"la Caixa" Foundation

The challenge of loneliness: empower, connect, raise awareness

ALWAYS SUPPORTED
PROGRAMME MANUAL

Always Supported

10 years

Programme for the Elderly

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Programme for
the Elderly

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With over 105 years of history, the programme for the Elderly of the "la Caixa" Foundation has always stood by people, supporting them throughout the ageing process, maximising their potential for personal development, promoting the creation of relational and participatory environments and addressing the new challenges that arise at this stage of life.

One of these new challenges is addressing loneliness. More than three million older adults in Spain are lonely. It is a reality often hidden in the homes of these people, who suffer but whose suffering remains invisible due to various factors. These include social stigma, the lack of knowledge on the part of those affected to recognise this feeling or know that it is a reality that can be improved, the decline in neighbourly relationships, the emergence of new family structures and so on.

Many factors contribute to loneliness becoming an increasingly common reality and, as a result, there is a growing need for strategies and programmes to respond to this situation.

For this reason, ten years ago the "la Caixa" Foundation launched the Always Supported programme, which is carried out in collaboration with social organisations. Its objectives are to empower individuals experiencing unwanted solitude to confront their situation, foster the building of support and assistance networks and raise public awareness about the importance of relationships, connections and the value of interdependence.

Teams of professionals from social organisations, specifically trained in the programme's methodology, implement it in close collaboration with the local administrations of the 15 municipalities (13 in Spain and two in Portugal) where the programme operates (see Appendix 0, p. 253).

The programme features an innovative methodology that provides personalised support while also acting preventively for individuals at risk of experiencing loneliness.

This manual includes both the conceptual framework of loneliness and the programme's methodology, incorporating the lessons learned from these ten years of experience.

We would like to once again express our gratitude for the commitment and collaboration of all the stakeholders involved in the programme, from the professionals of the different administrations (particularly in social services and healthcare) and the social organisations that deliver the programme, to the more than 200 volunteers and 630 entities (such as neighbourhood and women's associations, centres for older adults, pharmacies and other establishments) that make up the fabric of the community network that underpins Always Supported.

Introduction

The Always Supported programme celebrated its tenth anniversary in 2024. The manual you hold in your hands provides an overview of all the work carried out by the programme for the Elderly of the "la Caixa" Foundation in collaboration with various public and private organisations and institutions in Spain and Portugal.

The title, *The challenge of loneliness: empower, connect, raise awareness*, reflects that programme's objectives: on an individual level, to empower people experiencing loneliness; on a community level, to foster connection and relationships; and finally, in a broader context, to raise public awareness about the importance of interdependence and the need to recognise loneliness and its consequences.

This book is divided into four chapters. The first addresses the conceptualisation of loneliness, the second focuses on the intervention model, the third covers the programme evaluation, and the fourth presents the methodological tools designed. At the end, a series of appendices and the reference materials used are included.

In the first chapter, we aim to approach loneliness from a complex perspective. We propose, on the one hand, integrating different theoretical viewpoints and exploring loneliness not only in terms of relationships, but also from an emotional and existential perspective. On the other hand, we consider loneliness through three levels of intervention: *micro* (the individual), *meso* (the community) and *macro* (citizenship), incorporating both internal variables of the individual (subjective aspects, coping strategies, etc.) and external factors (environment, existing services, etc.). Finally, we highlight some challenges and critical issues that we believe need to be addressed to further the understanding of loneliness and the design of effective and efficient interventions.

The second chapter examines the intervention model from two complementary points of view: the individual, focusing on the intervention with the person experiencing loneliness, and the community, addressing the community-oriented approach. This chapter also develops the programme's profiles.

Regarding individual intervention, the programme proposes its own model, which considers more than one "way" of understanding the person experiencing loneliness. It integrates both risk factors and the mediating and modulating variables of situations of loneliness into a cohesive framework.

With regard to the programme's community-oriented approach, the chapter begins by outlining its reference framework, followed by a discussion of organisational aspects and methodological considerations. It concludes with planning and monitoring tools for community action and a description of various projects.

The chapter ends with an overview of the three profiles of people served by the programme: those experiencing loneliness, those without loneliness but with risk factors, and those with a need for connection.

The third chapter focuses on the evaluation of each of the profiles, as well as the process of supporting individuals. It provides a comprehensive description of the scales and questionnaires used (including their psychometric information) and outlines the evaluation process in detail, so that it can be replicated for those who may be interested.

As readers will see, the Always Supported programme places significant emphasis on the process of supporting individuals experiencing loneliness and on fostering meaningful connections. Additionally, this chapter covers the feedback provided by the people supported, the professionals and the collaborating organisations with regard to the programme itself.

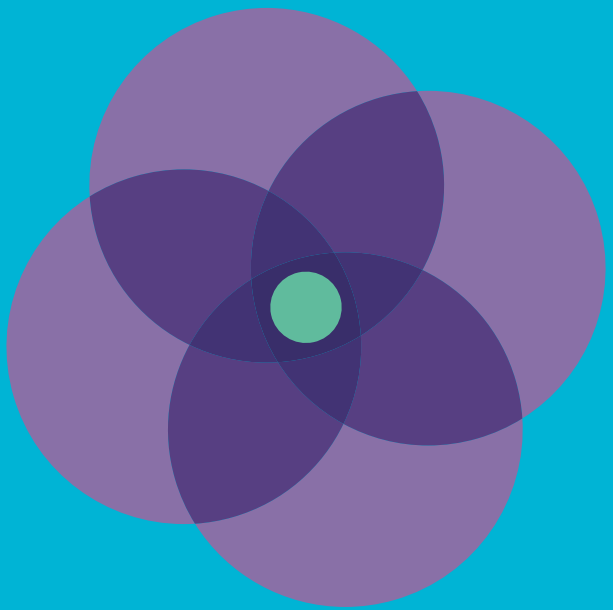
The fourth chapter describes the various methodological tools developed by the Always Supported programme, such as the case analysis tool, the action plan, monitoring instruments and so on. It also covers the training aspects provided, aimed at both the professional teams and the programme's volunteers.

At the end of the book, in the appendices section, you will find all the instruments and tools described throughout the text, which we hope will prove useful.

To conclude, we would like to thank all those who, experiencing loneliness, have placed their trust in the Always Supported programme. We extend our heartfelt thanks to the professionals who have contributed to the programme over the past ten years, as well as to the organisations and public and private institutions that make it possible.

Chapter 1

Loneliness: conceptualisation and challenges



1.
INTRODUCTION

For decades, we have seen a trend toward individualisation, with our societies becoming increasingly less communal and more focused on self-interest. Whether travelling on the bus, going to the gym or visiting the health centre, the scene is much the same – be it in San Sebastian, Pamplona, Barcelona, Madrid or London: people absorbed in themselves, headphones on, listening to music, watching series on their phones or tablets, scrolling through social media or taking selfies. People not interacting with one another, reminiscent of the title of Sherry Turkle's book, *Alone Together*.

We feel increasingly helpless (López, 2022), we perceive more strongly the impossibility of influencing the course of our lives and changing their conditions. Interdependence, the need for others and the connection with what is common and shared are increasingly questioned; it seems like we no longer need others. As the American sociologist Sennett (2018) noted some time ago, we live personal experiences that do not constitute a coherent whole from which to pivot relationships and bond with others. There is an increase in what, in psychology, Recalcati (2015) has termed the *clinic of the void*: an increase in experiences of unreality, a sense of non-existence, an absence of a life project and a lack of future projection (Yanguas and Pinazo, 2024).

In the contemporary society in which we live, our relationships seem to be marked by functionality – as if we could measure them in terms of cost-benefit – in which we always have to win (Duportail, 2019), in which values like commitment, generosity, mutuality, reciprocity, altruism, empathy, etc., which are intrinsic to interdependent and caring relationships, lose their meaning and leave a void that cannot be filled. We are what Riesman et al. (2008) aptly called the *lonely crowd*, solitary people who live together but with barely any connection.

More and more, it feels as though life is only about the urgent, the short term, the immediate; and in that context, meaningful connections and personal and collective commitment are undervalued. In the short term, we are often satisfied relying solely on ourselves; it is in the medium and long term that the need for others truly emerges.

We forget, as Pérez (2023) reminds us, that "a stable self only comes about in the face of the other" (citing Byung-Chul Han); that individuality is a product of development through interaction with others within a given sociohistorical context (John Dewey); that each and every one of us thinks of ourselves as individuals within the shared experience; that the self does not exist in isolation or as a given, but as a relational outcome, that it is "more 'I' the more 'we'" it incorporates; that we become ourselves through others (Ronald Cohen) by managing the shared world.

The data speak for themselves: the 2018 European Social Survey (ESS) found that 7.5% of Europeans over the age of 50 reported feeling lonely often or almost always; 23.3% of Europeans over 50 reported having a limited social network, meaning that they had no-one they could talk to about their personal problems or ask for help in case of need. Following this line, the 2014 European Health Interview Survey (EHIS) indicated that

6.6% of Europeans aged 15 and over said they felt lonely; the 2019 European Public Health Survey (EPHS) found that 5% of Europeans over 15 reported feeling lonely; and the 2015 World Health Survey (WHS) indicated that 8.3% of Europeans aged 18 and over said they felt lonely.

As relationships have become more fragile and people have become increasingly isolated, a kind of tyranny of happiness has taken hold. Slogans like "with effort you will make it", "success depends on you", etc., have colonised our way of thinking.

It is paradoxical that, in the age of isolation, personal discomfort (suffering) seems to be solved only by attitude and cognitive or emotional changes, or by resorting to individualistic spiritualities. We hear so often that "life is not complicated, we make it complicated" that many people have come to believe it, because happiness, we are told, is always within reach. But beware: vulnerability exists and one cannot always be happy, or at least one cannot be happy all the time.

We trivialise suffering, we believe that overcoming cancer almost depends on our attitude, or that living in your early twenties with constant abdominal pain that makes life difficult is a matter of having the right mindset and temperament. We think that if we struggle when accompanying a loved one at the end of their life, it is because we do not cope well with our pain; that if we have feelings of ambivalence after caring for our mother with dementia for fifteen years, it is because we lack psychological tools; or that overcoming long COVID, which constantly weakens us, is simply a matter of transforming our ideas, beliefs and assumptions. Beware of these fictitious empowerments! Focusing exclusively on the bright side, seeing only the positive, will often not only fail to alleviate our discomfort, but will also prevent us from seeing the reality of life, which is always subject to ups and downs and unexpected shocks.

The reality is that we are vulnerable, that the self that should be able to handle everything simply cannot; and it is sad to observe how we blame people for their suffering when they do not know how to manage it.

As mentioned earlier, we must accept that we cannot always be happy, that we will live with stones in our shoes that sometimes we will be unable to remove, that will bother us some days, and other days will simply cause us pain. As Marino Pérez, professor of Psychology at the University of Oviedo, is wont to say, there is no paradise without serpents!

We must accept that attitudes do not always triumph over circumstances, that the mind cannot always prevail over the sick body, that even if we make an effort we will not always achieve what we set out to do. Do we have some responsibility for what happens to us in our lives? Of course we do, but only up to a point.

There are problems and challenges that have a social or collective origin, or at least are not strictly personal. These challenges and difficulties require a cross-cutting, multidimensional response that is not strictly psychological or personal. Carers, people suffering from depression, families living in poverty, individuals unable to find work, people who are lonely, people who have failed, people who are ill... it is not that their

lives could be better if only they knew how to handle things better or made more of themselves, absolutely not! We need to adopt a more compassionate perspective, to understand that perhaps not all the responsibility lies with them. Not everyone has the same opportunities and there are issues that have an important social dimension, that go beyond the individual and that must be addressed from the social, from the community, to compensate for inequalities.

In the midst of the dense fog caused by individualism and that obsession with our "personal situation", we deny the existence of vulnerability, we forget that we are interdependent beings and live in the contradiction of being, on one hand, highly self-centred, and on the other, shying away from confronting ourselves out of fear. We fear emptiness, we dread boredom, we feel threatened by loneliness, and we are intimidated by simply being with ourselves.

Additionally, we have metabolised the idea that happiness is the most important thing, as if being happy were an imperative, as if there were a dictatorship of happiness where everything that is not happy is rejected. Barbara Ehrenreich expressed this in her 2011 book *Smile or Die: How Positive Thinking Fooled America and the World*: "Happiness today has become a tyrannical ideology where positive thinking, as well as aspects related to positive emotions, optimism or resilience has become normal and desirable through its naturalisation and its exaggerated relationship with longevity, with the prevention of certain diseases...".

Happiness is not everything, because there are anxieties that are worthwhile, worries that make sense, stresses that we accept because they simply mean something to us, pleasures that are not worth pursuing or that we choose not to value... In other words, we do meaningful things that do not make us happy. Perhaps we should say out loud that happiness is not the main goal of our lives, or at least, is not the only possible or desirable goal. Maybe we have forgotten that there is also friendship, truth, knowledge, justice, love...

We need to recover the idea that it is necessary to accept limits, to come to terms with what life hands us, to understand that we can only change what is possible within the realm of possibility, that it is not just about managing our own lives, but also about contributing to and building the common and shared. It is about stepping out of our own selfness and connecting with others.

In this context of glorifying happiness, trivialising discomfort and the breakdown of our relationships, loneliness (and, as will be discussed later, its trivialisation) seems inevitable. We are no longer surprised when we read that 30 million people (7% of Europe's inhabitants) declared feeling lonely in interviews conducted in 2016 for the European Social Survey (D'Hombres, 2018), or that a third feel lonely sometimes and 13% feel lonely most of the time, according to updated data from the same survey for 2022 (in a sample of more than 25,000 people aged 16 and over from all European Union member states).

2.
AN INTRODUCTORY LOOK AT SOLITUDE

"[...] To my solitudes I go, from my solitudes I come, because to walk with myself my thoughts are enough", wrote Lope de Vega (1562-1635) during the Spanish Golden Age, anticipating the complexity of loneliness (solitude), its transversal and multifaceted character. Indeed, if there is one thing that characterises loneliness, it is its complexity, which, as we shall see throughout this chapter, makes both its understanding and its intervention difficult.

Loneliness, which has only been addressed by the sciences in recent decades, has long been a subject of literature, philosophy and art. It is a feeling, an experience, a shared human condition that emerges from a very early age, linked to our very humanity, to our vulnerability. To metaphorise it as an epidemic, a disease, a tsunami or a war – as Susan Sontag taught us in *Illness as Metaphor* (1978) – only makes it more difficult to understand and deal with.

