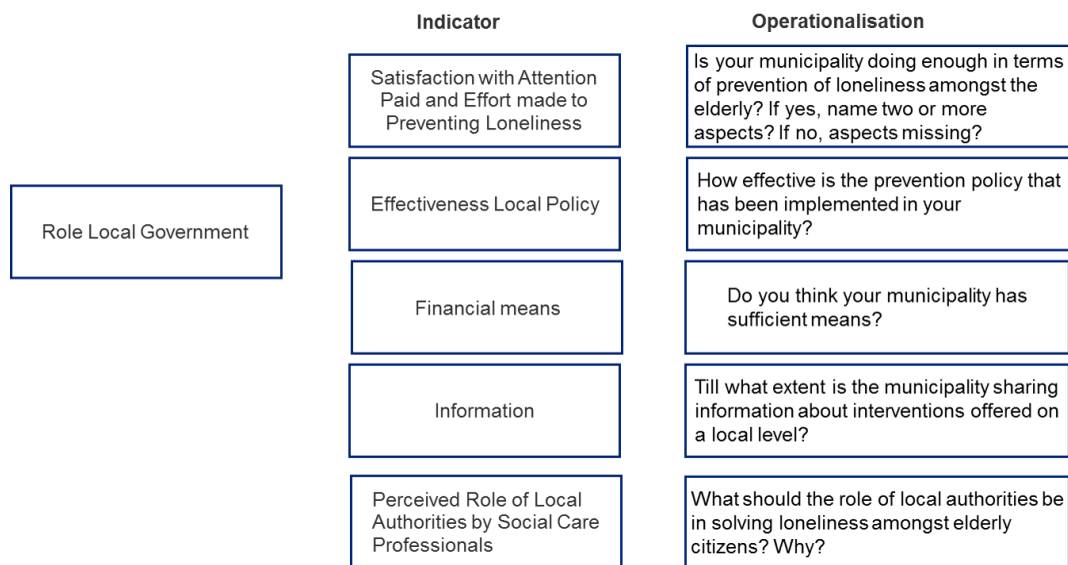
Variable	Indicator	Operationalisation
Informal Network &	General Perception of Informal Networks in Interventions	What do you think of activating informal networks in loneliness interventions (one's own network so e.g. family, friends and volunteers) amongst elderly citizens?
	Effectiveness of Informal Networks in Loneliness Interventions	In what manner can activating informal networks in loneliness interventions be helpful? If they can at all?
	Contribution to Self-Sufficiency and Well-Being	Till what extent are informal networks able to contribute to the well-being and self-sufficiency of the elderly in your municipality? Please elaborate on this.
	Access	Do you feel that elderly experiencing loneliness have the ability to maintain their own networks or to build one by themselves?
	The Role of Professionals	Till what extent do professionals play a role in interventions focusing on activating one's informal network, if they do at all?

Hypothesis 2 Theme - Role of Local Government and Policy

In order to accept or reject hypothesis two, data collected belonging to the theme “role of local government” was analysed. The operationalisation of this theme is illustrated in figure 4.4.

A service enabling role by local government should assist social care professionals with sufficient financial means and by bringing different groups together to address the issue, facilitate and set common goals and exercise some control (Craig and Manthorpe 1999: 60; Larsen et al. 2013: 778). Questions one, two, three and five were constructed to observe if the literature corresponds with what the social care professional thought about this issue and to see if they raised new issues. These questions were also asked to the policy advisors but than focussing on the role of local authorities in general in both countries. As learned during the literature review, local government's role should be facilitative to citizens by providing information about activities and help available to them. This was tested through question four in figure 4.4.

Figure 4.6 – Operationalisation Theme “Role Local Government”



In addition to these main themes each linked with a hypothesis, conditions for effective interventions were discussed with the respondents and results will be displayed in chapter 5.

4.4 Reliability and external and internal validity

Reliability is determined by the consistency and accuracy of the measurement of variables (Van Thiel 2007: 55). Van Thiel states that the more structured interviews are the better their reliability becomes (Van Thiel 2007: 113). For this reason the interview questions were determined prior to all the interviews and did not change during the data collection. Van Thiel furthermore notes that reliability in descriptive research increases when the results are displayed correctly (2007: 55). The author has tried to comply with this condition by remaining true to the data by displaying direct quotes of the respondents during the discussion of the results (next chapter) – results are thus partly descriptive. Accordingly, the author’s interpretation based on the knowledge obtained in chapters two and three is provided and possible explanations

will be provided in chapter 5 (correlational in nature, no claims made about causal relationships).

There are two types of validity. Internal validity means truly measuring what one wants to measure and external validity means to what extent the knowledge produced is generalizable (Van Thiel 2007: 56). To ensure internal validity for hypotheses one and two, two validated measurement tools were used (SSM and GWI). To ensure internal validity for these hypotheses, the operationalisation of measuring the topics of informal networks and of the role of local government was carefully constructed based on the literature. External validity has been attempted by disclosing the interview format so that it can be repeated with the same lists of questions, and by explaining throughout this thesis what choices have been made by recording these in memos and why those choices were made.

4.5 Analysis

Prior to analysing the data, the data had to be organised. This was done with the help of the program Nvivo, a program specialising in content analysis of qualitative data and organising qualitative data. The organisation of the collected data consisted of coding the interviews into the aforementioned categories also known as “thematic coding” (in Nvivo called “nodes”, see figure 4.2) (Van Thiel 2007: 162).

Due to the deductive character of this research, the hypotheses and the operationalisation thereof have been taken as guides for the data analysis. Figure 4.2, queries and word trees were used for identifying the words and themes mostly spoken. Query matrices were made to see where social professionals agreed or disagreed with each other on each theme (“counting” Van Thiel 2007: 164) within one country and accordingly responses by theme and by country compared to each other were analysed. Pattern-matching was additionally used to see if the hypothesized effects were really occurring in practice (Yin 1994 in Van Thiel 2007: 164). Memos were used during the analysis process to reflect on the data regularly to record the choices that were made (van Thiel 2007: 159).

4.6 Limitations

This paragraph will discuss the limitations on the data collection. The author would have wished to also have interviewed senior citizens to examine how they experience the loneliness interventions carried out in order to reject or accept the first hypothesis. Nevertheless, due to sensitivity of the issue and time constraints, insufficient senior citizens were found to participate in this research. Instead, the author interviewed social care professionals working with these people daily and sought to gain their perspective of the issues at hand. It should be noted that a discrepancy can exist between the experiences of social care professionals and those of senior citizens. Social care professionals still offer tremendous value because of their expertise in the area. They can judge the value of interventions and they are directly affected by local policy employed by the municipality, both of which are issues this thesis is addressing. As mentioned, the research approach taken in this thesis assumes that reality or truths are constructed by several individuals and organisations participate in the studied situation (McNabb 2004: 251). Therefore, the data collected through social care professionals will still be of value. Furthermore due to language barriers (the author of this thesis native language is Dutch and not Danish) data regarding the Dutch SPs and Pas might be richer than regarding the Danish Pas and SPs as a smaller chance of miscommunication or “lost in translation” was present. Additionally, in terms of representativeness, due to the small sample the findings obtained from the interviews should not be presumed to be generalisable to the greater population in both countries. Lastly, it should be noted that since the results are an interpretation of the data collected, the bias of the author will be involved, even though she tried to remain as objective as possible.

Chapter 5 - Results and Discussion

This chapter presents the findings of the empirical part of the research organised per themes as displayed in figure 4.2 that are based on the judiciary and policy analysis, the theoretical review, the exploratory interviews and the hypotheses. This chapter consists of three parts. First the results of the interviews with Danish social care professionals are presented and interpreted (paragraph 5.1). Secondly, the results of the interviews with Dutch social care professionals will be displayed and interpreted (paragraph 5.2). Both, in order to provide answers to sub question six: *“Are preventive interventions of loneliness among the elderly strengthening their informal networks effective, from both Dutch and Danish social care professionals’ perspectives, what are the prerequisites, and, how should this be organised on a local level?”* And sub question seven *“According to Dutch and Danish policy advisors how should preventive interventions of loneliness that strengthen informal networks of elderly citizens be organised on a local level?”*

Thirdly, a concluding comparison of Denmark versus the Netherlands will follow (paragraph 5.3).

5.1 Denmark

5.1.1 Approach & Effectiveness – Denmark

In this paragraph two subjects that emerged dominantly during the interviews when discussing the theme “approach and effectiveness” with the Danish SPs will be discussed. Accordingly, as mentioned in chapter 4, measuring effectiveness was performed by measuring one’s self-sufficiency through the SSM and for one’s well-being through the GWI. These results will also be displayed.