Octavio Paz wrote in *The Labyrinth of Solitude* (2004): "All men, at some point in their lives, feel alone; and more: all men are alone... Solitude is the ultimate depth of the human condition." And so it is, we are beings subject to ups and downs and shocks, vulnerable. No-one captured our vulnerable condition better than the Lithuanian-Jewish philosopher and writer Lévinas (2001) when he said: "The self, from head to toe, down to the marrow of the bones, is vulnerability."

We are social beings, we need to bond with others, we have an essential motivation to create and maintain interpersonal relationships (Yanguas, 2021; Yanguas and Pinazo, 2024). As the English poet John Donne (Ordine, 2022) noted, "No man is an island, entire of itself; Every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were. Any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee."

Therefore, the experience of loneliness is deeply rooted in that social nature of the human being, on which, as we have seen, bonds with other people constitute a basic need and an essential part of identity. Many conceptual models in psychology – from Deci and Ryan to Bowlby, Maslow to Winnicott, to name but a few – have emphasised the importance of relationships and given the affective bond with significant others a central role in both the development of a healthy personality and the maintenance of psychological well-being.

Identity is shaped by relationships with others. When these central affective bonds are altered, for example, by the death of our loved ones or by divorce and the consequent separation between parents and children, we experience the moments of greatest pain, loneliness and psychological and physical vulnerability in our lives. Affective loss, grief and loneliness are therefore closely intertwined concepts.

Loneliness, which, as has been pointed out, stems from our own ontological vulnerability and deep need for others, is also related to and overlaps with other experiences such as isolation, depression, despair, lack of purpose, a sense of loss of control or the experience of emptiness. For this reason, it is very difficult in "interventional" practice to find people who feel only loneliness, as it is often interwoven with the other human experiences described above.

All those other experiences – isolation, despair, sadness, lack of purpose, stress, etc. – as well as loneliness, are closely associated with health. In the case of loneliness, the emphasis on its link to health has been so profusely emphasised (it is worth consulting, for example, Hawkley, 2022; National Academies of Sciences, Engineering and Medicine, 2020; Holt-Lunstad et al., 2015) that loneliness has become a public health issue. Two points at least are striking: the first is the focus on "loneliness as a problem", which will be analysed later; the second is an overestimation of the impact of loneliness on health: scientific articles have been much more cautious (see House et al, 1988, for example) than press articles based on those scientific articles (*The Guardian*, 2013; *Scientific American*, 2019). In this respect, the allegory of the "loneliness epidemic" implicitly involves a reconceptualisation of loneliness as a health problem already taken for granted by the entire population, despite there being no virus or bacteria that causes it. That said, loneliness (which is not a health problem in itself) is "linked" to health. The scientific literature (Yanguas et al., 2020) that associates loneliness and health is abundant and does so in a twofold sense: loneliness causes illnesses, and illnesses that make us vulnerable cause loneliness. Loneliness is associated with cardiovascular diseases, sleep problems, substance abuse, cognitive decline and obesity, among several other ailments and health issues. Loneliness can also have a negative impact on mental health, including increased stress levels, reduced self-esteem and perceptions of lower social support. It is further linked to depression, anxiety, low self-esteem, a general decline in emotional well-being and, in extreme cases, suicidal thoughts, ideations and actions. Additionally, various scientific studies (Yanguas and Pinazo, 2024) have demonstrated the relationship between age discrimination and its negative impact on health, the overall well-being of older adults in general and, in particular, on loneliness.

Table 1. **Loneliness and health**

PSYCHOLOGICAL HEALTH	PHYSICAL HEALTH
↑ Negative emotions.	↓ Worsening vascular function.
↓ Quality of life.	↑ Systolic pressure.
↑ Depressive symptoms.	↑ Likelihood of recurrent cardiovascular accidents (CVA).
↑ Personality changes.	↓ Expression of genes linked to the anti-inflammatory response.
↑ Anxiety.	↑ Overexpression of genes associated with proinflammation.
↑ Sleep problems.	↑ Activity of the hypothalamic-pituitary-adrenal axis (HPA or stress axis).
↑ Mental health issues.	↑ Alterations in the immune system.
↑ Institutionalisation rate.	↓ Nutrition.
↑ Mortality.	↑ Obesity.
· Social relationships – and their absence – function as a health risk similar to that established in the "classic" risk factors.	↑ Motor decline.
· Generation of suffering and reduced quality of life.	↑ Reduced physical activity and functional capacity.

↑ Increase ↓ Decrease or worsen

Source: Compiled by the authors.

Loneliness is also an eminently social "issue", as it is linked to relationships and their absence (Yanguas et al., 2020). Loneliness is associated with a lack of commitment, a lower level of trust in relationships, risky behaviour and, given that loneliness is not exclusively individual, a lack of community integration: the community, the locality where we live our lives, provides us with feelings of belonging, identification with others, emotional security, reciprocal influence, a sense of sharing values and resources, emotional connection, fulfilment of needs, etc., and its absence can lead to feelings of loneliness (Yanguas et al., 2018).

Loneliness affects people of all ages, genders and lifestyles. What may appear to be a life full of activities, people and projects might, in fact, conceal a lonely life and an intense inner emptiness. Loneliness can manifest itself in the most unexpected moments: in a crowded place or during a quiet night in the peace and quiet of home.

3.
THE "CLASSIC" APPROACHES TO UNDERSTANDING LONELINESS

Five classic approaches or models summarise ways of understanding and intervening in loneliness throughout history (see, for example, Motta, 2021, for a more comprehensive review). All of these approaches, based on disciplines discussed below, have sought to understand and define key aspects of this phenomenon, which is both familiar (we have all experienced loneliness many times in our lives) and elusive at the same time:

» In the first model, looking at loneliness from the perspective of social needs underlines the role of the absence of relationships and the lack of communication, both in generating and maintaining loneliness. These are relationships "which are not necessarily of an intimate or trusting nature, but also those that fulfil the inherent social needs of the person, such as attachment, social integration, security, trust..." (Motta, 2021). Sullivan (1953) is considered a precursor of the "social needs" approach by proposing a direct relationship between subjective feelings of loneliness and objective social deficits. This perspective also draws in part on Bowlby's (1969) attachment theory, which proposes that early "secure" attachments are necessary for developing meaningful social relationships throughout life; conversely, a lack of attachment bonds can lead to isolation and loneliness at later stages of life. In any case, Heinrich and Gullone (2006) argue that "situational factors" at any life stage, such as death, divorce or relocation, can also be considered causes of loneliness or factors that cause it to persist and become chronic, as attachment figures shift from parents to friends and from siblings to partners and peers.

» The second model is the cognitive approach. This perspective, while emphasising the affective consequences of loneliness, proposes that its cause lies in cognitive processes (known as *cognitive discrepancy*) and defines loneliness as the discomfort or distress experienced when there is a discrepancy between the interpersonal relationships that a person wishes to have and those that they perceive they have. The cognitive discrepancy perspective is based on attribution theory and suggests that in order to understand the causes of their own and others' actions, people who feel lonely attribute causality. It is the way they attribute causality that affects their psychological state: if I understand my situation to be negative, unfair, never expected, etc., in one or more relationships, it is that judgement that leads me to feel lonely. Therefore, from this point of view, ideas, beliefs and attributions about relationships, as well as cultural factors and cognitive biases, play a fundamental role.

» The third type of approach is called *interactionist*. This model is also based on attachment theory, which proposes that loneliness results from the combination of the absence of an adequate social network and the lack of an intimate figure. According to this approach, the personality traits or individual character of each individual (such as social anxiety, shyness, introversion, etc.), interact with the situation. So do certain "social factors", such as hospitalisation, moving house, changes in income, culture (expectations about behaviour in relationships, for example), etc. All these elements influence our social relationships and loneliness.

» Loneliness as a deficit in our social relationships is the fourth model. This approach understands loneliness from the perspective of people as social beings with an essential need for belonging. When this need is not met, negative (or we might also say disturbing) experiences such as loneliness arise. In this case, loneliness has its roots in specific perceptions, evaluations and responses to interpersonal reality and manifests itself through behaviours, feelings and cognitions that are closely related. In the words of Heinrich and Gullone, the lonely person has "negative feelings, such as despair, depression, boredom, etc., and negative attitudes about themselves, others and the causes of events, as well as passive, self-absorbed and ineffective social behaviour" (Heinrich and Gullone, 2006).

» The fifth and final perspective understands loneliness as a consequence of the universal human need for belonging, and therefore sees it as an inevitable part of human existence. As such – and this is explored in more depth below – loneliness can be experienced by everyone regardless of age, economic or social status, health or marital status. This approach understands that true loneliness arises from the reality of facing the ultimate experiences of life, such as birth, death, change, the meaning of our life project, life crises, etc., which is referred to as *existential loneliness*.

These classic approaches come from a view of loneliness in which knowledge from various disciplines has interacted, offering us different perspectives for understanding it. Thus, Barrio (2024), in an interesting proposal, differentiates between evolutionary-genetic, psychological (among which we can distinguish behavioural, psychodynamic and, above all, cognitive models), affective, integrative and existentialist approaches, which obviously interact with one another.

What do all these perspectives share? A definition of loneliness as a subjective phenomenon and a certain theoretical agreement in characterising loneliness as something negative, producing pain and suffering, "aversive", as Perlman and Peplau (1982) would say. Existentialist perspectives stand apart from this consensus, understanding that there is a positive loneliness linked to creation, self-discovery and personal development. In our society, a minority view sees a dichotomy between desired and undesired loneliness, although it has no scientific basis.

The first approach, a minority one in Europe but more widespread on the other side of the Atlantic, is the evolutionary-genetic approach, with its key figure being John T. Cacioppo. Excessively focused on biological factors in terms of explaining the nature of loneliness, this approach takes a Darwinian view of the role loneliness plays in human evolution. It defines loneliness as "social pain", a sort of organic mechanism genetically inscribed and functional for the evolution of human beings (Barrio, 2024; Cacioppo and Patrick, 2008), serving to alert the individual to the danger of social isolation, which could jeopardise their survival. As Cacioppo and Patrick (2008) state: "Social pain, also known as loneliness, arose for a similar reason: it protected the individual from the danger of being isolated. Our ancestors depended on social ties for safety and the successful replication of their genes in the form of offspring who survived long enough to reproduce. Feelings of loneliness told them when those protective ties were compromised or deficient." For Cacioppo, loneliness is a biological

mechanism that alerts us to an unmet need, in this case relational, and predisposes us to take it into account and address it (Hawkley and Cacioppo, 2010). Loneliness would be organic, universal (affecting all people) and perceptually activated (perception of social isolation); it would arise from the interaction between the person and their environment, would be detected through sensory processes and would activate (that would be its function) the need to connect with others.

Psychology, on the other hand, has contributed different perspectives; all of them share the psychological nature of loneliness and understand it not as a genetically encoded organic process, as in the previous approach, but as the result of individual psychological processes. The following can be distinguished:

» The behaviourist view of loneliness has had a very limited development in the world of loneliness. It is based on the idea that loneliness is the result or the "response to the lack of social reinforcement" (Perlman and Peplau, 1998) and begins with the studies of Gewirtz and Baer (1958a, 1958b), in which a dialectic between social reinforcement and isolation is posited that has been given little consideration in conceptual terms.

» The more mainstream psychodynamic theories share the idea that loneliness is a feeling or emotion that arises from the lack, at any stage of life, of relationships that are essential for both proper psychological development and well-being. This viewpoint speaks of a "lack of", of dysfunction and, ultimately, of pathology. The most prominent figure in this area is Fromm-Reichmann (1959), who describes loneliness as the experience resulting from the absence of intimacy, a necessary condition for proper individual development, especially in childhood and adolescence. However, Weiss (1973), the other key author aligned with this approach, has a "more social" perspective and speaks of relational factors relevant to all people, such as trust and security, appreciation and recognition, attachment and closeness, guidance and advice, social integration or belonging and the opportunity to care for others.

» The cognitive model is currently the leading theory of loneliness in the scientific field, the most widely agreed, the most frequently cited and the most widely used in intervention. This model understands loneliness as a cognitive process defined by "a mismatch or significant discrepancy between a person's current social relationships and the social relationships they need or desire" (Perlman and Peplau, 1998). Thus, loneliness is conceived as an assessment between what is perceived or experienced and what each individual's standards (expectations) led them to expect from their relationships. Despite its success, due among other things to the fact that it is easily measurable, it overlooks very relevant dimensions of loneliness, such as the affective aspect, those related to living conditions, or the cultural factors that generate differences in relational expectations.

» The affective approach is also a partial perspective. It defines loneliness on the basis of the effects associated with it, which, according to the authors who defend this approach, essentially constitute it. Bound (2022) defines loneliness as an accumulation or "cluster of emotions, a mixture of diverse feelings that can range from anger, resentment and sadness to jealousy, shame and self-pity". Thus, the effects, emotions and feelings linked in other models to loneliness as a result or effect of it would, in this

model, be considered the very essence of loneliness, its constitutive part, such that loneliness would be described solely by its subjective manifestations.

» The lack of consensus on how to understand loneliness has led to integrative approaches that offer a holistic view, synthesising different models, which is where the Always Supported programme is positioned, as will be discussed later. In general, these approaches attempt, as the name suggests, to bring together different points of view in order to apply a complex understanding of loneliness. One of these integrative models is proposed by De Jong Gierveld and Tesch-Römer (2012), the "integrative model of individual and social context factors", which combines the cognitive discrepancy theory with certain social and affective elements that are secondary factors. Stein and Tuval-Mashiach (2015b) made a notable effort to give substance to a cross-cutting view of loneliness which, according to the authors, should: inhabit the dialectical tension between the overly specific and the overly broad or general; avoid confusion between antecedents, effects and characteristics of loneliness; address the complexity of varieties and meanings associated with loneliness; seek a common language related to the same signifiers when talking about what is related to loneliness that avoids polysemy and confusion; and assume and make explicit the inevitable "situatedness" of knowledge (Stein and Tuval-Mashiach, 2015b). Thus, loneliness should be defined through experience rather than by cognitive aspects, and should contain a sense of isolation (social, metaphysical, objective, subjective, etc.); a relational character, as isolation does not occur in a vacuum but in relation to someone or something, that is, with respect to someone or something; the presence of an experiential self and another, who may be physical or represented, human or non-human, in relation to whom that isolation is felt; unmet social needs; a discrepancy between what is needed or desired and reality; and psychological suffering or pain.

Lastly, existentialist approaches understand loneliness from an ontological perspective. Loneliness is thus an inherent, and often necessary and beneficial, expression of the human experience. As Mijuskovic (2015) states, loneliness is one of the principal conditions of humanity in its being, "it is based on the intrinsic nature of being human" and, as such, it can never and should never be eliminated, but merely reduced when it becomes painful. In other words, loneliness lies at the very core of the human condition. It would not, therefore, have a psychological or biological, environmental or sociological cause; it would not be a conditioned phenomenon, as it is part of human nature itself. Existentialist authors refuse to investigate loneliness empirically, to examine the risk factors or explore its relationship with health or living conditions, because they consider loneliness to be an intrinsic part of our human condition.

Table 2. **Classic approaches to loneliness**

APPROACH	DEFINITION OF LONELINESS	CRITICISMS
Psychodynamic	Loneliness as a lack of essential relationships for life at some point in the life cycle.	Pathologises the individual experiencing loneliness.
Behaviourist	Loneliness as a lack of social reinforcement.	Has an excessively mechanistic approach that overlooks essential aspects of the loneliness experience.
Cognitive	Loneliness as a cognitive process defined by the discrepancy between the person's relationships (experienced or perceived) and their desires.	Is excessively focused on the cognitive aspect, neglecting other relevant aspects, such as the affective or social.
Existentialist	Loneliness as a condition of our existence; it introduces the meaning of life, is dialectical and acknowledges the role of others and the importance of intersubjectivity.[1]	Lacks a "social" perspective on loneliness and on others, and does not give importance to contextual factors, living conditions, etc.
Affective	Delves into the subjective experience of loneliness and the set of feelings that constitute it.	Neglects essential aspects of the experience of loneliness; it describes but does not explain.
Evolutionary	Loneliness is organic; it alerts human beings to the dangers of social isolation.	Neglects essential issues: emotions, cognitions, context, living conditions, etc.
Integrational	Seeks a complex view of loneliness and the suffering caused by the lack of social relationships; it introduces emotions, feelings of isolation and discrepancy.	Leaves out certain aspects, such as social and existential factors, which are essential for a comprehensive and complex understanding of loneliness.

1. Reciprocal process by which awareness and knowledge of one person is shared with another, allowing for the recognition of otherness.

Source: Compiled by the authors.

On the basis of these historical and disciplinary perspectives, various authors have made substantial efforts to define loneliness. Each author focuses in their definition on what they consider essential to loneliness and "forgets" other aspects that do not align with their way of thinking. This is one of the particular challenges with loneliness and with the social and behavioural sciences in general: taking a part and making it represent the whole. Some examples of these viewpoints are described below (Yanguas and Pinazo, 2024).

» Bound (2022) spoke of "enduring emotional distress" (pointing towards the idea of chronicity), "in which the person feels alienated, misunderstood, rejected by others" (isolation), "having no-one to be intimate with" (meaningful relationships), "which can generate various feelings, such as sadness, jealousy, anger, resentment, shame or self-pity" (negative emotions).

» Sullivan (1953) defined loneliness as "a most unpleasant experience" (associated with suffering), "related to the need for intimacy in interpersonal relationships" (need for meaningful relationship).

» Weiss (1973) emphasised "absence" as an essential dimension. He stressed the oft-repeated need not to confuse "being alone" with "feeling lonely", warning that "loneliness is not caused by being alone, but by the lack of a relationship or set of necessary relationships". He stated that "loneliness always arises as a response to the absence, whether of a particular type of relationship or some particular relationship."

» Leiderman (1980) emphasised the "affective state", the "feelings of separation" and the "experience of needing others", when he said: "Loneliness refers to an affective state in which the individual is aware of the feeling of being separated from others, together with the experience of needing other people."

» Peplau and Perlman (1982) – representatives of the cognitive discrepancy hypothesis – emphasised the evaluative element and the unpleasant experience that encompasses the affective component, noting that loneliness is "the unpleasant experience that occurs when a person's network of social relationships is deficient both quantitatively and qualitatively."

» Andersson (1998), in the same "evaluative" line, emphasised the generalised "(dis) satisfaction" with personal, social and community relationships, highlighting this dissatisfaction as central to the genesis of loneliness.

» Rook (1990), on the other hand, introduced the element of emotional distress by relating loneliness to feelings of "separation, misunderstanding or rejection", the "absence of a social network" (of support), and of "meaningful relationships". She stated that "loneliness is an enduring condition of emotional distress that arises when a person feels separated, misunderstood or rejected by others, or lacks suitable people with whom to engage in desired activities, especially those that provide a sense of social integration and offer opportunities for emotional trust (intimacy)".

» Rokach (1990), avoiding the view of loneliness as a "disease" and instead conceptualising it as part of the "human condition", said: "Loneliness is natural and an integral part of being 'human', like happiness, hunger and self-realisation." And also: "Human beings are born alone, we experience the terror of loneliness in death and, often, much loneliness throughout the course of our lives."

» Younger (1995) introduced two new elements into the definition of loneliness: desire and lack of meaning, defining loneliness as "the feeling of being alone even though we desire to be with others. Lonely people experience a sense of utter solitude, as well as a lack of meaning and boredom".

» Killeen (1998) emphasised an exclusively subjective perspective, stating: “Loneliness is a condition that describes the feelings of distress, depression, dehumanisation and detachment”, “which a person suffers when experiencing a sense of emptiness”, “due to an unfulfilled social or emotional life”.

» De Jong Gierveld (1998), in a more complex and comprehensive definition, introduces, in addition to the unpleasant experience (emotional suffering), the ideas of unacceptability, cognitive evaluation, lack of quality, non-existence of relationships, dissonance between the desirable and the acceptable, and the notions of lack of intimacy and lack of communication. She defines loneliness as “an unpleasant or unacceptable individual experience of lack of quality in certain relationships. This includes situations in which the number of existing relationships is fewer than what is considered desirable or acceptable, as well as situations in which the desired intimacy is not achieved. Thus, loneliness is understood as the way in which a person perceives, experiences and evaluates their isolation and lack of communication with others”.

All these definitions (and others not shown due to their length) can be summarised in five basic dimensions that make up the concept of loneliness:

» A subjective dimension related to negative feelings and emotions.

» A social dimension where relational needs are not met.

» A cognitive dimension linked to a negative evaluation of social relationships, both in terms of quality and quantity.

» An existential dimension associated with personal values, meaning and purpose.

» A dimension of integration, attachment and belonging to groups, projects, community, etc.

Table 3. Different definitions of loneliness

AUTHOR	DEFINITION
Sullivan (1953)	Loneliness is the extremely **unpleasant** experience related to the **need for intimacy** in interpersonal relationships.
Weiss (1973)	Loneliness is **not caused by simply being alone**, but by being without a necessary relationship or set of relationships... Loneliness always appears as a **response to the absence** of some particular kind of relationship or, more precisely, a particular relationship.
Leiderman (1980)	Loneliness refers to an **affective state** in which the individual is aware of feeling separated from others, together with the **experience of needing** other people.
Peplau and Perlman (1982)	Loneliness is the unpleasant experience that occurs when a person's network of social relationships is both quantitatively and qualitatively **deficient**.
Rook (1990)	Loneliness is an enduring condition of **emotional distress** that arises when a person feels **separated, misunderstood or rejected by others**, or **lacks appropriate people** to engage in desired activities, especially those that provide a sense of social integration and offer opportunities for **emotional trust (intimacy)**.
Rokach (1990)	Loneliness is **natural** and an integral part of being "human", like happiness, hunger and self-fulfilment. Human beings are born alone, experience the terror of loneliness in death and often feel a great deal of loneliness in the course of our lives.
Younger (1995)	Loneliness is the feeling of being alone when **we want to be with others**. Lonely people experience a sense of total isolation, lack of **meaning** and boredom.
Andersson (1998)	Loneliness is the general lack of **satisfying personal**, social and community relationships.
De Jong Gierveld (1998)	Loneliness is an unpleasant or unacceptable individual experience of a **lack of quality in certain relationships**. This includes situations in which the number of existing relationships is less than what is considered desirable or acceptable, as well as situations where the desired level of **intimacy** is not achieved. Thus, loneliness is understood as the way in which a person **perceives, experiences and evaluates their isolation and lack of communication** with other people.
Killeen (1998)	Loneliness is a condition that describes the feelings of **distress, depression, dehumanisation and detachment** that a person suffers when they experience a **sense of emptiness due to an unfulfilled social or emotional life**.

Source: Compiled by the authors.

Table 4. Dimensions of loneliness. Adapted from Yanguas and Pinazo (2024)

EMOTIONS AND FEELINGS (subjective dimension)	INADEQUATE SOCIAL NEEDS (social dimension)	DISCREPANCY/ EVALUATION (cognitive dimension)	MEANING/ PURPOSE OF LIFE (existential dimension)	INTEGRATION/ BELONGING TO THE COMMUNITY (dimension of integration)
Suffering or emotional distress	Lack of people, need for others	Poor judgement of our relationships both quantitatively and qualitatively	Absence of life project	Lack of connection
Incomprehension, feeling of isolation	Lack of meaningful relationships, lack of trusting and intimate relationships	Dissatisfaction	Awareness of being existentially isolated	Absence of feeling of belonging
Feeling of social rejection	Lack of communication, absence, lack of reciprocal influence and connection	Inadmissibility	Lack of a meaningful life	Lack of identification with others
Sadness, resentment, anger, shame, self-pity, separation, incomprehension, emptiness, abandonment...	No shared values	Inadequacy of the quality of the relationship network	Feelings of (existential) emptiness	Disaffiliation
Desire for relationships with other people	Lack of social integration	Absence of a network of relationships	Alienation	
Distress	Little identification with others			

Source: Compiled by the authors.

4.
INTEGRATIVE AND COMPLEX APPROACH TO LONELINESS IN THE ALWAYS SUPPORTED PROGRAMME

Despite the many different views on loneliness, two primary typologies of loneliness – social and emotional – alongside a cognitive approach, have largely made their way to our country. The cognitivist approach, in addition to being the most widely used and scientifically validated, has two essential points in its favour. Firstly, it is a model that facilitates a swift and "objective" understanding of loneliness: loneliness is the discrepancy between what we expect from our relationships and what we actually experience. Secondly, it enables a "simple" assessment of loneliness: we can ask the person how often they feel a lack of companionship, or how often they feel isolated, or whether they have people to confide in, and thereby obtain a score.

This cognitivist approach, dating from the late seventies and early eighties, has brought with it – despite being older – the concept of two main types of loneliness, social and emotional, as proposed by Weiss (1973) from a, curiously enough, more psychodynamic perspective. Thus, emotional loneliness arises from the absence of a close, intimate bond with another person. For example, individuals who have recently lost a spouse or gone through a divorce are likely to experience this form of loneliness. Social loneliness, on the other hand, results from the absence of a broader network of social relationships to be part of, namely a group of friends who share common interests and activities. Thus, people who have moved from one neighbourhood or city to another for work might experience this form of loneliness.

On the other hand, various typologies of loneliness have developed from Weiss' dichotomy. Several authors have proposed different classifications of loneliness. Thus, to name a few, Hyland et al. (2019) identified the existence of four types related to mental health: low loneliness, social loneliness, emotional loneliness, and social and emotional loneliness (the latter characterised by the highest levels of psychological distress, followed by the emotional class); Tao et al. (2022) spoke of occasional, transitory and persistent loneliness; and the media, including more specialised publications, has suggested multiple possibilities: acute loneliness, chronic loneliness, superficial loneliness, deep loneliness, bereavement loneliness, romantic loneliness, digital loneliness, etc., some of which have very little empirical basis.

In the Always Supported programme of the "la Caixa" Foundation, we have moved away from the typologies of loneliness to focus on and propose an integrative approach based, on the one hand, on various authors mentioned above, and on the other, on the analysis of cases of people suffering from loneliness over the ten years of the programme's existence.

Our understanding of loneliness is characterised by taking into account (Stein and Tuval-Mashiach, 2015b; Yanguas et al., 2020) that loneliness is related to various factors:

» A **profound feeling of isolation** that can be emotional, communicational, existential, etc., and is a core part of the experience of loneliness.

» A **significant lack of satisfactory social connections** (such as contact, attachment, integration, trust, intimacy, etc.).

» A **set of negative feelings** that cause suffering, such as sadness, emptiness, abandonment, despair, threat, etc.

» A **poor assessment**, both quantitatively and qualitatively, between what is expected and the reality of relationships, all experienced individually or personally (Pinazo and Donio, 2018).

More specifically, our perspective of loneliness includes, at least, the following "dimensions":

» A profound feeling of isolation, of disconnection.

» Relationships (or a "life", in the case of existential loneliness) that are evaluated by each person as insufficient, either qualitatively or quantitatively.

» A (unique) personal self that experiences it (different people, different kinds of loneliness).

» A representation of the "other" (person, moment in life) with whom we are united by this feeling of loneliness.

» A deficiency associated with our relational needs ("the lack of").

» Negative emotions and feelings (pain, suffering, abandonment, emptiness) that are at the core of the experience of loneliness.

» A geographical context, with its own culture and idiosyncrasies, where the person lives and "suffers" their loneliness, with which they constantly interact.

As described in later chapters of this manual, understanding situations of loneliness requires us to analyse not only people's internal variables, but also to open up to the places where their lives unfold and to include contextual, community, situational factors, etc. In other words, since loneliness is a personal experience, people's lives take place in a geographical environment where relationships, collective projects, support networks and, ultimately, life itself, are forged.

A complex understanding of loneliness must integrate, in addition to this more *micro* level of analysis (personal matters), *meso* and *macro* levels as well. Christina Victor (Victor et al., 2009; Victor and Sullivan, 2015; Pinazo and Donio, 2018), from Brunel University, London, suggests that loneliness is experienced in the form of multiple realities that are unique, distinct and changing, and that the person constructs and reconstructs within the context of their life and life story. Furthermore, she proposes that loneliness depends on the interplay of various factors that interact with each other, some of which are specific to the person (those we have seen so far), and others external (some under their influence and others that are entirely beyond their control):

» Interpersonal engagement: engagement with people and projects throughout the life cycle.

» Life events, such as transitions and losses, that happen to people, whether health-related (illness) or social (retirement, widowhood, loss or emancipation or migration of children).

» Socioeconomic factors, such as income or the availability or not of care services.

» Social environment in which the person lives: housing, architectural barriers, facilities, type of community (individualistic or collectivist), setting (rural or urban).

» Lifestyles: use of leisure time, hobbies, etc.

» Cultural factors and social stereotypes, such as ageism.