Customised approach

As observed in the theoretical framework, no “one-size-fits-all” approach exists amongst loneliness interventions (Victor et al. 2004 in Aartsen and Jylha 2011: 37). All respondents confirmed the importance of recognising that senior citizens experiencing loneliness have different needs and causes and therefore a customised approach is needed per individual. A customised approach implies examining per individual what their situation entails and the needs that they have, in which they are involved and targets are set. This does not imply that group activities or group gatherings do not work, but it does mean that applying a fixed approach to a certain target group will not provide satisfying results, one of the social care professionals explained her experience with this:

“You can’t sort of say for this group this works and for this group something else works. It is very much up to the individual. I mean, we have been successful in making people more self-sufficient, activating relationships and keeping those. But when we did a targeted group approach and we researched its’ effectiveness, for some it worked, they became more self-sufficient but most stayed the same. It did not change their social network or relations” (SP7).

Qualitative monitoring

Effective interventions mitigating loneliness are scarce as learned from the theoretical review and those that have been conducted were mainly quantitative studies. More qualitative research could be conducted, as learned in chapter 3. All four respondents confirmed the latter. They stressed that when measuring results, measuring qualitatively is preferred because quantitative wise the effectiveness of approaches is hard to prove. Frustration was expressed by all four respondents that the Danish government is focusing on results in numbers, whilst sharing experiencing, although less sexy, can explain effectiveness better in this case. Moreover, time is needed but not always given when measuring results, particularly with elderly citizens:

“You have to accept that progress is slow with elderly people and its effectiveness may not be directly observable, you have to keep in mind that you are working against time, an ongoing reduction of capabilities and policymakers forget this sometimes. They think you can rehabilitate all older people in having a good well-being and being self-sufficient” (SP5).

Increased self-sufficiency for one's social network and one's physical health

Self-sufficiency was measured through the SSM and results are displayed in figure 5.2. It is important to note that in Denmark an increased focus has emerged on physical self-sufficiency amongst elderly citizens under new rehabilitation measures.³⁴ This topic dominated part of the interviews amongst respondents when self-sufficiency was being discussed.

All four respondents indicated that in terms of social networks their clients became more self-sufficient through the interventions. The second area of improvement that

³⁴ “In line with the new national drive for improved prevention and rehabilitation services, many local authorities have, since 2006, begun to establish ‘health centers’. The general concept is to set up an organizational unit that offers patients who have been referred by their GPs targeted health promotional, preventative and rehabilitative support, training, guidance and/or treatment, co-ordinated and delivered by a multi-disciplinary team. Within this umbrella concept, local authorities are free to create their own center, model, and consequently center vary greatly in terms of target groups, aims and range of services. Some are general center for all citizens, some focus on rehabilitation and re-training after hospital discharge, while others have health promotion and prevention as their aim, or are targeted at those with chronic illnesses, including older people (Campbell and Wagner 2009: 8).

all respondents mentioned was physical health. However, these two improvements are not always simultaneously applicable in cases. Improvement in terms of self-sufficiency in physical health can actually increase the loneliness according to three respondents. One explained this as follows:

“I don’t know quite how I feel about it, many people want it and are happy with it, but I also think that the focus is in the wrong place. Because if you train the person to clean up the house so you don’t have to visit them, there is less contact and they will be spending all their efforts on cleaning up, instead of going out and buying milk and having a chance to socialise. If you give the possibility of training people to buy milk again with others facing the same experience, you are covering the physical part by having them walk around and the social part at the same time, because they will be socialising at the same time (SP7). “

Ambiguity about focusing on rehabilitation thus (physical health) exists. When the social care professionals deal with senior citizens that need rehabilitation *and* are lonely it is especially the case that loneliness might increase whilst physical health also increases.

“I think that people love to be self-sufficient, but I see people who we do the rehab training to that are also lonely and we train them to become even more lonely – because as long as people are coming in their homes doing the laundry or so on, they see somebody. But when you are able to do that yourself, nobody comes (SP8).”

It is interesting to note that during the Danish policy review the focus appeared to be high on elderly’s well-being but in practice it is rather high on physical well-being.

**Figure 5.1 Responses Danish Social Care Professionals
Self-Sufficiency Matrix**

Domains Self-Sufficiency	R5	R6	R7	R8
Housing				
Physical Health	X	X	X	X
Mental Health				
Daily Life Activities				
Day-Time Activities				
Income				
Domestic Relations				
Social Network	X	X	X	X
Community Participation				
Addiction				
Judiciary				

Increased well-being through social relationships

Well-being was measured through the GWI and can be found in figure 5.2. Three of the four Danish social care professionals found that their interventions were generally contributing to their client’s well-being because of improved relationships. Their clients were often widows and missed meaningful relationships. These relationships were valuable because people felt they could relate to someone, felt meaningful again or would just enjoy spending time with others during organised group activities. Other areas mentioned were feeling healthy, eating and sleeping, managing themselves and having good relationships. The idea of activating an informal network for senior citizens experiencing loneliness, based on their interpretations, appears to be important to senior’s well-being.

Figure 5.2 - Responses Danish Social Care Professionals GWI

Domains GWI	R5	R6	R7	R8
Enjoying Eating and Drinking			X	
Sleeping and Resting Well				
Having Good Relationships and Contacts	X		X	X
Being Active				
Managing Themselves			X	
Being Themselves				
Feeling Healthy			X	

*R6 did not feel current interventions employed contribute to any field of the GWI.

5.1.2 Role of Local Government

This paragraph displays and discusses the responses that were obtained when discussing the theme “local government” with the Danish SPs and the Danish PAs. Factors they perceived as important and as the responsibilities of local authorities were financial means, measuring, the substance of activities, information provided to SPs and citizens, home visits and cooperation amongst different parties. These factors will now be discussed in further detail.

Sufficient Financial means, substance of activities and measuring

As the theoretical review pointed out, two roles of the local authorities that help social care professionals in their work are funding their positions (Boivard et al. 2002: 425) and through ensuring sufficient, available facilities for senior citizens to build informal networks (Baum & Palmer 2002; Bowling & Stafford 2007; WHO 2007 in van Dijk 2015: 20-21). All respondents were satisfied in terms of the financial contributions of the local authorities. Both policy advisors had, at the time of the interview, already been involved in researching the phenomenon among seniors citizens and in developing tools to identify loneliness for volunteers and home carers carrying out the home visits.

They had already done so for 5 years with funding received from both the Ministry of Social Affairs and 25 local authorities (of the 98 in Denmark).

One policy advisor also pointed towards the importance of monitoring and measuring the results achieved with activities organised by municipalities including the compulsory home visits that are conducted in the whole of Denmark (PA4). The PA especially pointed towards using universal tools in order to make it systematic (PA4). The literature review also pointed towards the role that local authorities can take in measuring results. Furthermore, the other policy advisor noted that the role of local authorities should be to facilitate and teach other parties such as volunteers, workers in nursing homes and home carers how to signal loneliness. They should accordingly also know where they “report” this to. At the time of the interview both policy advisors had been working on tools to do so for employees in nursing homes, volunteers carrying out the home visits and home care takers.

Information

Providing information to citizens about activities and help available to senior citizens is important, according to the academic literature. Both Danish policy advisors noted that when they performed research into the role that municipalities could play in reducing loneliness amongst senior citizens five years ago, this was a point of improvement (PA3, PA4). Providing information as a local authority does not only allow citizens to receive information about available activities and help, but also ensures that information is complete and up-to-date. This information can then be provided to all social care professionals working with this social issue, allowing them to know who can offer what, so that they can inform their clients. One respondent illustrated the value of this with the following example:

“My colleague visited a man one year and some months ago and informed him about help the municipality could offer. Then his son was calling her due to some problems with his dad one year later. She asked him how he found out about her number. He told her that his father put a note on the refrigerator that said ‘If house burns down call this person (SP8).”

The two social care professionals working directly for a municipality were satisfied with the information they received from their municipality about the services they could offer senior citizens experiencing loneliness. However, it was mentioned by one respondent that other professionals (for example, GPs) should also be informed about the interventions and help offered by the municipality so they can also refer their clients, if appropriate. This remains challenging because GPs have been hard to reach. As seen in the analysis of policy in Denmark, it is important for social care professionals and citizens to be well-informed. In the case of the two SP's directly working for a municipality, this is true for them, but it is unclear to what extent information has been successfully shared to the citizen (other than the one example shared above).

Another aspect that emerged, that did not appear in the literature review, was the importance of local authorities as a source from which to extract demographic and situational data. This is because all seniors in Denmark receive two home visits from their municipality as soon as they turn 75. The government has access to important data for this age group. Additionally, social care professionals receive information from the municipality of senior citizens whose spouse recently passed away. As the passing of one's spouse is a risk factor to the emergence of loneliness amongst senior citizens, a preventive visit or extra monitoring of those senior citizens is useful. Sharing information with different groups is thus paramount to the role of local governments in loneliness interventions in Denmark.