5.
THE VOICE OF PEOPLE WHO EXPERIENCE LONELINESS

A growing body of qualitative research (Dahlberg, 2007; Cela and Fokkema, 2017; McKenna-Plumley et al., 2023; Akhter-Khan et al., 2022) has explored loneliness through the eyes of people who experience it. Several common characteristics are noted in the experience of loneliness across a wide range of individuals, varying in age, culture and living conditions. In summary:

» Common psychological aspects of the experience of loneliness:

- Loneliness is synonymous with suffering. Loneliness is a negative, painful experience, which generates discomfort and desolation, and is also experienced as something shameful, stigmatising, a sign that something is wrong. Therefore, the distinction between desired and undesired solitude so common in our society is not consistent with either the opinion of people experiencing loneliness or with the vast majority of experts.
- Loneliness is coped with. People in a situation of loneliness try to avoid it through various strategies – as yet little studied – such as: making changes in their ideas, beliefs and attributions; lowering expectations; practising avoidance; maintaining a high level of activity; finding paths associated with spirituality, etc.
- The experience of loneliness leaves an indelible mark, so the vast majority of people who have experienced loneliness fear feeling it again in the future.
- The vast majority of people suffering from loneliness highlight emotions and feelings as key aspects of their experience. Thus, sadness (the most commonly described), but also boredom, fear, emptiness, feelings of anxiety, hopelessness and sense of loss, as well as feelings of anger, frustration, guilt or jealousy are central to the experience of loneliness.
- Loneliness has cognitive and perceptual characteristics, and is related to thought processes associated with self-blame, low self-esteem, feelings of incompleteness and a lack of purpose in life, perceptions of coldness of others towards the lonely person, changes in the perception of time (where time might pass too quickly, too slowly or even stand still), etc.
- Loneliness is associated with personality type and personal identity. Thus, personality traits such as introversion and shyness are related to greater loneliness, and it is common to hear statements from people experiencing loneliness expressing that it is part of their character.
- Cognitive approaches that include adjusting one's thought patterns and internalising a positive outlook could help alleviate loneliness.

» Interpersonal aspects of the experience of loneliness:

- Loneliness is not only the lack of a network, but also the absence of specific relationships that provide support and emotional closeness. This is why many people in situations of loneliness do not speak of a lack of relationships in a general sense, but of a lack of specific types of relationships. In this respect, loneliness is often related to having no friends (meaningful relationships), regardless of whether or not they have other relationships (such as family members or romantic partners).
- The absence of specific types of relationships plays a different role in each situation of loneliness. For instance, the lack of satisfactory family relationships (with daughters or sons) plays a crucial role in the case of older adults in need of care; the lack of a partner (the desire to have a new partner for companionship and emotional intimacy) occurs in late adulthood and early later life, both in coping and future outlook, etc. In other words, it is not possible to consider relationships from a generalist point of view; it is necessary to specify the type of relationship and the role it plays in each situation.
- The same applies to the absence of relationships with people with similar characteristics. The lack of peers from the same generation, with whom it is easier to talk and understand each other, is often mentioned by older adults as a significant absence. The same is true for people who have migrated, as they often miss not people in general, but, let's say, co-ethnic peers. We need not only relationships, but also different types of relationships that play different roles, as well as relationships with different generations.
- Loneliness is associated with a lack of close and meaningful relationships, not exclusively with superficial connections. Thus, the absence or loss of meaningful relationships precipitates loneliness, as there is no longer the opportunity to share thoughts, experiences and intimacy. Loneliness, therefore, arises not from a complete lack of relationships, but from a lack of people one really trusts, knows, feels "compatible" with or close to. And beware, companionship (being with non-significant others when one misses specific relationships) can actually generate more loneliness by heightening the sense of loss.
- Loneliness is also disconnection (not exclusively a "lack of people") and feelings of isolation, which should not be confused with feelings of loneliness. These feelings of disconnection are related to not fitting in or not being understood, a lack of alignment or feelings of belonging with close social groups, as well as to a deeper sense of detachment from the world, which can sometimes be existential in nature.
- Loneliness may involve negative interpersonal experiences, such as feeling left out, rejected, unrecognised or betrayed. People may feel that no-one cares about them, that they are disliked, different or invisible, experiencing feelings of alienation, etc., all of which contribute to making the person feel unwanted, inferior and alone.
- Loneliness is often the result of a negative social comparison in which the person believes that others are, for example, more active, more accepted, or feel relationally more fulfilled, etc. This negative comparison includes the non-fulfilment of previous expectations, such as a lack of companionship or attention, etc.
- In summary, people experiencing loneliness seek a broad range of interpersonal relationships that respond to multiple relational needs: attachment, connection, intimacy, belonging, etc.

» Other aspects:

- Loneliness implies a lack of control over the "conditions" in which the person's life unfolds: from perceived little or no control over social contacts to facing physical barriers, such as a lack of accessibility in housing or the community, which can make social contacts difficult (for example, older adults who find it difficult to leave the house, even if they have close and meaningful relationships).
- Loneliness is precipitated by transitions and losses. These transitions (retirement, for example) and losses (death of a spouse or friends, divorce of children leading to the loss of contact with grandchildren) play a major role in both the emergence and persistence of loneliness. In this regard, coping with situations of loneliness can be particularly complicated in older adults, as this stage of life often involves a near-constant presence of factors that contribute to feelings of loneliness, such as frequent losses.
- Loneliness fluctuates in duration, intensity and type. For some people, loneliness is a constant, everyday experience; for others, it is transient and fluctuating. As will be discussed later, there is insufficient knowledge about how the duration, intensity and type of loneliness are interrelated.
- Loneliness is a diverse experience: descriptions of the types of loneliness commonly used (social, emotional, existential) do not adequately reflect the nuances of how it is lived. Thus, loneliness as deprivation (loss of significant relationships, but also absence of close bonds) is different from loneliness experienced as loss (associated with bereavement processes), from loneliness experienced as absence (absence of a significant other, a partner or a friend, to turn to and call upon; longing for connection with someone to talk to, to confide in, to discuss problems with and, in short, to share the world with), from the loneliness of abandonment (feelings of invisibility, lack of recognition, exclusion, lack of care, situations of poverty and vulnerability, lack of attention...), etc. People experiencing loneliness require an approach capable of taking on board this complexity.

6.
FORGOTTEN LONELINESS: EXISTENTIAL LONELINESS

If emotional loneliness has to do with the lack of a satisfactory intimate connection, feelings of emptiness and an absence of emotional connection, and social loneliness is linked to the lack of sufficient ties of friendship and family, as well as the absence of interpersonal relationships in a broad sense, existential loneliness is much more difficult to define. One need only look at the concepts present in the scientific literature: existential loneliness, existential isolation, phenomenological loneliness, phenomenological isolation, fundamental loneliness, definitive loneliness, etc. Existential loneliness has been the subject of multiple approaches both from psychotherapy (Yalom, 1980) and from a more humanistic point of view (Moustakas, 1961) or from existential philosophy (Tillich, 1944). As shown in the following table (McKenna-Plumley et al., 2023), existential loneliness has been defined in many different ways in the literature, although all definitions coincide in addressing a profound sense of separation.

Table 5. Some definitions of existential loneliness

SOURCE	DEFINITION
Moustakas (1961)	"Existential loneliness is an intrinsic reality (proper to the individual) [...] man is fully aware of himself as an isolated and solitary individual, aware that he is separate from himself as a feeling and knowing person."
Yalom (1980)	"Existential loneliness [...] extends far beyond ordinary social loneliness; it is the loneliness of being separated not only from people, but also from the world as one commonly experiences it."
Mayers et al. (2005)	"A third form of loneliness, existential loneliness, has been defined as a primary and unavoidable condition of existence (Burton, 1961; Mijuskovic, 2015; Moustakas, 1961) for which no permanent remedy can be found. Proponents of this form of loneliness believe that, since all human beings are born into a world in which perfect communication with others is impossible and only death is certain, a fundamental feeling of loneliness arises."
Ettema et al. (2010)	"An intolerable emptiness, sadness and longing, resulting from an awareness of one's own fundamental separateness as a human being."
Bolmsjö et al. (2019)	"A feeling of being fundamentally separate from others and from the world." "Existential loneliness can be understood as the immediate awareness of being fundamentally separate from other people and the universe [...], especially when the person is in crisis, when he or she is unable to disclose on a deep (authentic) human level, as well as when experiencing negative feelings, such as sadness, hopelessness, grief, meaninglessness or distress."
Larsson et al. (2019)	"A basic feeling of loneliness that occurs when, as human beings, we are confronted with the reality that we are separate and alone in the world, despite having other people around us."
Van Tilburg (2021)	"Existential loneliness stems from the realisation that a human being is fundamentally alone and feels emptiness, sadness and a longing for connection."
Fried et al. (2020) and Prohaska et al. (2022)	"Existential loneliness describes the feeling of being separated from other people and society, feeling an inner emptiness, being aware of one's own finitude [...], feeling a sense of longing that cannot be satiated through any kind of social interaction. [...] Despite having strong relationships, the person still feels empty."

Source: Compiled by the authors.

There are two fundamental terms: existential loneliness and existential isolation. Existential isolation can be conceptualised as "feeling that one is distanced from one's subjective experience" (Pinel et al., 2017). Breitbart (2017), citing Yalom, writes that "existential isolation is something fundamental, inherent to the human essence, an isolation of oneself from others. No matter how close one is to another (a child, a parent, a lover), there is an unbridgeable gap. Whatever our experience of the world, it is not the same as that of others." We are alone, separated from each other; our reality is that we will never be able to fully share or experience in exactly the same way what we feel with each other, and vice versa.

Existential loneliness is an emotional experience of disconnection from oneself, others and the context in which one lives. Despite being surrounded by people in the neighbourhood, colleagues at work, partners, children, etc., existential loneliness is a significant feeling of emptiness, isolation and disconnection. This state can sometimes be accompanied by additional feelings of sadness, a lack of meaning, misunderstanding and a lack of recognition, hopelessness, lack of purpose (a life without meaning); sometimes nostalgia; sometimes existential "anxiety" (asking the big questions of life and reflecting on the many limitations of human existence, mortality...); etc.

In summary:

» People who experience existential loneliness perceive themselves as disconnected from others, from their own humanity, from the world.

» They experience feelings of isolation, alienation, emptiness, abandonment and loss of identity.

» They describe feeling a lack of meaning, an absence of a life project or of a life that is considered worthy of being lived and meaningful.

» They notice a lack of connection with other people, a lack of relationship with the "outside world", an inability to communicate, as well as various fears: of disappearing from the earth or from life, of being forgotten, of being abandoned, of death, of anxiety, of pain and suffering.

» Existential loneliness can be linked to the abandonment we feel at certain times in our lives (such as deaths, divorces, etc.), to experiences of physical or mental decline or limitation due to illness, to the sense of finitude associated with ageing, to feelings of loss and longing, or to a sense of being a stranger in the face of a need for connection, belonging and companionship.

Table 6. Dimensions of existential loneliness

DISCONNECTION	FEELINGS	COMMUNICATION	SENSE OR MEANING OF LIFE
From oneself	Isolation	Impossibility to communicate	Lack of meaning
From others	Alienation		Lack of purpose
From the rest of humanity	Emptiness		Lack of life project
	Abandonment		
	Lack of connection		
	Fear		

Source: Compiled by the authors.

Mayers and Svartberg (2001) conceive existential loneliness as "a deeper form of loneliness in which the self is perceived as disconnected from others and the universe, along with a deeper feeling of loneliness, coupled with feelings of emptiness, alienation and abandonment." Van Tilburg (2021) believed that existential loneliness "is not the direct result of a lack of desired connections, but is related to a deeper sense of disconnection from the world." Finally, Leary and Asbury (2022) warned that existential loneliness might play a different role: "It seems that experiences of emotional and occasionally social loneliness are likely to be followed by feelings of existential loneliness, implying that existential loneliness may underlie or be a consequence of these well-established facets of loneliness."

Heidegger (1927) asserted that authenticity and self-fulfilment are found in genuine relationships with others; and in contrast, when authentic relationships are lacking and emotional loneliness is experienced, existential loneliness can become even more pressing. Therefore, it can be stated (Yanguas and Pinazo, 2024) that existential loneliness is associated with a sense of lack of meaning and incomprehension, which is a profound state of detachment and disconnection that goes beyond the physical absence of companionship. It arises through very diverse experiences and situations, such as when a person feels disconnected from themselves, from others, from the world around them; when they experience a lack of a life project, of meaning and significance, or have difficulties in finding purpose and direction in existence; or when crises, losses or transitions are of such magnitude that they affect the deepest part of their being.

The human being is a meaning-oriented being, we need to have purposes and lead a life congruent with our values, and to seek, in short, a fulfilling life, even if that fulfilment is something very difficult to achieve.

Before concluding this point, we would like to make a final analysis, through research studies (in particular, McKenna-Plumley et al., 2023; McKenna-Plumley, et al., 2020; Ikhtabi et al., 2022), on the way in which people who suffer existential loneliness live and express this experience.

Basically, four fundamental issues emerge in the qualitative analyses provided by participants in these studies:

» Deep feelings of disconnection, especially interpersonal disconnection.

» Strongly felt feelings of disconnection, emptiness, abandonment, etc., associated both with meaning or purpose in life and with people and community (the geographical context in which they live).

» Intense negativity in the evaluations made both about their situation and the feelings expressed.

» Stress and consequences on perceived mental health.

Table 7 (p. 38) offers definitions provided by people who experience existential loneliness and the essential elements of it:

Table 7. Main elements of existential loneliness

ESSENTIAL ELEMENTS	DEFINITIONS MADE BY THE PARTICIPANTS
Feeling alone	"Feeling that you are alone in this life." "Existential loneliness is the feeling of being alone in this life, that no relationship can change this."
Disconnection from the world and other people	"The feeling of loneliness that can never be fixed by the people around you because of the feeling of detachment."
Loneliness despite having relationships	"Having the company of others, but still feeling detached from others." "Feeling that no-one understands my thoughts, feelings and worldviews. I can feel 'existentially alone' in a room full of people."
A deep form of loneliness	"A deeper form of loneliness with no obvious cure that permeates all areas of life."
Inability to be understood, to fully share thoughts and feelings	"The feeling of knowing that you can never see exactly who another person is because you cannot live in their own individual world."
Lack of meaning in life or lack of purpose	"A lack of true meaning in life." "Feeling utterly alone in the face of an empty, infinite universe, with nothing meaningful to hold on to." "I would define existential loneliness as losing sight of the purpose of life." "A feeling of not belonging due to a lack of purpose."
Existential loneliness	"Feeling that you are alone and that you will end up dying alone." "Feeling completely alone in the universe."

Source: Compiled by the authors.