Home visits

Two SPs also stressed the importance and their satisfaction with the legal requirement of home visits. The access gained through these and the ability to share information about activities and help were perceived by both as effective and worth continuing. One of the PAs noted that it can help in reaching those senior citizens that initially will decline any external help. In some municipalities, if people do not respond to the invites for home visits, at a certain point they will receive a date with a time on it, and they have to call the municipality to decline. Either home visits will then be performed, or the municipality will connect through the phone call they receive, which provides them some opportunity to check upon the senior citizen. In terms of challenges, this PA pointed out that people that receive homecare do not receive those preventive

home visits. People receiving homecare are normally fragile and have a higher chance of becoming lonely, but they are not being monitored for this—only for their physical health. According to this PA, more attention should be given to this by the municipality. More attention should also be given to ensuring that volunteers performing the home visits (as is the case in some municipalities) do not only check upon physical health but also on emotional health.

The need for an integrated approach

Local governments can play an important coordinating role in overseeing and bringing together all social care professionals. Three of the four respondents additionally pointed out that cross-sector cooperation is also valuable and this could be improved. Important actors mentioned were GPs and nurses, particularly in terms of referring their patients to municipal services when they suspect loneliness. Another important task for municipalities seeking to “build bridges” was connecting with the informal sector (SP5). Respondent 8 of municipality B pointed to the value of her volunteer coordinator, with whom she shares an office, especially when it comes to consulting about solutions for senior citizens as “she knows a lot about the volunteers” (SP8). Physical meetings to “put a face to the name” were preferred by all respondents. All four respondents saw the municipality as the player to initiate and bring together the aforementioned parties to realise “better cooperation, exchange of information and building good relationships and trust amongst each other (SP7).”

5.1.3 Informal Networks - Denmark

This section explores, in addition to section 5.1.1, to what extent informal networks can be useful in loneliness interventions amongst senior citizens. The answers represented in this section were part of the theme “informal networks and interventions” of the data collection. Several reasons explaining the value of informal networks are elaborated upon below. Furthermore, the engagement of professionals was also mentioned to be important by SPs to a certain extent. This will also be discussed.

Informal networks useful in mitigating loneliness

Informal networks can help in reducing loneliness amongst senior citizens and were highly valued by all Danish social care professionals. Due to the intrinsic value (as learned in the literature) that informal contacts carry with them, informal networks provide more meaningful relationships with senior citizens than professionals do—senior citizens value that. This is not to say that professionals do not have intrinsic value when performing their work, but they have a different purpose. In this case, that purpose is to connect the senior citizens with an informal network, so that they (professionals) can continue helping others in need. When senior citizens feel valued and connected, they will leave their homes more often and because they can share experiences, deeper relationships emerge (R6, R7). Moreover, informal networks have more time on their hands to establish these meaningful relationships than professionals do (R5). Informal activities can be organised based on a common interest (fishing, for example) or age (90+, for example)—this is not what professionals are trained to be doing. All Danish social care professionals agreed that informal networks can mitigate loneliness.

Another reason informal networks are valued, even if not directly recognized for reducing loneliness, is because of limited financial resources and manpower available. Informal networks are thus a means to complement formal networks. This potential for informal networks to be used increasingly in the future was stressed by all respondents.

“This is the way we have to do it in the future because we do not have the resources to do it differently (SP8).”

One social care professional also felt it is the duty of the current generation of retiring people to contribute to social welfare of fellow citizens:

“People now are retiring from their jobs when they are 65, and they have many years to live with good health. The economy is not going to take the responsibility. There is a huge influx of people that can do things. I mean, you can’t travel the world all the time (SP7).”

Moreover, it also serves as prevention for informal networks *themselves*:

“If we start early with letting them volunteer, those people will benefit from it as well before they themselves become too fragile (SP5).”

Role of professionals remains important

The involvement of professionals is paramount in loneliness interventions focused on increasing one’s network (Andersson 1998: 268; Van Dijk et al. 2013b: 68; Expert 5; Expert 6). This was also noted by all four respondents. The role of professionals in playing matchmaker (as learned from the literature) between the person suffering from loneliness and the informal network remains critical. Social care professionals can push the seniors into the right direction, for example, to become involved with activities.

“They are unable to exit their homes, the fear of falling is an issue, the fear of meeting people. In our municipality we have lots and lots of opportunities, but you need to get out of your home, your comfort zone, and declare that you are lonely and ‘hey, would you like to be my friend?’ This is hard, very hard, especially when they have lived with their spouse, and they are widows. They really cannot see the point. A professional can give them that small push to....help them getting there (SP7).”

They furthermore are valued because of their expertise. They can identify loneliness amongst people quicker than others, and, accordingly, connect them to an informal network. This primary role is important, and volunteers lack the training to “spot” lonely seniors (SP8).

“They are the gatekeepers in the end. They can see if someone feels lonely and then bring that person in touch with a volunteer or family. They know how to do this. Volunteers are not going to seek people who are lonely. They do not come behind closed doors (SP8).”

Furthermore, professionals know what activities the municipality has to offer, and they have a network for referring activities or inquiring about others when they cannot find the appropriate intervention. They are additionally valuable in teaching others how to identify signs of loneliness amongst elderly citizens and thus valuable sources of knowledge and training for informal networks. One example of the knowledge they can share is around how to effectively organise an activity in a manner that will help mitigate loneliness.

Even though informal networks help in mitigating loneliness, the role of the professional in identifying loneliness, their expertise, and the information and training they can provide remain of uttermost importance. Thus, activating informal networks are effective so long as professionals are part of the initial stage (“matchmaker”) and are involved in guiding informal networks as needed.

5.1.4 Preconditions Interventions - Denmark

This section will briefly go into the main preconditions mentioned by the Danish SPs of what constitutes an effective intervention—results are displayed in figure 5.3. The size of the circle corresponds to how often the precondition was mentioned as vital to an intervention.

Three of the four SPs all mentioned trust as a vital precondition of any intervention (SP5, SP7, SP8). Building up trust is important to establishing a relationship between the senior citizen and social care provider in order to prepare them for the next step (for example, connecting them to a volunteer, encouraging them to reactivate family relations, or encouraging them to establish friendships). This view of trust as a precondition for effective interventions corresponds with the observations of the literature review. Other conditions mentioned were being informed as a professional about what the municipality has to offer, accompanying a senior to and during group activities (if applicable), easily accessible locations (in consideration of diminished mobility by elderly citizens), having sufficient time as a social care professional to invest in a senior citizen, and, lastly, senior citizens need to feel that they are welcome when they are taking part in group activities.

**Figure 5.3 - Preconditions Interventions
Danish Social Care Professionals**



5.2 Netherlands

5.2.1 Approach and Effectiveness – Netherlands

In this section, two subjects that emerged dominantly during the interviews when discussing the theme “approach and effectiveness” with the Dutch SPs will be discussed. Accordingly, as mentioned in chapter 4, measuring effectiveness was performed by measuring one’s self-sufficiency through the SSM and for one’s well-being through the GWI. These results will also be shared.

Customised approach

The theoretical review pointed out that a one-size-fits-all approach is not applicable amongst senior citizens experiencing loneliness because loneliness can have very different causes as suggested by Victor et al. (2004 in Aartsen and Jylha 2011: 37). This was confirmed during the interviews. All respondents repeatedly mentioned the need for a customised approach. The major distinction made in using informal networks in loneliness interventions was between individual help in the form of volunteers, versus group help in the form of communal activities. All respondents perceived both approaches as effective. Nevertheless, it remains important that policymakers are aware that every individual situation needs to be examined prior to deciding on an intervention, and having the time to properly examine the situation is critical. Different interventions work for different clients.

Increased self-sufficiency for one’s social network, day-time activities and one’s physical and mental health

Social care professionals generally thought it was a good thing to focus on one’s self-sufficiency because often people can do more than they think they can (SP3). Self-sufficiency was measured through the SSM and results are displayed in figure 5.4. All four rSPs indicated that, in terms of social networks, their clients became more self-sufficient through interventions. Senior citizens experiencing loneliness often do not

have an informal network, but through the interventions their social networks increase in the majority of cases. This, in turn, improves their quality of life because they have people to share experiences with, talk to, and enjoy activities they have in common.

Three of the four respondents (see figure 5.4) also mentioned that senior citizens' self-sufficiency improved in terms of physical health, mental health and day-time activities. Physical health amongst senior citizens improves often because activities (either group or individual) are outside of the house. They have to move to get to the activities or go for a walk with a volunteer. Beyond the social aspects, this keeps them physically active. One respondent noted that even "the small tours to the coffee machine in the activity centre are a win for their physical health" (SP4). Furthermore, physical health also improves, as noted by two respondents, because at the centres for group activities, food is being served. Senior citizens that are alone and feel lonely tend to eat less. When there is a moment to eat together during the activities they are more likely to do so and enjoy it as well (SP2, SP4).

The fact that senior citizens have more activities during the day than prior to the intervention improves their day-time activities which reduces boredom and can prevent them from falling into a downward spiral. One respondent also noted that some senior citizens eventually become part of informal networks themselves for helping others with loneliness (SP2). Community participation can prevent them from re-experiencing loneliness. Lastly, overall mental health improves because an improved mental state of health flows from improvements in all of the aforementioned areas.

One respondent that specifically works with aged informal caregivers did note that because they already play the role of an informal network for someone else, they themselves lack the time either to enjoy their own informal network (if they have one) or to focus on building upon one. Even though they would like to be self-sufficient in regards to their social relationships, they lack the time and strength. This would be an interesting area to explore further in the future.

**Figure 5.4 Responses Dutch Social Care Professionals
Self-Sufficiency Matrix**

Domains Self-Sufficiency	R1	R2	R3	R4
Housing				
Physical Health	X	X		X
Mental Health		X	X	X
Daily Life Activities				
Day-Time Activities	X	X		X
Income				
Domestic Relations				
Social Network	X	X	X	X
Community Participation		X		
Addiction				
Judiciary				

Well-being

Well-being was measured through the GWI and results can be found in figure 5.5. All four Dutch social care professionals found that their interventions were generally contributing to their clients' well-being because of improved relationships. These relationships were valuable because senior citizens enjoyed spending time with others, felt the time spent with others was meaningful, received support from others, or could share their experiences with others, in turn, reducing their loneliness. Other areas mentioned that improved because of the interventions and directly influenced their well-being were managing themselves, being active, sleeping and resting well, and enjoying eating and drinking.

Figure 5.5 - Responses Dutch Social Care Professionals GWI

Domains GWI	R1	R2	R3	R4
Enjoying Eating and Drinking	X			
Sleeping and Resting Well	X			
Having Good Relationships and Contacts	X	X	X	X
Being Active		X		X
Managing Themselves			X	
Being Themselves				
Feeling Healthy				

5.2.2 Role of Local Government and Policy – Netherlands

This paragraph displays and discusses the responses that were obtained when discussing the theme “local government” with the Dutch SPs and the Dutch PAs. Important factors perceived as duties of local authorities were initiating contact with different parties, planning and overseeing interventions, realising an integrated approach, helping with the identification of lonely senior citizens, and facilitating and enabling services in several ways. These factors will now be discussed in further detail.

Government as initiator and planner, but not as implementer

In the literature, it has been noted that the local government plays an important role in the planning and implementation of healthcare interventions, mainly in terms of initiating contact with different parties and overseeing the process. Prior to the emergence of meetings that took place every three weeks three weekly between social care professionals and the municipality in Municipality A, there was no clear overview of existing interventions that could help in reducing loneliness amongst senior citizens. Moreover, social care professionals were barely aware of each other’s existence and each other’s role in this social issue. Due to the municipality’s role as initiator and

planner of continuous tri-weekly meetings with all relevant parties, a clear overview of existing interventions and improved knowledge of each other's existence and role was created. The respondents working in this municipality (three of four SPs) all noted this and were all positive about these developments. Local authorities thus could play an important role in bringing different groups together and by ensuring that these meetings occur. The need of municipality A to keep taking a leadership role in this and to continue with these efforts was expressed by two of the three respondents.

Nevertheless, regarding the implementation of interventions, two respondents and the workgroup repeatedly mentioned the issue of "not reinventing the wheel (SP3, SP1, workgroup session). This implies that the municipality should work with the interventions that already exist, and evaluate these initially instead of coming up with and implementing other solutions. Moreover, the role of the municipality according to a policy officer of municipality A was not to take over social care professionals' work, as the municipality does not have that expertise, but rather outsource these tasks to professionals with expertise (PA 2).

Integrated Approach

Respondents of municipality A were all generally satisfied with their workgroup sessions (every three weeks, social care organisations and the municipality meet to discuss their approaches to loneliness amongst senior citizens in their municipality). These workgroup sessions are especially useful in learning what other organisations are doing and in team building. This in turn, has resulted in being able to refer patients to one another or asking each other for advice in case of uncertainty over a case. In the beginning, parties were hesitant to use the workgroup because some perceived each other as competition; but through the workgroups, parties realised they work towards common goals and they all have their own areas of expertise. Cooperation between different parties has improved, and the SPs spoken to in municipality A were happy with the approach and satisfied with the efforts the municipality made. With busy schedules, it is more challenging to keep contact with other organisations in the same field. With the tri-weekly group sessions, this structure is ensured and secured. Areas of improvement mentioned were for even more parties to become involved. PA1 noted that municipalities in general could be more creative in involving maintenance workers, energy providers and social work students and teaching them how they can

identify loneliness amongst senior citizens and provide the senior citizens with information about the support available from the municipality.

It is interesting to note that the interviewee that was not part of the workgroup (municipality B) noted that she was lacking contact with other parties in her field. She wished for more exchange of information with other social care organisations and more understanding of the responsibilities and activities of each organisation. She felt there was much to gain from this and found that her municipality needed to take leadership in mobilising and guiding this. Even though this is only based on the experience of one respondent, when considered alongside the satisfaction of the other three interviewees with the efforts of municipality A, this can indicate that the municipality can play an important role in bringing different parties together and guiding the process as the literature had stated.

Identification of lonely elderly citizens

Local authorities could take a leadership role in reaching those senior citizens that are hard to identify. These are elderly citizens that experience loneliness but will not seek solutions for themselves due to embarrassment or a lack of pro-activeness. This issue was raised by three respondents of municipalities A and B, and all three wanted the local government to take a leadership role in realising this (SP1, SP3, SP4). One social care professional noted that with her work in her previous municipality, home visits to citizens of 75 years and over were enforced by the municipality. She perceived this as a valuable opportunity to check on senior citizens that remain unknown to social care professionals and the municipality but might feel lonely. In addition to checking upon their social well-being, their mental and physical status can also be checked. It also serves as an opportunity to provide information (SP1).

“With activities and citizen participation sessions, you only reach the really active lonely ones, but a major part of them remains invisible (SP1).“

“The biggest problem remains that there is no active strategy deployed for reaching people, whilst this normally is where prevention starts (SP4).”

The local government as facilitator and service enabler

As learned from the Dutch policy framework in chapter 2, local authorities should facilitate the formation of informal networks and informal interaction amongst elderly citizens. There are some areas in which this could be improved according to the social care professionals. In municipality A, one respondent noted that reaching some of the establishments where social activities are carried out is challenging due to the lack of suitable transport options for seniors. Additionally, there are some parts in municipality A where a meeting and activity centre is not present. It was also noted by two respondents that meeting spaces in some parts of municipality A were missing.

Respondents of both municipalities A and B noted that informing citizens about the activities and help offered in the municipality could be improved. Municipalities often offer an extensive range of activities, but citizens are not very aware of their offerings, and municipalities sometimes also lack a complete overview of the activities and interventions offered. During the workgroup sessions in municipality A, it was repeatedly mentioned that senior citizens still prefer to receive their information on paper, not digitally. Where local authorities could also play an important role is in informing other parties of how to recognise loneliness amongst senior citizens, to whom they can report this, or what people themselves could do (PA1, SP3, SP4).

One respondent noted that because of budget, organisations often do not invest in PR, and local authorities could help in facilitating information campaigns. This could partly help in the aforementioned issue of identifying hard to reach lonely senior citizens. The lack of time was perceived as a factor challenging all social care professionals in their work occasionally, whilst for the issues they are dealing with time is needed in order to gain trust from their clients and also to connect senior citizens to an informal network. Two social care professionals pointed out that budget cuts were to blame for this. Four SPs mentioned the limited financial resources as challenging in performing their work. Policy advisor of municipality C pointed out that, often, policy makers and local governments do not want to invest in preventive loneliness interventions because they do not see direct results. However, an increase in budget is needed for these issues to be tackled structurally.

An issue that has briefly been mentioned in the literature review but was mentioned repeatedly by different parties was the municipality's responsibility and role to measure results of organised activities and existing interventions (PA1, SP4, SP2). They noted that the municipality should take leadership of this.

The Dutch policy advisor that played a major advisory role of developing a program against loneliness amongst senior citizens in municipality C indicated that municipalities should be more creative in finding solutions and do so structurally. Strong family bonds should be introduced, socially caring for each other should be reintroduced starting at primary school, and public campaigns should be implemented to make citizens aware of loneliness as a problem in society and the need for citizens to care for each other. People entering retirement should consider living with their friends again.

“In the end, it is all about re-training people to care about others (PA1).”

One social care professional also noted that caring for fellow human beings in general should be encouraged more.

“I do not think people do not want it or do not want to cooperate, but it was just not in our model before (SP2).”

Local government thus plays a role in the activation of informal networks amongst senior citizens, but, in many areas, their efforts could be improved and the concrete roles that they can play should be further explored.