One last point. Now that later life is extending over time, for many people two or three decades of their lives, it is more necessary than ever not only to live, but also to exist. This is why we need to fill our lives with content, to be travellers and not wanderers, as Marije Goikoetxea (professor at the University of Deusto) often says, and it is from this intrinsic need that a forgotten form of loneliness emerges: existential loneliness.

7.
SOME CRITICAL ISSUES OF LONELINESS TODAY

In the last decade, and within the context already mentioned in the introduction of the weakening of relationships and the trivialisation of discomfort, intervention programmes have found it difficult to deal with the complexity of loneliness.

Both from a conceptual and evaluative point of view, there is (as mentioned above) a strong focus on cognitive discrepancy, leaving aside emotional, perceptual and social needs aspects, among others, which are unfortunately not taken into account. The evaluation is still very rudimentary. Asking someone when they last felt lonely, how intensely they felt lonely (mild, moderate or severe) and whether they have enough people they feel close to is not enough to minimally understand the different situations experienced by people who feel lonely.

Furthermore, there is a disparity between the experience of loneliness and the way it is approached professionally. From the "technical" perspective, loneliness is presented as a diaphanous concept that does not generate doubts (Rubio and Nieto, 2024), a notion that seems universal, which is experienced homogeneously; in contrast, the reality of people in situations of loneliness is much more complex. The nuances of their experience go beyond the frequency of feeling lonely, the extent to which they miss other people or the feeling of abandonment. It is common to find that people have doubts about whether they feel lonely, not only because of stigma, which do exist, but also because not all individuals explicitly understand when they feel lonely and when they do not. Likewise, there are difficulties in finding a single word to describe that amalgam of emotions, beliefs, assessments, feelings, etc., which people suffer and which often go beyond the gap between their reality and what they expect. Since the evaluation will determine the existence or not of a possible discrepancy, doubts arise as to our capacity to adequately grasp the very diverse situations of loneliness.

The difficulty of managing heterogeneity becomes evident when variables that are very relevant to understanding loneliness, such as gender, culture, generation, etc., are not usually taken into account. It makes no difference to us whether loneliness is experienced by a man or a woman, whether they are 65 or 85 years old, whether they live in the countryside or in a city, etc., because we offer them the same solution (usually company). We ignore how to deal with heterogeneity and, to use the English metaphor, we view care and loneliness intervention as a "one-size-fits-all approach", when those of us working in care know that the different dimensions that make up the different forms of loneliness require different approaches. For example, increasing general social contact may not be effective for someone experiencing emotional loneliness because they lack a close, intimate connection.

On the other hand, assessment tests for measuring loneliness place excessive emphasis on the frequency of feelings (*never*, *rarely*, *often*, *always*; *yes*, *no*, *sometimes*) and pay too little attention to duration or intensity: "How long have you felt lonely? Do you feel very lonely?", for example. There is a lack of knowledge, and we need research. We do not know whether frequent loneliness of low intensity and short duration is worse than

less frequent loneliness but of greater intensity and duration; we are unaware of know the importance of living chronic or prolonged loneliness. And what about the nuances of loneliness: is loneliness characterised by feelings of sadness or lack of recognition worse, or perhaps the kind dominated by feelings of emptiness and abandonment? We do not have the answer.

Returning to the issue of assessment, Victor et al. (2005) offer a paradigmatic example. They describe that the De Jong Gierveld Loneliness Scale has a sensitivity of 79% and a specificity of 68%. Sensitivity is the probability that the test correctly identifies as being lonely a person who is indeed experiencing loneliness; and specificity is the probability that the test correctly identifies as "not lonely" someone who is not. If we relied exclusively on this widely used test, our intervention would not be applied to 21% of those who need it and whom we have not identified, while we would administer it to 32% of those who do not need it. Insufficient.

There is another relevant issue linked to assessment. The ability of prevalence studies, so extensively employed, to capture situations of loneliness, is under question. We do not have a gold standard, a barometer of loneliness if you will, and since it is done through participant evaluation in which we ask whether someone's reality and their expectations coincide or not, we are unaware of the veracity of their answers, because given the existing social stigma around loneliness, it is quite understandable that many people may not wish to admit to this situation. Moreover, if we solely assess the discrepancy between what one wants and what one has, it may be that what is being measured as loneliness is actually dissatisfaction with relationships. For example, if we ask someone whether they receive the calls, visits or invitations they desire, and they answer in the negative, the feeling associated with this "lack" does not necessarily have to be a feeling of loneliness. They may feel angry or dissatisfied, without feeling lonely or isolated.

If we combine the way loneliness is assessed with the social stigma surrounding it, we obscure the complicated lives of people experiencing loneliness. If I admit that my child or mother suffers from loneliness, what am I acknowledging – that I am a bad parent or a bad child for not being able to end their loneliness? If I accept that I feel lonely, what does that mean – that my children do not pay attention to me? It is difficult to understand and assume that we can feel loneliness in spite of being loved, cared for and supported; that, as mentioned earlier, loneliness does not always stem from a deficit or from a lack, but is inherent to what we call the *human condition*.

Taking up the approach of viewing loneliness as a problem and, specifically, as a health problem, this perspective trivialises the possibilities of understanding and addressing loneliness by reducing its multidimensionality and complexity, while also medicalising our existence. Some proposals to consider loneliness as a new geriatric syndrome, made both in the press and in specialised journals, are evidence of this type of thinking, as is the widespread use of terms like *epidemic*, *tsunami*, *war*, etc., previously mentioned.

Two considerations arise from the problem-focused approach to loneliness: first, that loneliness is something "pathological", that it is harmful, that it must be eradicated;

second, that there is an external "combatable" cause (grief, loss, etc.) from which it stems. A quick search in any database (PubMed, for example) reveals a huge number of studies that frame loneliness as a problem in order to define it, measure it, delve into the risk factors, identify negative health outcomes and argue intervention strategies – all based on the premise that loneliness is pathological.

There is no reasonable doubt about the accuracy of their results, but this entire body of research is far removed from the reality of many older people, and its contribution to improving their quality of life is limited. Are the risk factors modifiable? Which ones – age, marital status, living conditions, the loss of loved ones? In many cases it is impossible to modify them and, therefore, from the problem-focused paradigm, the solution to loneliness becomes very complicated. Moreover, to assume solely that loneliness is caused by something external, be it bereavement, lack of family, illness, environmental or cultural factors, or biochemical imbalances in the brain, etc., is to implicitly accept a deterministic view and therefore to assume that loneliness can be predicted, controlled and "cured", treating it essentially as a disorder. But this perspective is not being questioned. What we are challenging is the idea that the only possible approach is that of "causality", that loneliness is caused by a lack of attachment relationships, for example. What if loneliness were also a feeling that has always been with us, something intrinsic to our humanity? Should we not stop viewing it as something exclusively caused by "modifiable" external factors, and instead accept that loneliness dwells within us, like joy or sadness, and learn to live with it?

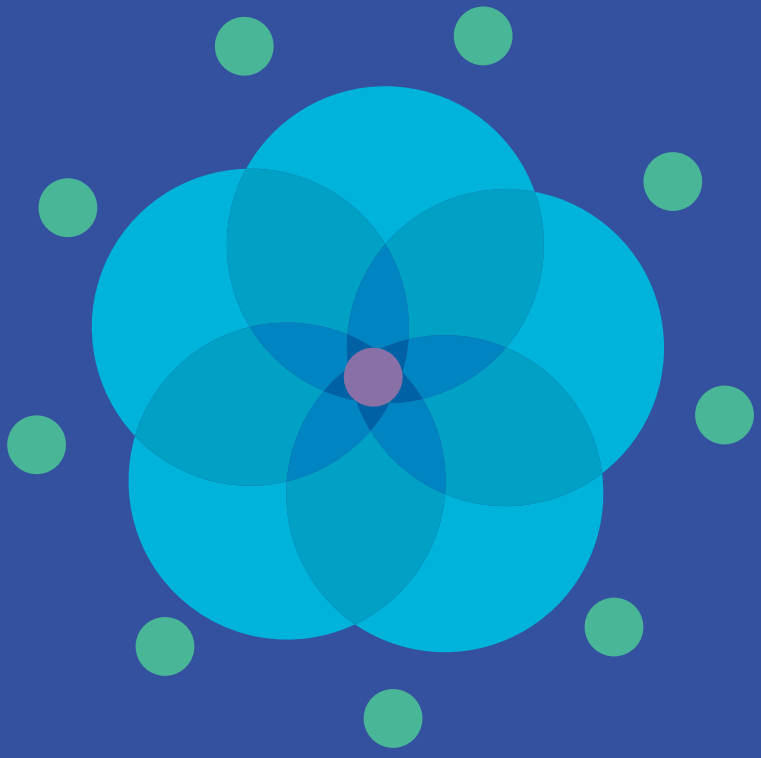
Other "critical" issues arise from the intervention. On the one hand, since loneliness is a phenomenon with both internal dimensions within individuals and external ones outside them, the focus is more on the community and interpersonal perspective than on the individual. Many of the existing programmes, both in Spain and abroad, focus their intervention on this *meso* and *macro* view of loneliness, which is essential; however, they neglect individual attention, which by no means has to be exclusively synonymous with therapy, but rather with companionship. There is a lack of balance between the internal and external perspectives of the person.

Two further points. Interventions, whether community-based or individual, place a lot of emphasis on the relational aspects of loneliness, which, although essential, are not everything. In fact, many people in situations of loneliness know what many professionals seem to overlook: that loneliness is not "cured" solely by company, that there are "non-relational" forms of loneliness, and that loneliness invades and penetrates multiple areas of a person's life. The idealisation of community as a "remedy" for loneliness is also striking. Going back to the introduction of this text, which addressed the fragility of relationships, it is hard to believe that an effective strategy for tackling loneliness can be organised on such weak relational foundations as the ones we currently have. Investing in social and relational architecture seems to be a prerequisite.

When older people who suffer from loneliness are consulted, it is unfortunately quite common for them to reveal that they find it difficult to talk about their experience because of the associated shame and stigma. Loneliness remains a taboo subject; those who experience it feel stereotyped and their experience trivialised.

Chapter 2

Intervention model



1.
INTERVENTION WITH THE PERSON

1.1. THE ALWAYS SUPPORTED PROGRAMME

The Always Supported programme was launched a decade ago with the objectives of fostering relationships, empowering people to cope better with loneliness, promoting social connections and minimising situations of loneliness. It is designed from three complementary perspectives:

1. **Individual or personal.** We support people with the aim of facilitating their empowerment through the acquisition of "personal resources", that is, knowledge, skills, experience, strategies, etc., that enable them to cope with situations of loneliness and manage their social relationships.
2. **Community.** This support is established through building connections, creating bonds and support networks among people and promoting interdependence.
3. **Raising public awareness** of the importance of relationships and loneliness.

The programme is aimed at people over 60 who live independently in the community and who may or may not be experiencing loneliness. In the latter case, they may present some risk[1] factors (for example, they have a weak social network, are carers, are going through transition or loss, etc.) that make it likely they will suffer loneliness in the short or medium term. They may perceive fragility in their relationships, and may have feelings of lack of belonging or inclusion in the community where they live.

When we talk about *empowerment*,[2] we refer, beyond the etymology of the word, to the person being the protagonist of their own change, having control over their reality and being responsible for the actions in which they are involved and by which they are affected, in order to be able to positively transform their situation.

Our goal is to empower people to cope with their loneliness. Therefore, we aim to facilitate the autonomy, dignity, self-esteem, etc., of the individual, promoting greater knowledge and understanding of themselves so they can connect with their desires and strengthen their will when it comes to making decisions, taking action, being the master of their own destiny, readjusting their life project, etc., and thus confront their loneliness and the reasons that cause it.

1. Essential aspects of these risk factors are described throughout this chapter (see specifically section 1.3.1, p. 46).
2. The idea of empowerment includes: *a*) the awareness of individual capacities; *b*) the acquisition and development of skills that enable active participation, either individually or in groups, in processes relevant to the person in which they must decide on important aspects of their lives.

From the perspective of the Always Supported (*Siempre Acompañados* in Spanish, literally meaning "always accompanied") programme, *accompany* – derived from the Latin word *companio*, formed by *con* ("with") and *panis* ("bread"), meaning "with bread" in the sense of "sharing the same bread" – is associated with the idea of walking a path together. The person who accompanies and the one who is accompanied share a common journey through the recognition of their dignity, and this means, among other things:

» that the person cannot be used merely as a means;

» that they are capable of determining their own goals in interdependence;

» that they demand to "be treated well", with consideration and respect, both in the fulfilment of their needs and in their role as a citizen (rights).

We aim to *accompany* people by facilitating relationships of trust, commitment and collaboration and by maximising their abilities to develop a personalised itinerary. In this itinerary, in addition and if necessary, different resources, programmes, services, community assets, volunteers, etc. should be jointly coordinated, managed and integrated, at the most appropriate time and place to suit the person's life project and their personal empowerment process.

In short, in the Always Supported programme, we *accompany* people who find themselves in a situation of vulnerability, with the aim of facilitating their empowerment so they can develop their own tools for managing their relationships or their loneliness through our support.

The processes of accompaniment and empowerment are based on another fundamental principle: the recognition of the intrinsic abilities people, in this case, older adults, who are seen as self-determined beings, active subjects of their own story and, therefore, capable of empowering themselves to manage their own loneliness.

1.2. THE ETHICAL PERSPECTIVE OF THE PERSON

The Always Supported programme has a personalised approach to care, a personalised approach which, as mentioned above, seeks an active role for older adults in the process and has personal autonomy as one of its core values.

We aim for personalisation based on interdependence, an active role through personal empowerment and integration with the community. The programme provides support, and the person makes the decisions.

Thus, this ethical and rights-based approach (Goikoetxea, 2022)[3] is fundamental, and in this respect it is important to highlight nine fundamental "principles":

3. For the preparation of this text we have used materials provided by Marije Goikoetxea Iturregi, professor at the University of Deusto, during a lecture given to professionals of the "la Caixa" Foundation's programme for the Elderly and entitled "The challenge of ethics in working with older adults".