5.2.3 Informal Networks and Interventions - Netherlands

This section explores, in addition to section 5.2.1, to what extent informal networks can be useful in loneliness interventions amongst senior citizens. The answers represented in this section were part of the theme “informal networks and interventions” of the data collection. Several reasons explaining the value of informal network are elaborated upon below. Furthermore, SPs considered the engagement of professionals to be important to a certain extent—this will also be discussed.

Informal networks important in loneliness interventions

The importance of informal networks in mitigating loneliness as noted during the theoretical review (Aartsen & Jylha 2011: 2), was confirmed by all respondents. Informal networks can help in building meaningful relationships, whereas with professionals this is harder because they have a different purpose (noted by expert 2 and expert 3 during exploratory interviews). Professionals seek to create an informal network for a senior citizen so that they can close the case. They are target-oriented and constantly asking themselves what goals they have and when their roles stop. Informal networks often have the intrinsic value to build a structural relationship with a senior citizen with no time limit.

Moreover, social care professionals noted that support is often also provided for small things “like just checking in with how someone is doing or making a small meal” (SP1)—“really practical things that professionals are not paid to do” (SP4). Informal networks furthermore are able to engage senior citizens in activities of a common interest, and they have the time to do so. Time and finances play an important role in this issue. Time is important because social care professionals have less and less. Finances are important because budgets are reduced and because informal networks are more cost effective to utilise for this issue. For some senior citizens, informal networks are easier to approach and ask for help than professionals. In addition, it is easier to create a “cosy atmosphere” with each other, as contact with a social care professional is more formal (SP1, SP4). Thus, from a Dutch social care professional’s perspective, informal networks are more effective in loneliness interventions.

Professionals remain important as matchmakers, for their expertise and providing support

Even though informal networks in loneliness interventions are immensely valued by all respondents, different reasons were provided for the importance of the involvement of professionals in loneliness interventions. Firstly, informal networks rely on the guidance, support and expertise of the professionals. Helping elderly people that are experiencing loneliness is not always easy, so it is valuable to informal networks if they can talk to someone with expertise if they experience difficulties or find certain things challenging. In this manner, professionals play an important role in directing informal networks in their relationship with senior citizens.

“I closed the case in September, but, well, you never really conclude a case, because you continue to guide the volunteer (SP2).”

Secondly, in providing trainings to informal networks, professionals’ expertise is valuable to ensure that people belonging to the informal network are sufficiently equipped.

“If you then want volunteers to carry out the work, you need to ensure they are well equipped and commit to that. For example, what can they expect when they carry out home visits, how can they see that someone is really not taking care of himself? (SP2).”

This in turn, helps the professionals as well, which seems to indicate that an interplay between professionals and informal networks involved in this issue is valued:

“They are our ears and eyes. With the instructions we gave them they signal back to us about situations, whereas before the course they would not necessarily think about it (SP4).”

Three social care professionals also stressed the importance of their role as matchmaker between an elderly citizen and an informal network, as was also noted in the literature. Firstly, their role is to correctly understand the situation of someone prior to deciding on what approach to take:

“She fell and had problems with her hips. She was in a lot of pain but did not go to the doctor because he did not like her, in her perception, and she did not want to be a burden to him. I think it took me two to three conversations to motivate and convince her that she matters but also to find out she did not want to go there because her husband passed away there. I went with her to the doctor. She started to trust me. Then I told her ‘why don’t you come and drink a cup of coffee with me where I work’ (meeting centre)? She did eventually, which is when I introduced her to my colleagues that do the activities. So, yes, that is how it goes sometimes—first through me with baby steps, than the volunteers take over (SP1).”

Secondly, some elderly people will not take the initiative to make initial contact and need a push in the direction, which is, as all social care professionals stressed, where social care professionals can be helpful. This was supported by the theoretical review

(Andersson 1998: 268). Overall, both professionals and informal networks have their own values in interventions targeting loneliness amongst senior citizens, and they can best address this by complementing each other in interventions.

5.2.4 Preconditions Interventions - Netherlands

This section will briefly go into the main preconditions mentioned by the Dutch SPs of what constitutes an effective intervention. Results are displayed in figure 5.6. The size of the circle corresponds to how often the precondition was mentioned as vital to an intervention.

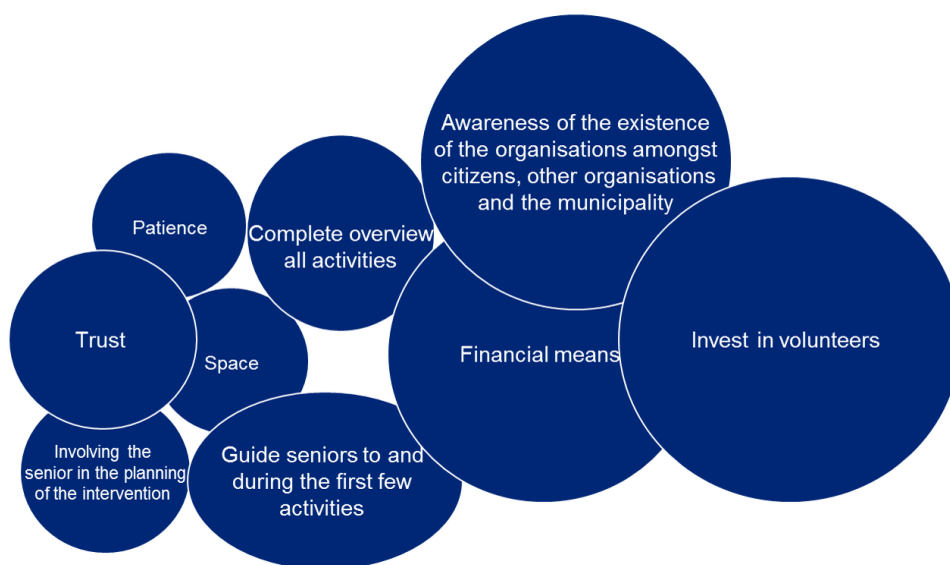
Three of the four respondents mentioned investing in volunteers as a prerequisite for an effective intervention. One respondent noted: “you do have to ask yourself, as a municipality, what is more expensive: investing in a meeting place run by volunteers or secondary care” (R1)? This was not mentioned in the literature review but since it is expected that informal networks are playing an increasing role in social care related issues, investing in them is vital. Three respondents also mentioned financial means as a prerequisite. In terms of putting their own time into interventions but also having budget available to do projects that are time-intensive. One respondent, for example, referred to a project in her work at a different municipality where home visits were carried out—due to budget cuts, the home visits were eliminated, although they were, according to her, truly effective. Three of the four respondents also noted that awareness of the existence of the organisation amongst citizens, the municipality, and each other was important. This means specifically for citizens to know where they can seek help, and for the municipality to know what is being offered locally and to consequently communicate a complete overview of interventions to their citizens and organisations to strengthen cooperation amongst each other.

Two of the four respondents noted trust as a vital precondition of any intervention as corresponds which the literature review’s findings (Movisie 2013:3). Building up trust is important to establish a relationship between the senior citizen and social care provider prior to activating an informal network. Two of the four respondents also mentioned guiding senior citizens to and during the first set of activities. It often proves challenging to persuade senior citizens experiencing loneliness to activate an informal

network and the barriers can therefore be high for them in doing so. They require a push in the right direction along with comforting and encouragement.

Other conditions mentioned were space provided by the municipality to carry out activities, patience, involving the senior in the planning and evaluation of the intervention, and the municipality having a complete overview of all activities.

**Figure 5.6 - Preconditions Interventions
Dutch Social Care Professionals**



5.3 Denmark versus the Netherlands - A Comparison

This section explores by theme the similarities and differences between Denmark and the Netherlands and potential explanations for these. It furthermore illustrates what each country could learn from the other's approach.

5.3.1 Approach and Effectiveness – Denmark versus the Netherlands

In both countries, all SPs and PAs were stressing the importance of a customised approach. This implies that there is not a fixed framework determining loneliness or a fixed intervention that solves loneliness for senior citizens. In both countries, the desire for policymakers and municipalities to be aware of this was emphasized in order to avoid one-size-fits-all policies by local authorities. They rather need to realise that time is required to explore each senior citizen's situation individually and policy should be developed around an individual approach. This provides SPs more space and time to apply such an approach.

In Denmark and the Netherlands, SPs all indicated that physical self-sufficiency and social network self-sufficiency improved. However, while the Dutch SPs indicated that physical self-sufficiency increased *because* of an improved social network, the Danish SPs indicated that it was either one or the other, but they would not improve simultaneously. Moreover, according to the Dutch SPs other areas such as self-sufficiency in mental health and self-sufficiency in day-time activities improved because of social network improvement. Amongst the Danish SPs none of these areas were mentioned. As mentioned previously, Danish SPs felt that the focus on physical self-sufficiency in light of rehabilitation policy has been too high, failing to address the social well-being of people. Based on the interventions employed by the Dutch SPs spoken to, they appear to do better at this and Danish local authorities could take the Dutch approach as an example of how if one's self-sufficiency in social relations is strong, other areas will improve as well. In terms of senior citizen's well-being measured through the GWI, in both countries almost all SPs pointed towards an

increased well-being of their clients because of improved social contacts that were meaningful to the senior citizens and would reduce their loneliness. Based on their perceptions, it could be said that that for both countries, informal networks are effective in terms of improving well-being. In terms of improving self-sufficiency, informal networks activated (and thus making them more self-sufficient in terms of social relationships) during interventions in the Netherlands would also increase self-sufficiency in areas such as mental health and physical health, whereas in Denmark self-sufficiency in other areas would not improve because of informal networks.

5.3.2 Role of local government - Denmark versus the Netherlands

In terms of the role of the local government as a service enabler, regarding financial means, all Danish respondents were content with the finances available for this issue. All Dutch respondents noted that limited budget restricted them directly or indirectly in performing their tasks well (putting time into an intervention, spreading awareness about their organisation and activities, among others). They furthermore noted the lack of some important facilities (meeting centres, transport). As seen in chapter 2, financial sources to cater for social care related issues to the elderly in the Netherlands are scarce. In Denmark on the other hand, the amount spent on this is significantly higher (OECD Stat 2015). Moreover, financial resources to spend on these issues is generated through local taxes. This might explain why one country has more to spend than the other, and why the Danish and Dutch SPs are respectively satisfied and dissatisfied with the financial means and facilities available to citizens in their countries. It could also be a factor that influences the lack of monitoring of social interventions in the Netherlands, as one of the Dutch policy advisors pointed out. In Denmark, the PAs were satisfied with the budget made available to them by 25 municipalities and the Ministry of Social Affairs to monitor effectiveness. Additionally, the Danish PAs received financial means to develop instruments to teach volunteers and caretakers how to signal loneliness. This is another area in which the Netherlands can improve and available budget would help in realising this. In fulfilling their roles as service enablers, Dutch local authorities should ensure that sufficient financial means are available to the parties to whom they are outsourcing social care tasks. Moreover, with the increasing focus on informal networks carrying out social tasks and people expected to be more self-sufficient, there should at least be some financial help available to realise this.

An integrated approach was perceived as valuable by respondents of both countries and could in both countries be further improved. Whereas amongst the Dutch SPs there was still a need SPs to bring together more social care organisations and to involve other professionals, in the Danish SPs expressed only the need for improved cross-sector cooperation (for example, with GPs and volunteers). In both countries, SPs expected the municipality to take a leadership role in this and guide this as they are seen as the ultimate actor to build bridges between different sectors.

In both countries the municipality was perceived as the central point for providing up to date information about all help available to SPs and citizens. Danish SPs were generally satisfied with the information they received from their municipality; Dutch SPs, less so. In municipality A, since the emergence of the 3-weekly workgroup sessions, this had been improved but could be further improved and in municipality B it lacked completely. The Dutch SPs, also expressed dissatisfaction about the little information that citizens receive about options available to them, whereas in amongst the Danish SPs this was not the case. In order to improve this, the initial step would be to ensure that a complete overview of all activities is made available by the municipalities and shared with SPs and citizens. This would, of course, also require financial investment in an information campaign. Based on the experiences shared of the Danish SPs and PA's, their approach could be taken as an example in this. Where Dutch local authorities could also learn from Danish local authorities is in using information from the municipality to effectively anticipate certain negative developments. It is known that the main cause of loneliness for elderly citizens is the death of a spouse. If the municipality would signal this information to a SP, they could monitor that person more carefully around that time.

Home visits were perceived as effective by all Danish respondents. Due to the fact that municipalities are legally obligated to perform home visits, it ensures that at least efforts are being made to reach all elderly people (when senior citizens do not reply to the "request for appointment", a date will be announced when social care professionals will visit). In terms of better reaching citizens and finding and identifying senior citizens experiencing loneliness (all of which are challenges noted by Dutch SPs), by implementing compulsory home visits in Dutch municipalities this could be improved, and this idea could be piloted.

5.3.3 Informal Networks - Denmark versus the Netherlands

In both countries SPs confirmed the importance of informal networks in mitigating loneliness, as they are better enabled than professionals to create meaningful relationships, are less target-oriented than professionals, and have more time on their hands than professionals do. Furthermore, in both countries, SPs pointed out that social care tasks are increasingly shifted towards informal networks because of restricted budgets, and, thus, it is a cost effective way to do so.

In both countries, SPs confirmed the continuing involvement of professionals, particularly in the setting up phase, by correctly scanning the situation and accordingly fulfilling the role of matchmakers between elderly citizens and informal networks. In addition to the matchmaking role that social care professionals can fulfill, their expertise is valuable. Dutch respondents pointed towards guiding informal networks in difficult situations with an elderly person and providing trainings. Danish respondents noted providing trainings, but also identifying lonely senior citizens and sharing information on help available through the municipality and referring citizens to other social care professionals.

5.3.4 Preconditions Interventions - Denmark versus the Netherlands

Preconditions for interventions between Dutch and Danish SPs differed. Whereas the Danish SPs all agreed on trust as a vital precondition, only two Dutch SPs noted this as vital. A more extensive range of preconditions for effective intervention amongst Dutch SPs was apparent. The three preconditions mentioned most frequently were investing in volunteers, financial means, and spreading awareness of SPs services and existence.

Chapter 6 - Conclusion

The main aim of this chapter is to formulate an answer to the central research question of this study: *“Are activating informal networks in loneliness interventions effective on a local level in the Netherlands and Denmark, and, if so, how should this be organised?”* It aims to do so by combining the theoretical part with the empirical part. Firstly, it will look back on the individual sub questions elaborated upon in the previous chapters, it will look at the hypotheses and the findings that emerged through the empirical data collection, and it will arrive at a conclusion. Secondly, limitations of the research will be displayed. Lastly, recommendations for municipalities and avenues for further research will be offered.

6.1 Main Findings

This section will discuss the main findings of this thesis and will do so by providing an answer to each sub question.

The central question guiding this study was *“Are activating informal networks in loneliness interventions effective on a local level in the Netherlands and Denmark, and if so, how should this be organised?”* In order to answer this question, various steps were taken. First, an overview of the policy and judicial context was provided in order to answer the first two sub questions: *1. What preventive social care policy do the Dutch and Danish governments have in place to tackle loneliness among the elderly and what is the role the municipalities can play in this? And 2. When are preventive interventions of loneliness among the elderly effective, from both Dutch and Danish public policy perspectives?*

Regarding sub question one, in terms of social policies in place in the Netherlands relating to loneliness prevention, municipalities are encouraged to stimulate participation amongst elderly citizens in terms of caregiver support, performing volunteer work, or engaging their senior citizens in social participation. It also includes providing information on health problems and providing transportation for the elderly to move around if they are unable to use public transport. A shift has been evolving from being a care consumer to an active citizen. This implies that an increased responsibility of one’s own social, physical and mental health rests with people

themselves, including during interventions. This implies that senior citizens have an increased role in the decision-making process of what form this intervention will take and how they can even self-manage it. Lastly, cooperation with cross-sector parties is stimulated, particularly with GPs.

In Denmark, social policy prescribes municipalities to provide support to frail elderly, to perform wellness promotion at senior centres, and to offer activities focusing on building on their informal network and increasing their physical activity. Municipalities have a major responsibility in informing elderly citizens about these activities but also on providing transportation, nutrition and personal care options. Within this, the focus must be on self-care and using their resources optimally. In addition, municipalities are responsible for ensuring two yearly home visits to all citizens above 75 years in which social, physical, and mental health are monitored. Tackling loneliness in the adult population is one of the national public health goals. For health promotion guidelines, municipalities can consult with the DHMA. Social and physical health are seen as shared responsibilities between the government and citizens where the role of the government is to provide the citizens with the correct information to keep them healthy, and the role of the citizens is to decide what they want to do with that information. Working together with other parties is also encouraged.

In answering sub question two, an increased focus in both countries has emerged on people's own responsibility for their health and well-being. This implies that even if things are not going as well, people first have to examine in what manner they can solve things themselves or through their informal networks. Thus preventive interventions are effective in both countries when senior citizens are self-sufficient. In Denmark, increasing well-being of the elderly population has also been mentioned as a specific goal. Therefore these two factors (self-sufficiency and well-being), were chosen as the indicators, with which to measure effectiveness of loneliness interventions.

A review of the academic literature and exploratory interviews with experts was conducted in order to answer sub questions three, four and five. The third sub question was: *3. What are the causes and consequences of loneliness among aged citizens?* The fourth was: *4. What is known about the types of preventive interventions (focusing on increasing one's informal network) and its effectiveness that are in place to reduce*

or prevent loneliness amongst elderly citizens? And five was: 5. What is known about the role the local municipalities can play in this?