1. The starting point is the recognition of individuals in a situation of loneliness. Each person is an end in themself, not a means, and is capable of determining their own goals in interdependence with others.
2. Equal dignity demands equal rights. Therefore, it is obligatory to treat the person well, with equal consideration and respect. "Good treatment" is, thus, a fundamental aspect of the Always Supported programme.
3. All people are autonomous, but not self-sufficient; we are individuals who develop and whose needs are met in "relationships with others". Transforming relationships and minimising loneliness are, therefore, two objectives that are always linked.
4. A self-fulfilled life is an autonomous life in which each person takes responsibility for themselves and their self-fulfilment project. The Always Supported programme also aims to support them in achieving this self-fulfilled life.
5. The programme understands that it is not enough to simply respect decisions (passive autonomy), but that it is also essential to provide support so that a person can fulfil and carry out, in continuity with their life, their obligations to themselves and to others, as well as their personal projects (active autonomy). In other words, we professionals are at the service of people.
6. Since, as mentioned earlier, the equal dignity of every human being requires treating them well, with consideration and respect, we aim to provide each person with tailored support and resources. Therefore, personalising the intervention is an obligation for this programme.
7. Our aim, with each person, is to support them as well as possible, that is, with professional commitment.
8. Supporting requires, in addition to full respect for their dignity and rights, taking into account their interests and preferences, and always counting on their effective participation.
9. We aspire to enable meaningful lives, in line with each personal identity, not only to identify relational deficits or situations of loneliness, but also to seek new opportunities to reconfigure the life project.

The programme is based on three areas of intervention:

1. **Individual.** Person-centred care, supporting and facilitating their empowerment process through:
   - personalised support;
   - group interventions.
2. **Community.** Fostering support and collaboration networks, taking into account the existing resources in the area.
3. **Awareness raising and sensitisation.** Highlighting the importance of social relationships and encouraging interdependence.

It is also supported by three levels of intervention (for a full description of these, see section 3.3, p. 99):

1. **Level I**: Promoting engagement and improving social connections, which is later referred to in the profiles covered by the programme as the ***network profile***.
2. **Level II**: Improving social relationships and preventing situations of loneliness, which we call the ***preventive profile***.
3. **Level III**: Intervening in situations of loneliness, referred to as the ***loneliness profile***.

We aim to achieve all of this by:

» taking into account the territorial idiosyncrasies and unique culture of each area, which means recognising the diversity and heterogeneity of each specific geography, of each community where bonds and the sense of belonging are established;

» involving competent professionals and with collaborative work, using a shared methodology among the various public administrations, organisations, associations and individuals in each area.

1.3. STARTING POINT: RISK FACTORS

The Always Supported programme addresses situations of loneliness by focusing on:

» risk factors;

» various variables that define the different social relationships;

» variables that have the capacity to transform feelings of loneliness;

» variables that mediate feelings of loneliness.

1.3.1. Risk factors

A risk factor (the modulating and mediating variables are explained in sections 1.5 and 1.6, p. 58, and p. 59, in more detail) is any characteristic of a person or their environment that makes the onset of distress, suffering, condition, illness, disorder, etc. more likely. Similarly, there are protective factors, which would be those that, when present or active, prevent or reduce the likelihood of distress, suffering, condition, disorder, etc., such as resilience.

Risk factors can be classified in many ways (see the 2023 review by Barjaková et al. for more information). We primarily work with two complementary perspectives: one focused on the individual and their community, and the other based on the constituent dimensions of these risk factors (physical health, demographics, psychological risks, etc.).

1.3.2. Distinction between individual and social risk factors

As the programme adopts both an individual and a community perspective, we apply this dual approach when analysing risk factors: an individual perspective and a social one.

Individual risk factors have been well defined in the scientific literature for some time. The most relevant ones (the evidence for each factor is reviewed below) are age, gender, migration history (whether the person has migrated or not), educational level, economic conditions, psychological factors (personality, negative affect, low mood, etc.), health (illnesses, mental health, need for assistance, etc.), marital status (and whether the person is in a partnership), lifestyle and living arrangements (living alone or with others, with children, etc.) and the degree of participation in social activities.

Social risk factors focus on the environment (urban or rural, neighbourhood characteristics, access to services, etc.) and on what are known as *contextual factors* (socioeconomic characteristics, sociocultural context, etc.).

As a complement to this perspective of risk factors (individual versus group), there is another interesting approach that also facilitates intervention across different dimensions. These include:

» Risk factors associated with health:
  – Common chronic illnesses and conditions: heart disease, stroke, cancer, etc.
  – Functional status (difficulties in activities of daily living), bidirectionally associated with social isolation and loneliness.
  – Sensory impairment.
  – Others.

» Demographic factors:
  – Age.
  – Gender.
  – Living alone or with others.
  – Marital status.
  – Having or not having family and friends.
  – Financial resources.
  – Having or not having housing.
  – Educational level.
  – Owning or not owning a car (related to the ability to travel independently).
  – Others.

» Psychological factors:
  – Psychiatric disorders such as depression, anxiety, etc.
  – Cognitive deficits that predispose the individual to feelings of loneliness.
  – In the case of carers, burnout or mental exhaustion, ambivalence, guilt, stress, etc.
  – Others.

» Sociocultural and environmental factors.

» Supportive relationships (especially with family, friends and carers).

» Community: characteristics.

» Other factors: communications, housing, migration, sexual orientation, etc.

» Life events:
  – Widowhood.
  – Admission to a care home.
  – Migration.
  – Losses in general and the loss of a partner in particular (a frequent and highly significant event).
  – Retirement and other transitions (divorce, etc.).

From the perspective of intervention, the risk factors of loneliness can also be analysed according to the modifiable - non-modifiable dichotomy. Modifiable risk factors are those that can be influenced to reduce their impact on the situation of loneliness; non-modifiable risk factors, on the other hand, are those that cannot be influenced.

The modifiability or non-modifiability of these factors may be associated with various issues:

» The constituent elements of the risk factor. For example, age is not transformable; gender, a priori, is not alterable; etc. On the other hand, if a person lives alone, living with others could be a way to address this risk factor, at least in theory.

» The intervention proposal of the programme, in this case, the Always Supported programme. For example, having a low level of social participation and social contacts is, a priori, transformable if action is taken on this factor, such as increasing participation in volunteer projects.

» The possibility of coordinating with other policies outside the Always Supported programme. By way of example, the loneliness of some older adults is due to problems of social isolation, such as accessibility issues in their homes. This is not about a lack of social network or the absence of significant people, which are issues that can be addressed by a loneliness support programme, but rather to an objective barrier: the difficulty of going down stairs and the absence of a lift. This risk factor (accessibility) could theoretically be modifiable if there were policies in place in a specific area to address the situation, although these are not within the scope of a programme focused on supporting people experiencing loneliness. Otherwise, if access to the outside world is not facilitated, the factor that "produces" loneliness in a given individual, namely isolation, will continue to do so.

The methodology of the Always Supported programme requires a thorough review of risk factors to determine whether or not they are modifiable. In cases where they are modifiable, intervention is carried out, either within the programme itself or through the community intervention model (see section 2.5, p. 77).

There is a possibility, which is certainly common, that not all risk factors can be addressed, and therefore the intervention cannot be completed in its entirety.

1.3.3. Current state of knowledge on risk factors for loneliness

We summarise several meta-analyses (including Barjaková et al., 2023; Gallardo-Peralta et al., 2023; Valtorta et al., 2016) regarding the empirical evidence on risk factors. This bibliography is included to provide an updated synthesis of the current state of knowledge on the issue.

1.3.3.1. Age

The results are varied. Some studies have found high levels of loneliness among adolescents and young adults, lower levels in adulthood, and an increase in loneliness in later life, indicating a U-shaped relationship between age and loneliness (somewhat inverse to well-being over the life cycle). Others, however, find that loneliness decreases linearly with age; still others find that it increases. In general, the relationship between age and loneliness is not linear but more complex, with various peaks and troughs in feelings of loneliness at different ages, although the highest peaks are observed in youth and later life.

In any case, the link between age and loneliness tends to be very weak (for example, Hajek and König, 2021) and ceases to be statistically significant when other risk factors are taken into account (for example, Dahlberg et al., 2021; Hawkley and Kocherginsky, 2018). This is confirmed by longitudinal studies on stability and changes in loneliness throughout life, which find that, although there appears to be a U-shaped relationship between age and loneliness cross-sectionally, the average level of loneliness remains fairly stable over the life course (Mund et al., 2020).

Age is therefore indirectly related to loneliness, and differences in loneliness across the lifespan are probably due to the varying prevalence of other risk factors for loneliness in different age groups. This is consistent with the theoretical proposition that age is a distal factor of loneliness, operating through other factors.

1.3.3.2. Gender

Gender is another factor present in almost all studies. A recent meta-analysis, measuring loneliness exclusively through standardised questionnaires that do not directly ask about loneliness and examining the relationship between gender and loneliness (Maes et al., 2019), concludes that men are slightly more lonely than women, but the difference is very small overall and often not statistically significant. When direct measures of loneliness are used, the prevalent finding is that women are more lonely than men or that there are no significant gender differences in loneliness (Bayat et al., 2021). One possible reason for this discrepancy is the willingness to admit feelings of loneliness between men and women, as men are more likely to hide their feelings if asked directly (Borys and Perlman, 1985).

Furthermore, gender-related outcomes depend on the type of loneliness measured. Men are more likely to experience social loneliness, while emotional loneliness is more common among women (Ten Kate et al., 2020; Von Soest et al., 2018). However, it could again be the case that women are more willing to admit to emotional loneliness, while men perceive it as more acceptable to acknowledge only social loneliness.

In summary, the results on gender differences in loneliness depend on what type of loneliness is being measured and how it is being measured, since men and women differ in their willingness to acknowledge feelings of loneliness. Nevertheless, it is also possible that there is no statistically significant relationship, meaning that gender, like age, only correlates with other factors that do have a direct impact on loneliness. In other words, gender also appears to be a distal risk factor for loneliness.

1.3.3.3. Migration

Most existing studies focus on nationality or an indicator of not belonging to a majority ethnic group. Focusing on European studies looking at how migration background affects loneliness, they find a predominantly positive relationship; in other words, immigrants of all ages report higher levels of loneliness compared to the native population (for example, Barjaková et al., 2023). However, some studies qualify that other risk factors for loneliness such as education, health or satisfaction with social relationships also need to be taken into account (Ten Kate et al., 2020).

In summary, migration is possibly associated with loneliness rather indirectly, with objective socioeconomic circumstances, such as health or income, or subjective feelings of belonging, being highly relevant.

1.3.3.4. Education

The evidence on the relationship between education and loneliness in older adults is quite varied, as shown by several literature reviews (Cohen-Mansfield et al., 2016; Dahlberg et al., 2021). Some analyses suggest a negative (that is, protective relationship: the higher the education level, the lower the loneliness), and some very recent studies (though not all) confirm this (Arpino et al., 2022; Nyqvist et al., 2021).

Therefore, there seems to be a direct, albeit weak, relationship between education and loneliness.

1.3.3.5. Work and unemployment

A recent systematic review summarises the evidence on the relationship between unemployment and loneliness (Morrish and Medina-Lara, 2021): loneliness is lower for those who are employed than for the unemployed (Morrish and Medina-Lara, 2021). However, these relationships often do not reach statistical significance and sometimes even opposite results are found (Luhmann and Hawkley, 2016).

It is possible that employment has a differential link with loneliness depending on age and geographical area. Having a (full-time) job is associated with lower levels of loneliness compared to being out of work among middle-aged adults, but younger adults, both those who work full-time and those who do not work at all, have elevated levels of loneliness (Hutten et al., 2022). Those who are younger than the average age for a given life event, such as the loss of close people, experience greater loneliness compared to those who are older than the average age (Buecker et al., 2021).

When longitudinal studies are examined, there appears to be a potentially bidirectional relationship between employment and loneliness (Morrish and Medina-Lara, 2021).

In summary, although cross-sectional data mostly point to unemployment being related to higher levels of loneliness, there is no strong evidence that this relationship is causal; rather, it appears to be bidirectional.

1.3.3.6. Financial situation

Longitudinal studies offer contradictory results: some find that a worse financial situation is associated with an increase in loneliness (Hajek and König, 2020; Von Soest et al., 2018), while others do not find a statistically significant relationship (Dahlberg et al., 2021). There appears to be a negative relationship between a better financial situation and loneliness (for example, Hawkley et al., 2020), including a meta-analysis on loneliness in older adults (Pinquart and Sörensen, 2001): having sufficient financial resources is more important for loneliness among middle-aged adults compared to younger and older adults (Luhmann and Hawkley, 2016), and the link between finances and loneliness weakens with increasing age (Franssen et al., 2020), probably because of the existence of public pensions in Europe. In fact, financial hardship is linked to loneliness among older adults more strongly in Eastern Europe than in Western Europe (De Jong Gierveld et al., 2012), and limited socioeconomic resources, together with poor health, may explain higher levels of loneliness among older adults in Spain, Italy, Czech Republic and Poland (Fokkema et al., 2012).

In summary, a worsening economic situation leads to an increase in feelings of loneliness, although part of the relationship may be due to other factors, such as health and social participation.

1.3.3.7. Psychological factors

The main psychological components as potential risk factors for loneliness are the five personality traits: extraversion, neuroticism (that is, the long-term tendency to experience negative emotions), agreeableness, openness and responsibility (Buecker et al., 2020). The remaining studies (Barjaková et al., 2023; Gallardo-Peralta et al., 2023; Valtorta et al., 2016) focus on various different concepts (for example, negative affect, shyness, low mood, personal mastery, feelings of worthlessness, irritability, hopelessness, resilience, optimism, etc.).

In general, loneliness is associated with extraversion and neuroticism (or its opposite, emotional stability). Other psychological characteristics that have been found to be associated with loneliness include, for example, low self-esteem or self-efficacy in both adolescents and older adults (Cohen-Mansfield et al., 2016); shyness; low levels of mastery in older adults (Van Tilburg, 2021b); high negative affect (possibly through a bidirectional relationship) (Böger and Huxhold, 2018); and low self-control (Stavrova et al., 2022).

1.3.3.8. Health

The literature on the relationship between health and loneliness adopts two different approaches: one examining the effects of loneliness on health (for example, Baarck and Kovacic, 2022; Holt-Lunstad et al., 2015), which are widely mentioned, and another examining the effects of health on loneliness, which are the most relevant for us.

Review studies on loneliness in older adults mostly find that those with better subjective health and fewer functional limitations report feeling less lonely (Cohen-Mansfield et al., 2016; Dahlberg et al., 2021). There is a positive relationship between poor physical health and loneliness (for example, Barjaková et al., 2023).

Regarding mental health, literature reviews and meta-analyses show that depression is statistically significantly related to loneliness in older adults (Cohen-Mansfield et al., 2016; Dahlberg et al., 2021). Longitudinal studies also show that depressive symptoms are associated with increased feelings of loneliness among middle-aged and older adults (Hajek and König, 2020; Nyqvist et al., 2021). Likewise, there is a strong association between mental health and loneliness in cross-sectional studies with samples of all ages (Barjaková et al., 2023).

In summary, there is evidence that physical and mental health are associated with loneliness.

1.3.3.9. Marital status, having or not having a partner

In cross-sectional studies, having a partner or spouse is consistently associated with lower levels of loneliness, while being single, divorced or widowed is associated with higher levels of loneliness (for example, Arpino et al., 2022; Cohen-Mansfield et al., 2016). This relationship with loneliness is often one of the strongest among all predictors, especially when it comes to widowhood (Hajek and König, 2020).

Longitudinal studies broadly confirm the above and suggest that the link between relationship status and loneliness may be causal.

There is some evidence that loneliness already increases before a divorce or separation, whereas no such change is observed in the case of widowhood, where the shift to loneliness only occurs after the event (Buecker et al., 2021). As seen in other studies, having a good marital or partner relationship, the emotional support received from the partner, having the partner as a close confidant or even a good sex life, are protective factors against loneliness, while a poor-quality relationship with the partner is associated with more feelings of loneliness (De Jong Gierveld et al., 2009).

In conclusion, partner status (or its change) is one of the most important direct determinants of loneliness. The group at particular risk of experiencing loneliness are widows and widowers, although divorced or single individuals are also affected.

1.3.3.10. Lifestyles and living arrangements

Among the few longitudinal studies that assess the impact of a change in living arrangements (moving to live alone, transitioning to an "empty nest", starting to

cohabit) on subsequent loneliness, none find a statistically significant relationship (Kristensen et al., 2021). However Buecker et al. (2021), suggest that there may be an inverse relationship between loneliness and living arrangements, meaning that lonelier individuals may be more likely to live alone.

Cross-sectional studies show that living alone is associated with significantly higher levels of loneliness compared to other living arrangements (for example, Barjaková et al., 2023). It appears that the presence of a partner in the home makes the biggest difference for loneliness, at least for older adults (De Jong Gierveld et al., 2012). On the other hand, living with children (or parents in the case of young adults) does not seem to help protect against loneliness (Hawkley et al., 2020). In fact, there may be a U-shaped relationship between household size and loneliness, with older adults living with someone else being the least lonely.

In summary, living alone is strongly associated with more feelings of loneliness, while living with others is linked to less loneliness, especially if there is a partner in the home. For older adults, living in nursing homes or other care facilities is possibly associated with higher levels of loneliness than living in the community.

1.3.3.11. Social network

Having a larger social network and at least one significant intimate connection (a confidant) is related to fewer feelings of loneliness (for example, Milicev et al., 2022). However, longitudinal studies tend not to find statistically significant effects, at least when it comes to older adults (Dahlberg et al., 2021; Nyqvist et al., 2021). It is possible that loneliness also affects the size of the social network, and this link may be stronger than the reverse (Böger and Huxhold, 2018).

Some authors suggest that more important than the number of social contacts is perhaps the frequency of socialising with them. Evidence shows quite consistently that the more frequently people socialise with others the less lonely they feel (for example, Guthmuller, 2022). There are also indications in longitudinal studies that being with social contacts more often leads to more pronounced decreases in loneliness (Hawkley and Kocherginsky, 2018; Von Soest et al., 2018), although this is not always the case (Nyqvist et al., 2021).

Contact with friends is generally more protective than contact with family and neighbours (for example, Pinquart and Sörensen, 2001), but sometimes it is family members who matter most (Hawkley et al., 2020; Ten Kate et al., 2020), and the difference is possibly due to different environments.

Meeting friends when one feels like it is associated with less loneliness among young people, but the amount of time spent interacting with them on social networks is not (Marquez et al., 2023). Moreover, when satisfaction with contact with friends is taken into account, the statistically significant link between objectively measured contact frequency and loneliness disappears (Nicolaisen and Thorsen, 2017). In other words, what seems to matter for loneliness is being satisfied with how often one sees friends, regardless of the frequency itself.

It also appears that better quality of relationships is associated with lower levels of loneliness and matters more than the quantity of those relationships (Pinquart and Sörensen, 2001). In addition, a recent meta-analysis shows that the relationships between the quantity and quality of friendships and loneliness may be bidirectional (Schwartz-Mette et al., 2020). Conflicts in personal relationships in general are strongly linked to feelings of loneliness, whereas good relationships, for example with neighbours, seem to protect against loneliness. The same is true for receiving social or emotional support from one's social network (Dahlberg et al., 2018).

Interestingly (and this is relevant for loneliness programmes), giving emotional or instrumental support seems to be associated with less loneliness in older adults (De Jong Gierveld et al., 2009 and 2012), but in some cases, receiving the support actually has the opposite effect (De Jong Gierveld et al., 2012). Similarly, providing informal care is associated with less loneliness across all age groups, while the relationship is reversed if the care is very intense (Hutten et al., 2022).

Having (more) children appears to be associated with lower levels of loneliness among older adults, but what is truly essential is the quality of the relationship and the frequency of contact with them (De Jong Gierveld et al., 2009; Niedzwiedz et al., 2016).

In short, loneliness is in fact directly and strongly linked to various aspects of people's social networks, and it seems that, rather than the size of the network, its quality and functionality are the factors that define the relationship. Frequent contact with friends and family, good relationships with them and giving and receiving social and emotional support are important protective factors against feeling lonely.

1.3.3.12. Social participation

Social participation is usually measured by the frequency of participation in a combination of activities (which produces an overall measure of engagement) or in specific activities, such as religious activities or volunteer work. Some studies also look at the effect of mere membership of different groups or organisations.

In general, studies in older adults tend to find a positive link between a lack of social activity and loneliness (Fokkema et al., 2012; Niedzwiedz et al., 2016). In other words, the less socially engaged a person is, the more likely they are to feel lonely. There is also some evidence that this relationship is due to a reduction in social activity (Aartsen and Jylhä, 2011), or dissatisfaction with the amount of social activity rather than its absolute level (Guthmuller, 2022).

In the general population, the relative level of social activity compared to other people of the same age also has a significant link with loneliness (Victor and Yang, 2012). Moreover, there is some evidence for the bidirectionality of the relationship with loneliness, which has a stronger impact on social activity than vice versa (Böger and Huxhold, 2018).

When examining the frequency of participation in specific social activities (such as volunteering, religious activities or various group gatherings) across all age groups,

the association with loneliness is often not statistically significant, at least when other factors are taken into account (for example, Marquez et al., 2023), or is only significant in some countries (Tonković et al., 2021).

Social activity possibly affects loneliness through its impact on social networks. Social support has been found to explain the association between religious attendance and loneliness (Rote et al., 2013), while group membership has been statistically linked to both the size of the social network and the frequency of contact with others.

In summary, being more socially engaged is generally associated with lower levels of loneliness. However, the relationship is possibly bidirectional and mediated by the characteristics of the social network, making social activity a proximate, but not entirely direct, risk factor for loneliness.

1.3.3.13. Environment

Relatively few studies focus on the relationship between the living environment and loneliness, and there are also few that use environmental characteristics as control variables.

Greater friendliness (availability and accessibility) in the neighbourhood (in terms of, for example, services, social venues or leisure facilities) is mostly linked to lower levels of loneliness (Bower et al., 2023), as is greater access to social areas and a stronger "affective closeness" to neighbours, for example (Bower et al., 2023).

Residential density, the degree of urbanisation or living in an urban or rural area do not seem to have a significant association with loneliness, at least when other characteristics of the built environment are taken into account (Bower et al., 2023), with some exceptions showing that a higher degree of urbanisation is linked to slightly higher levels of loneliness (MacDonald et al., 2020). With respect to transport, there appears to be a negative relationship with loneliness (the better the transport, the less loneliness), especially when public transport is taken into account.

In summary, certain characteristics of the living environment show relationships with feelings of loneliness, and the most important determinants are the subjective assessment of the neighbourhood and access to various facilities or green spaces.

1.4. INTERVENING IN SOCIAL RELATIONSHIPS

Another area of assessment and intervention is associated with social relationships and especially with three "classic" variables with which three types of relationships are conceptualised and which are fundamental both for the well-being of the person and for coping with loneliness:

» Social network.

» Social support.

» Engagement.

1. **Social network** refers to the interactions of a person or a social group (general social network). It is the structure of social relationships, which is why it is often discussed in terms of size and frequency of contacts between members of a network (family, friends, professional, etc.). In addition to frequency, there are other highly relevant attributes:

» *Affective closeness*, which refers to those personal relationships with whom we can share emotions, feelings, and significant matters.

» *Tangibility*, which refers to the confidence in receiving support if needed.

2. **Social support** is a specific type of relationship that is highly relevant, especially when we need support and help in times of vulnerability. It is a transactional process (we both give and receive support). Through social support, our relationships provide us with a "space" for the exchange of:

» emotional experiences (emotional support);

» assistance with practical matters (instrumental support);

» relevant information for daily life (informational support).

3. **Engagement** (commitment to relationships) is related to the frequency and quality of formal activities (for example, religious activities, attending meetings, volunteering, etc.). It is also connected to informal activities (for example, telephone calls, meeting up with friends, etc.) that a person engages in with members of their social network and feels "committed" to participating in. Engagement is defined by commitment to people and projects. The higher the engagement, presumably, the lower the loneliness.

The Always Supported programme intervenes, whenever necessary, to increase and improve both the social network (especially the quality of relationships) and social support and engagement, as relationships are a fundamental part of all interventions in loneliness.

The most commonly used types of intervention programmes are the following:

» Increasing contact with other people is the most common type of intervention. It can be carried out in pairs or groups and can involve other people in the same situation, as well as family members, volunteers, etc. The goal is to widen the social network, make connections, share activities and so on. Formats with or without a predefined script can be used and, depending on the objective pursued, training for the participants is necessary. For example, if the aim is to provide instrumental support (such as

supporting someone with transport, shopping, etc.), a lower level of training is required than if the idea is to offer emotional support.

» A second type of widely used intervention is that which encourages participation in group activities and, through them, foster supportive relationships, friendship or companionship among group members. They can be grouped into two main formats:
  – Groups based on interest in the activity: songwriting, gardening, painting, pottery, dance, music, etc.
  – Discussion groups: through guided and facilitated debates on a predetermined topic of interest, ranging from a film to the role of older adults in our society, and including health and other issues. Beyond the mere exchange of opinions, it is important for group members to provide each other with emotional support.

» Contact with animals or animal-assisted therapy is a type of activity in which participants are paired with an animal, usually a dog or cat; it can also involve group sessions with animals. The goals of this type of intervention focus on promoting care, improving the social network, providing social support and engaging in purposeful activities. Interactions with the animal may include talking to it, holding it, petting it, playing with it, taking it for a walk, etc.

» Social skills interventions promote the development of an individual's abilities to deal with loneliness and social relationships. Participants are trained to increase access to interpersonal resources or contacts and to develop psychological skills, such as expectation management, self-esteem, self-management, communication, etc., as well as mindfulness during interactions, which is essential for maintaining and developing strong interpersonal relationships. These interventions are aimed, like most of those we are describing, at improving social networking, support, connection, care and self-care, management of well-being and stress.

» Multicomponent interventions may combine non-specific approaches using a mix of techniques with explicit objectives. For example, healthy ageing programmes are common, which, although not specifically focused on loneliness or relationships, use techniques (such as reminiscence or physical activity) in a group format (group activities) that can alleviate certain situations. The components of these interventions are not clearly conceptualised or described and can combine fitness, art, social or leisure activities, improved transport, access to information or resources, etc. They are sometimes conceptualised as aiming to increase the frequency of social interaction, social support, personal development and social participation.

» Other interventions seek to increase the possibilities for spontaneous and intentional interaction by providing opportunities to connect and interact with others.

» Peer support groups, led by professionals, are also common; these involve people experiencing loneliness and have been widely described in the literature (for example, Zagic et al., 2022; Wang et al., 2023; O'Rourke et al., 2018).

1.5. INTERVENING WITH RESOURCES CAPABLE OF TRANSFORMING FEELINGS OF LONELINESS

One of the key aspects of intervention in loneliness is providing tools and support to help individuals learn to manage their own loneliness, what we sometimes call *personal resources*. These tools, such as coping strategies, are capable of influencing those feelings of loneliness by modulating or transforming them. They can be worked on both individually and in groups, with the most relevant being:

Table 1. **Most common types of intervention for feelings of loneliness**

Emotional management	Training in emotional self-regulation: learning to identify, understand and manage emotions. Includes modifying emotions that hinder the person: laziness, fatigue, fear of failure, fear of being a burden, etc.
Changing coping strategies	Coping strategies are the cognitive and behavioural efforts we make to deal with external or internal situations that cause us stress, such as. loneliness. We work on changes in coping strategies for loneliness: from passive to active strategies; from strategies focused on filling life with activities to those focused on a purposeful life, etc.
Managing vulnerability	Learning to identify, understand and manage vulnerability and fragility. These are similar to emotional coping strategies, only with a particular focus on loss, but also on other physical and emotional vulnerabilities that lead to loneliness.
Time management	Learning to manage and plan time.
Building a life with meaning and purpose	Specific methodologies have been developed to help people lead a life more in line with their personal values.
Creating and developing a new life project	With a similar goal to the previous one, but these are strategies specifically designed for times of transition. Closely related to existential loneliness.
Loss management	Learning to manage losses (grief), one of the main causes of loneliness.
Social skills	These are used to improve social relationships and ways of interacting. They include, among others, non-verbal skills related to body language, such as facial expression, eye contact, gestures and postures, etc.; basic conversation and communication skills, etc.

Cognitive changes	Changes in ideas, beliefs and attributions about relationships, loneliness, etc.
Cognitive inflexibility	Intervening on cognitive inflexibility (very common in people experiencing loneliness), for example, by learning how to change habitual routines that cause discomfort, how to step out of the relational comfort zone to expand the social network, how to move from a context where the person feels secure to a broader one, etc.
Dichotomous thoughts	Transforming dichotomous thoughts very common in people experiencing loneliness, for example, "I used to have everything: a husband, children, parents... now I have nothing."
Indirect changes	Working on indirect changes, such as greater acceptance and more distancing (diffusion).

Source: Compiled by the authors.

The programme understands that knowing how to manage these personal resources (along with other community and supra-community interventions described later) offers each individual the possibility of acquiring and implementing tools that help them manage their own loneliness. In other words, we seek personal empowerment through interdependence.

It is beyond the scope of this manual to provide information on the various types of existing interventions, but the empirical evidence (see, for example, Lasgaard et al., 2022), which was scarce until recently, has improved in recent years, and the benefits of these types of intervention are beginning to be seen.