In responding to sub question three, causes of loneliness amongst the elderly can be divided in three subcategories, namely, intra-individual causes, inter-individual causes and societal causes. Intra-individual causes are due to personal traits such as a lack of social skills and low self-esteem. This thesis did not look at interventions for loneliness that emerged because of such causes. Inter-individual causes are, the loss of social and personal resources such as losing a partner, friends, relatives and having increased physical disabilities, reducing one's social network and activities, reducing social support leading to increased levels of loneliness, and physical impairments leading to limited possibilities to do social activities which, in turn, can lead to a decrease in social integration. Societal causes are decreasing of families, spreading out of families, and more women entering the labour force plus the emergence of an individualised society. Regarding the latter, elderly can feel disconnected from society because it has transformed severely from how they knew it. Loneliness is correlated to a wide range of health problems (see more chapter 3, paragraph 3.3) and is a cause of mental health problems. It is also associated with reduced well-being (one of the outcome indicators chosen to measure effectiveness of interventions),

With regards to the fourth sub question, the theoretical review portrayed that informal networks can mitigate loneliness and be useful in loneliness interventions amongst elderly citizens. People within informal networks often have an intrinsic value and are therefore able to create meaningful relationships with senior citizens (as opposed to professionals). They can provide social support which is, in the light of a decreasing social network of friends and passing away of their spouse, valuable. Social networks are correlated to one's well-being. They furthermore can stimulate social participation, which is sometimes something that senior citizens lack, contributing to their feelings of loneliness. What also emerged during the theoretical review though is the importance that professionals remain engaged in the intervention to a certain extent, particularly as a social network activator in the initial stage and in providing back up and accountable specialised support. Furthermore, professionals are useful in pushing elderly citizens in the right direction (motivating them to participate in activities, for example). Lastly, professionals are often trained in diagnosing loneliness, so they are useful in identifying senior citizens suffering from loneliness as well as training others

to do so (thus, sharing expertise). A specific, preferred intervention in the theoretical review and research of this area is still scarce (quantitatively, little effectiveness has been shown, and, qualitatively, very little research has been conducted). Furthermore, a one-size-fits-all approach cannot be applied to loneliness interventions. A few prerequisites for effective interventions however, could be constituted. According to the theoretical review, these include involvement of the participant in the planning of the intervention, process evaluation, having meaningful and trusting relationships between the senior citizen undergoing the intervention and the professional and/or informal network intervening.

One of the roles the local authorities can play, in answering sub question five, is through outsourcing the tasks to social care professionals that activate informal network stimulation. It was furthermore learned that they can play an important role in the planning (for example, initiating contact with social care professionals, and setting common goals), in the convening of social care professionals, and in the implementation of interventions. In these ways, some involvement ensures that there is some level of control by local authorities, so that they can respond to needs of social care professionals. The role of the local authorities is thus that of a service enabler, working through other actors to achieve its goal of activating informal networks among senior citizens. Towards citizens, the role of local authorities is more facilitative, facilitating interactions among informal networks and providing correct and up to date information (Larsen 2013: 778).

Qualitative data collection through semi-structured interviews were conducted in order to answer the sixth sub question: *“Are preventive interventions of loneliness among the elderly strengthening their informal networks effective, what are the prerequisites, and, how should this be organised on a local level from both Dutch and Danish social care professionals’ perspectives and policy advisors?”* And the seventh sub question: *“According to Dutch and Danish policy advisors how should preventive interventions of loneliness that strengthen informal networks of elderly citizens be organised on a local level?”*

The empirical data collected through these interviews with Danish and Dutch SPs and PAs allowed for the answers to this sub question through testing the theoretically informed hypotheses:

H1 “Activating informal networks in loneliness interventions among elderly people on a local level positively contributes to the effectiveness of these interventions.”

H2 “The involvement of local government as a service enabler in loneliness interventions amongst the elderly focusing on activation of informal networks, positively contributes to these interventions.”

Reflecting on these two hypotheses, the following conclusions can be drawn. For the first hypothesis, effectiveness is defined in this thesis as increased self-sufficiency and increased well-being. This hypothesis can therefore be accepted. Self-sufficiency was measured through using the SSM. In both countries, physical self-sufficiency and social network self-sufficiency improved. According to the Dutch SPs, self-sufficiency in terms of mental health and self-sufficiency in day-time activities also improved. Danish SPs pointed out that self-sufficiency increased in either social networks or physical health but not simultaneously. Attention should be paid by local authorities to improve both areas at the same time. The other outcome indicator used, improved well-being measured through the GWI, also showed that in both countries well-being of senior citizens improved due to informal networks. Additional qualitative data was collected through questions about informal networks and their effectiveness. In both countries, SPs confirmed the importance of informal networks in mitigating loneliness as they are better enabled than professionals to create meaningful relationships, are less target-oriented than professionals and have more time on their hands than professionals do. Furthermore, in both countries, SPs pointed out that social care tasks are increasingly shifted towards informal networks because of restricted budget and, thus, in this manner, it is a cost effective way to do so. Lastly, it should be noted that informal networks are effective in loneliness interventions, under the condition that time and space is provided to SPs to apply a customised approach to their clients and under the condition that social care professionals are involved to some extent to realise a successful outcome.

With regard to the second hypothesis, this hypotheses can also be accepted. In both countries local authorities contributed in one way or another positively to loneliness interventions, although for both countries there are opportunities to improve in some areas. The roles of local authorities as initiators and connectors (bringing different parties together) was highly valued by Dutch and Danish SPs. Also, local authorities’

role is pertinent for financing SPs' jobs, meeting spaces in municipalities, and activities, and for enabling and conducting research. Furthermore, the municipality's role as information provider contributes to better interventions. Lastly, Danish SPs valued the role of the municipality as coordinator of compulsory home visit to people of 75 years and above.

6.2 Policy Recommendations

This section will provide policy recommendations for policy makers and local authorities in both countries to consider regarding loneliness interventions. It will first do so for Dutch policy makers and local authorities, and then for Danish policy makers and local authorities, and, lastly, for both countries. It should be kept in mind that the recommendations are based on the results of a small sample and therefore the extent of representativeness to the whole population in the Netherlands and Denmark should be carefully considered.

6.2.1 Policy Recommendations Netherlands

In fulfilling the role as service enabler, Dutch local authorities should ensure that sufficient financial means are available to the parties they are outsourcing social care tasks to. Furthermore, they should invest in the further development of facilitating informal network formations by themselves (through meeting spaces, for example). Currently, the budget available is too small to realise this. With the increased focus on informal networks carrying out social tasks and the expectation that this will only increase, and with people expected to be more self-sufficient, there should at least be some financial help available to realise and facilitate this.

Secondly, also in terms of fulfilling its role as service enabler, municipalities must improve the sharing of information. This implies that every municipality has a complete overview of activities and help offered within the municipality. Accordingly, municipalities should invest in informing their SPs, citizens and other relevant parties about these resources. Municipalities should also consider using data they already collect about citizens effectively in order to identify individuals at a high risk for loneliness (e.g., those who suffer a negative event tracked by the municipality, such as the death of a spouse).

In terms of better reaching out to all elderly people, including those that are hard to identify, the Netherlands should consider carrying out compulsory home visits to people of 75 years and above. This is not only useful for identifying those senior citizens that are normally hard to reach, but allows for monitoring of the physical, mental, and social status of elderly citizens, to allow for more preventive care. Additionally, it serves as an appropriate moment to inform senior citizens about the services and help available through the municipality.

In the initial stage of implementing aforementioned measures, financial investment is needed but in the long-term potential costs for health issues flowing from (severe) loneliness as outlined in paragraph 3.3 could be prevented. Public health savings through these recommendations could therefore be realised on the long-term. Moreover, the quality of life for senior citizens in their final years could improve because of extra attention and knowing that help is available to them.³⁵

6.2.2 Policy Recommendations Denmark

In terms of self-sufficiency, according to the Danish social care professionals and policy advisors the focus on physical self-sufficiency has been too high and an effort should be made to bring the focus of interventions back to the social side of health. As could be seen through the experiences of Dutch SPs, when social self-sufficiency improves, other areas of self-sufficiency follow.

6.2.3 Policy Recommendation both countries

In both countries, municipalities should encourage social care professionals to teach non-traditional parties, such as housing corporations and energy providers, how to identify loneliness amongst senior citizens and to whom they can refer their findings. Furthermore, in both countries, local authorities are expected to take a leadership role in realising an integrated approach. Their roles as initiator and coordinator is paramount and could in both countries be improved. In the Netherlands, this suggests that local municipalities should bring all SPs together and focus on involving other parties, such as GPs and volunteers that could be valuable in loneliness interventions. In Denmark, this implies that local authorities should strengthen their efforts to involve

³⁵ Potential social and financial savings that could be realised through prevention amongst elderly citizens have been researched on a small scale by MO group, see also Soeters and Verhoeks 2013.

other parties with SPs in the process. In both countries, senior citizens should be increasingly encouraged to volunteer, as this can be a preventive form in itself.

6.3 Reflection, limitations and avenues for further research

Limitations

Interventions were generally perceived as effective by the social care professionals. However, a discrepancy can exist between them and the senior citizens actually undergoing the intervention. It is regretful to say that the people undergoing the interventions are not included in this paper, but due to practical reasons and time constraints this was not feasible. Also, this research included a small sample and concentrated sample (Dutch SPs were mainly from one municipality). For this reason, its findings should not be assumed to be representative of the entire Dutch and the entire Danish population. Representativeness could be increased with a bigger sample and broader more representative SP sample (SP's from different municipalities).

Reflection and avenues for further research

Certain choices were made in terms of the research design because of practical reasons such as limited time and financial resources available. The effectiveness of interventions for example, could also have been measured over bigger sample through quantitative surveys. Due to the resource intensive nature of developing such a survey, recruiting a big sample of participants and the absence of a longer period than 7 months to write a thesis this choice was not realised. It would also have been interesting to measure the effectiveness of preventive interventions on an individual level of a big sample of senior citizens partaking in interventions, but this has been challenging to realise even on a small scale due to the sensitivity of the issue. However, if this (recruiting of these participants) could be achieved, it is recommended for further research. It would then also be recommended to perform baseline research to research the effects of preventive interventions through informal networks over time. The latter has been tried to realise by the author of this thesis also on a small scale, but due to time and practical restraints this was not possible. It is therefore also recommended that, in order to measure true effectiveness of interventions, longitudinal research of a minimum of three years is conducted. Also, if financial and practical reasons would have allowed to include a bilingual translator (Dutch – Danish)

with a good level of English the qualitative data would have been more reliable and it is suggested that in further cross-cultural research people with such a skillset are included.

In terms of reflecting on the results, the Danish SPs and policymakers appeared to be generally more satisfied with their approach and finances available than Dutch SPs and PAs. Only one issue was emphasized by multiple SPs and PAs and that was too much of a focus on physical self-sufficiency. A possible explanation for the discrepancy of satisfaction between SPs and PAs of both countries could be that Denmark has started earlier with decentralisation of social policy tasks to municipalities (2007), more finances available and the preventive home visits that they carry out since 1996. The result of this study are particularly of interest to policy makers, policy advisors, social care professionals and people working with elderly citizens and are rather a starting point for further research.

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Appendix 1

Netherlands

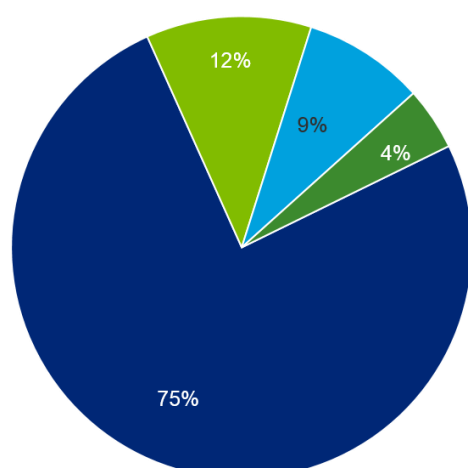
Percentage of people that indicate to be lonely or indicate to experience severe loneliness*

Age	Lonely	Severe Loneliness
19-34	33,8%	7,4%
35-49	37,4%	8,4%
50-64	40,3%	9,0%
65-74	40,9%	7,3%
75-84	49,5%	9,9%
85+	59,2%	13,8%

Source: RIVM – Measurement represents the Dutch population in the year 2012

*Please note that for each category (thus lonely or severe loneliness) the percentages have been each calculated separately over the whole population

Denmark



- 75% Never or rarely experiences loneliness
- 12% Often or occasionally experiences undesired loneliness
- 9% Often or occasionally experiences undesired loneliness even if amongst others
- 4% Very often experiences loneliness also when amongst others

Source: Marselisborg 2015 – Measurement is N =8681 of Danes over 65 years of older. Measurement conducted in 2012.

Appendix 3

Respondents exploratory interviews

Respondent	Job function
Expert 1	Professor and scientific advisor of a Dutch vitality and ageing center and of a social care organisation for the elderly
Expert 2	Professor social intervention and local social policy at a Dutch university
Expert 3	Scientific associate public mental health at a Dutch research Institute
Expert 4	Research associate social domain at a Dutch research institute
Expert 5	Researcher of a medium-sized Danish advisory organisation
Expert 6	Researcher of a medium-sized Danish advisory organisation

Appendix 4

Interview – Effective Preventive Interventions

- Briefly explain aim of research.
- Main question in research: “Till what extent are preventive interventions of loneliness targeted to the elderly, and its approach, effective in the Netherlands and Denmark?”
- Effectiveness in this research implying:
 - Does one’s well-being increase? Well-being defined as: “Experiencing enjoyment of life”. This is measured through the Groningen Well-being Indicator (GWI). *Please see appendix 1, page 3.*
 - Does one’s self-reliance increase? Self-reliance defined as: “Depending on professional help as little as possible, leading an independent life and participating in society.” This is measured through the Dutch “self-sufficiency matrix”. *Please see appendix 2 page 4.*
- Ask if interviewee agrees with recording. Inform about anonymity of research and sharing of results afterwards.

Introduction

1. Could you briefly introduce yourself, describe your position and tasks within this origination/company/municipality?
2. What are the main tasks and aims at your work?
3. Are you belonging to the formal care sector, the informal care sector or both?
4. Could you briefly tell me in what way you are involved with elderly care and the prevention of loneliness amongst the elderly? This can be both preventing the loneliness to occur but also try to not let it worsen.

Approach and effectiveness

5. What are the two main and mostly occurring causes of loneliness amongst the elderly in your municipality? (For example, intra-individual, inter-individual, societal).
6. Till what extent are societal developments (living longer, higher education, housing, religion, children living far away) of influence?
7. Could you describe the municipality's approach(es) of the intervention(s) targeted to the elderly to prevent loneliness (e.g. informal or formal, frequency, parties involved, educational component, till what extent is the person his/herself involved in the approach)?
8. Till what extent does this approach contribute to increasing one's well-being and self-sufficiency?
9. Are you content with this approach in terms of increasing one's self-sufficiency and well-being? Why or why not?
10. Name two advantages and two disadvantages of this approach in terms of increasing the person's well-being and self-sufficiency.
11. What is missing or how could you perform better in contributing to the well-being and self-sufficiency of people in your municipality?
12. Could you name two prerequisites that make preventive interventions a success?
13. Are the citizens in your municipality happy with this approach? Why or why not?

Role of Local Government

14. What should the role of local authorities be in solving loneliness amongst elderly citizens? Why?
15. Till what extent is the municipality sharing information about interventions offered on a local level?
16. Are the national Danish/Dutch government and the Danish/Dutch municipalities doing enough in terms of prevention of loneliness amongst the elderly? If yes, could you name two or more aspects? If no, what are the aspects that missing?

17. How effective is the prevention policy that has been implemented in your municipality? Do you think your municipality has sufficient means?

Informal Networks & Interventions

18. What do you think of activating informal networks in loneliness interventions (one's own network so e.g. family, friends and volunteers) amongst elderly citizens?

19. In what manner can activating informal networks in loneliness interventions be helpful? If they can at all?

20. Till what extent are informal networks able to contribute to the well-being and self-sufficiency of the elderly in your municipality? Please elaborate on this.

21. Do you feel that elderly experiencing loneliness/depression have the ability to maintain their own networks or to build one by themselves?

22. Till what extent do professionals play a role in interventions focusing on activating one's informal network, if they do at all?

Last but not least

23. According to you, what would your approach be to help to increase an older person's well-being and self-sufficiency? Why would it work?

24. Is there something you would like to ask? Or something you would like to say?

Appendix 1 - Groningen Well Being Indicator (GWI) (Part of appendix 4)

Could you please name the three most important areas that the elderly experiencing or risking to experience loneliness you are dealing with find important?

- Enjoying eating and drinking
- Sleeping and resting well
- Having good relationships and contacts
- Being active
- Managing themselves
- Being themselves
- Feeling healthy

Regarding the three areas that you mentioned, are they satisfied?

If yes, why?

If not, why? And is your approach / preventive intervention bringing improvement in these areas?

Appendix 2 (part of appendix 4)

Where were the elderly you are working with prior to the intervention of this SSM scale and where are they now? Or in which areas do you see improvements in self-sufficiency through your intervention?	1. Acute problems	2. Not self-sufficient	3. Barely self-sufficient	4. Adequately self-sufficient	5. Completely self-sufficient
Housing					
Physical Health					
Mental Health					
Daily Life Activities					
Day-time activities					
Income					
Domestic Relations					
Social network					
Community Participation					
Addiction					
Judiciary					