1.6. INTERVENING ON VARIABLES THAT MEDIATE FEELINGS OF LONELINESS

Maintaining projects, interests and activities, as well as social engagement, is fundamental for a good later life. Throughout the life cycle, people change their roles, among other reasons, to maintain social integration, increase social capital and improve quality of life, even as our social network generally diminishes. Thus, leading an active life, participating in projects and activities – especially those that are meaningful – not only favours the building of new relationships, but is also a prerequisite for reducing levels of loneliness (Niedzwiedz et al., 2016; Aartsen and Jylhä, 2011).

The Always Supported programme intervenes (using its own resources and, especially, in collaboration with other community entities and resources) on variables that can "mediate" feelings of loneliness, specifically:

» Promoting social engagement and participation.

» Encouraging health habits, such as physical exercise, nutrition, improvement of lifestyle habits (sleep), for example, which particularly affect people experiencing loneliness.

» Reducing the digital divide and facilitating technological literacy.

» Facilitating artistic expression (painting, writing, etc.) through essentially solitary activities that promote well-being when the person is alone.

All these mediating activities (most of these intervention programmes have already been discussed in section 3, p. 96) aim to improve subjective well-being that facilitates the empowerment of individuals to be able to manage their own loneliness.

1.7. THE MODEL OF INTERVENTION WITH THE PERSON

The Always Supported programme's model of intervention with the individual includes four main elements (see Figure 1):

» Minimising risk factors.

» Improving social relationships (social connections).

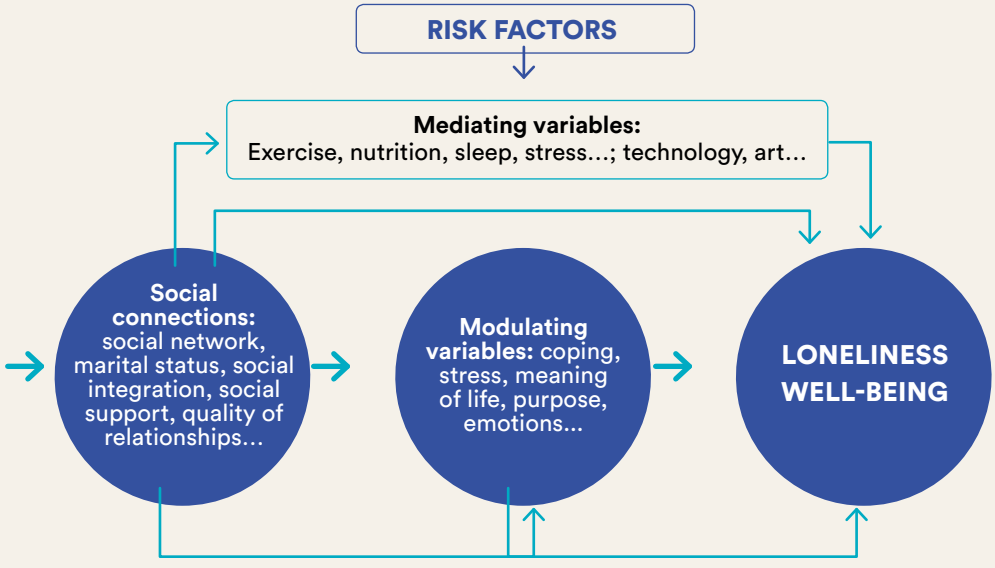
» Working with variables that mediate situations of loneliness.

» Intervening on variables that modulate loneliness.

» Seeking to improve situations of loneliness and enhance well-being.

Always with the individual and in a personalised manner.

Figure 1. **Intervention framework of the Always Supported programme**



Source: Compiled by the authors.

2.
COMMUNITY ORIENTATION

2.1. INTRODUCTION

At the present time, several processes are significantly transforming both the life cycle and the primary relational network, leading to situations of difficulty – more localised or more generalised – which call for the strengthening of public policies and social strategies that promote a fulfilling life across the different stages of life, and which also protect, strengthen and regenerate the fabric of family and community relationships (Fantova, 2021).

In this regard, one of the emerging issues in the question of loneliness is the role of community and community relationships, as it is becoming increasingly clear that the community and local area are some of the keys to the future of social sustainability.

This approach does not imply an idyllic or static vision of "the community" and everything related to it. Local communities are being affected by the rapid transformations of the contemporary world, and global challenges are altering the existing balances in the immediate environment. The reconfiguration of family structures, changes in the life cycle, the weakening of community ties and the loss or under-utilisation of places or moments for gathering, among other aspects, mean that common points of reference, leadership and the dynamics of social cohesion are now more diffuse and contingent. In most local communities, the primary networks or movements that aspire to provide collective responses are practically non-existent or very weak due to their inability to organise, protect and promote common goods.

On the other hand, public policies and interventions organised by sectors of activity (which, in principle, seems rational) face difficulties in dealing with complex challenges like loneliness. These difficulties affect both individuals and communities.

There are not only vulnerable people or groups, but also fragile communities. This not only fails to prevent us from actively contributing to building more participatory, equitable and supportive communities, but it also urges us to do so. As previously highlighted, the community represents a fundamental factor for individual and collective quality of life and well-being: an environment of welcome, hospitality, trust, care and protection (Del Pozo, 2023).

However, it is important to recognise that the community-based approach is not the only way to "address all problems". It should not be idealised or presented as a panacea, but its limits, derived from its nature, principles or scales, should be known and accepted. It is also essential to promote it in such a way that it is not perceived as a substitute for individual or sectoral intervention. The community approach complements and integrates the individual and sectoral, and vice versa. If the community approach were to exclude these types of interventions, or if they were to exclude the community approach, it would ultimately contribute to the alienation of the most vulnerable sectors.

That said, we know that transforming this reality by means of social processes generated through community action or intervention would require transversal and structural components, as well as a wide range of local stakeholders, which goes beyond the scope of a specific programme aimed at addressing loneliness within a particular segment of the population.

For this reason, the Always Supported programme does not adopt an overall, comprehensive approach (Hernández, 2010) or a community-wide intervention, but rather proposes a sectoral approach aimed at addressing the different situations of loneliness among older adults with a community orientation or focus. That is, from the logic of person-centred support (individual and group) and from the community logic (connection and collaboration), it seeks to address the different situations of loneliness in different ways, sharing perspectives and objectives with other community agents in order to jointly develop strategies that:

» support the care of and companionship for older adults of different ages, abilities, possibilities and interests;

» connect or reconnect these people with their community;

» promote relationships, bonds, cooperation and support based on proximity;

» foster stronger, richer and more dynamic community networks;

» encourage the development of communities that are better able to respond individually and collectively to the challenges they face, especially the relational challenge.

In this way, the central element around which the community orientation of the Always Supported programme pivots is collaboration with and among community agents, taking into account local dynamics and the resources available in the area, and supporting and relying on community relationships and the environments of the people receiving care.

2.2. REFERENCE FRAMEWORK

Based on a theoretical framework on loneliness and later life developed by the programme's scientific director, Javier Yanguas, and enriched with contributions from various authors on the community approach (Marchioni, 2019; Fantova, 2020; Cofiño et al., 2022), along with applied research and experiences accumulated over ten years in different regions, an intervention model has been designed that encompasses the following dimensions:

» **Individual.** Person-centred care that aims to develop individuals' abilities and empower them to manage their feelings of loneliness.

» **Group.** Care focused on generating changes in individuals and in their daily lives by using the group as a tool for learning and change.

» **Community.** An approach based on proximity and closeness, seeking collaboration across different sectors and various stakeholders to try to reach those who feel lonely and provide them with more integrated support. This facilitates connection, new bonds and a sense of belonging by strengthening neighbourhood, social and community networks.

These different dimensions incorporate key elements that represent the theoretical and methodological framework of the programme, and more specifically, of its community-oriented approach. Before delving into each of them, it is important to bear in mind certain aspects:

» They are synergistic and should not be viewed separately. They need to be considered as a whole, as they influence and affect each other. Their significance is greater or lesser to the extent that they interact with each other.

» They are always present or acquire greater weight depending on the phase of the programme or how long it has been running in a given area. While Always Supported has a very specific purpose, its approach is not short term, but rather one of continuity and sustainability over time.

» They could be organised in many ways because they simultaneously impact both the community reality and the intervention itself. The numerical order that follows reflects one way of structuring them and does not indicate any hierarchy of value or preference.

Figure 1. **The 10 keys to the community orientation of Always Supported**

1	Participation and networking	Of lead entities, local stakeholders and volunteers
2	Diversity and heterogeneity	Recognising the idiosyncrasies and specificities of each community
3	Knowledge	Considering the conditions and available resources
4	Relationships	Collaboration and trust with and among local actors
5	More integrated support	Through coordination and shared responses
6	Encounters	Fostering moments for social interaction and active participation
7	Awareness raising and training	Highlighting the importance of social relationships and fostering interdependence. Educational approach
8	Meaningful experiences	To provide collective responses to felt needs with a focus on transformation
9	Innovation	Generating knowledge and innovative methodologies. Offering endogenous responses through experimentation
10	Evaluation	To incorporate learning and continuous improvement

Source: Compiled by the authors.

Key 1. Participation and networking

By *participation* and *networking* we refer to collaboration and coordination between different actors and organisations to jointly address the needs and challenges of an area, group or community. This approach promotes cooperation and synergies among public and private entities, the third sector and citizens, enabling a more integrated and effective intervention. Such a network will require a relational and organisational system that allows the sharing of resources, knowledge and experiences to optimise efforts and improve care outcomes.

In addition, networked intervention fosters the building of trust and mutual support among participants, enhancing the capacity to respond to complex and emerging situations. This not only improves the effectiveness of interventions, but also contributes to the empowerment of communities and promotes their active role and resilience in facing local challenges.

In the case of Always Supported, the following stakeholders participate in the programme:

» **Lead entities.** Partnerships are established to promote and develop the programme between the local administration, a local entity and the "la Caixa" Foundation. The city council, which in addition to its public responsibility to attend to social demands and being the closest administration, provides primary care services related to people's well-being and social interaction; the local entity, which has strong ties and knowledge of the area as well as experience, influence and the ability to facilitate dialogue; and the "la Caixa" Foundation, which provides the theoretical and methodological framework, as well as the sustainability of a professional care team.

» **Network of local stakeholders.** Interaction, cooperation and networking are encouraged among various services, projects and initiatives, involving individuals and entities from the area that actively participate or collaborate occasionally in supporting people and strengthening community bonds and relationships.

» **Volunteering.** Support is provided with the collaboration of volunteer organisations and individuals who contribute to fostering personal development, social and community interaction or awareness raising and outreach.

Key 2. Diversity and heterogeneity

Both concepts refer to recognising the cultural, socioeconomic and demographic differences among individuals, groups and communities, specifically:

» Recognition of both inherent and acquired diversity within the population to adapt resources and strategies to the particular reality of each person or group, thereby promoting more inclusive care.

» Recognition of the diversity and heterogeneity of the different local communities when developing the same social intervention, to adapt strategies and approaches to the particularities of each context and the characteristics of the community, the place where bonds are formed and the feeling of belonging of the older person.

Key 3. Knowledge

With this term, we refer to knowing (recognising, understanding, becoming familiar with...) the conditions and resources available in each area (demographic and socioeconomic characteristics, facilities, services, programmes, social fabric, groups, activities...), prioritising those with an impact on community life and, specifically, those most closely related to older adults.

Key 4. Relationships

One of the priorities in any action or intervention in a community is to foster interdependence and shared responsibility through the establishment and continuity of trust-based relationships and among the different local stakeholders. For Always Supported, maintaining these relationships over time enables more coordinated and effective responses that promote the social interaction of the people supported by the programme in particular and older adults in general.

Key 5. More integrated support

Coordination with and among local stakeholders to provide shared responses to specific needs using existing resources is essential for a more integrated and effective social intervention. This coordination allows for the optimal use of available resources, avoiding duplication and fostering synergies that enhance the impact of actions. Moreover, by working together, local stakeholders can more clearly identify the specific needs of the community and design more suitable and tailored responses to address the different situations of loneliness.

More integrated support also facilitates the creation of more sustainable networks where different players can complement each other's skills and experiences. This collaborative approach to addressing loneliness not only improves efficiency in the use of resources, but also strengthens the social fabric by promoting a culture of shared responsibility and mutual support.

Key 6. Encounters

One of the aims of the programme is to foster moments of social interaction among older adults by providing opportunities to develop meaningful relationships and new connections within an environment where they feel valued and listened to. In addition, these encounters also encourage the active participation of people in their community life and generate a more inclusive and supportive environment.

Key 7. Awareness raising and training

Always Supported seeks to address the challenges posed by the new longevity through an educational approach, providing tools and knowledge to help stakeholders and the wider community become aware of the changes associated with ageing. This is achieved through the following actions:

» **Providing information and raising awareness** about the importance of social relationships and about the various situations of loneliness experienced by older adults.

» **Training for the most engaged local stakeholders** to help them understand the theoretical and methodological approaches of the programme and the challenges of new longevity, so that they can take ownership of these ideas and use them to improve their practices, experiences or interventions.

» **Ongoing training for Always Supported teams** to ensure high-quality care by enhancing their professional competencies and personal skills.

Key 8. Meaningful experiences

Understood as transformative initiatives created through the identification of shared needs and objectives in the areas of loneliness and ageing, these experiences foster the responsibility and capabilities of each local stakeholder, taking into account the characteristics and idiosyncrasies of the context where they are developed.

In the programme, such initiatives are referred to as territorial projects (see section 2.5.6, p. 92). By focusing on common goals and adapting to the specificities of their environment, they ensure a more effective and integrated response to the local challenges of longevity while strengthening the community fabric.

Key 9. Innovation

We refer to innovation that promotes the ability to experiment and adapt methodologies based on the context to strengthen local responses, and that also allows the development of practical and applicable knowledge to be shared and replicated in other settings, thereby increasing its impact and effectiveness. This innovation, therefore, not only improves the quality of interventions, but also fosters a culture of continuous learning and adaptation that is essential for addressing current and future challenges.

In the specific case of Always Supported, innovation generates knowledge and innovative methodologies through experimentation in each area, enabling the development of endogenous responses tailored to local characteristics. This experimental approach not only fosters the creation of new procedures and collaboration agreements, but also ensures that the solutions are relevant and sustainable, contributing to the quality and social innovation of the programme.

Key 10. Evaluation

In Always Supported, evaluation of the various initiatives and of the community organisation is fundamental to incorporate lessons learned and promote continuous improvement. This process involves a systematic analysis of results, identifying both achievements and areas for improvement. By integrating these insights, the methodologies and strategies can be adjusted, thus ensuring that initiatives, shared objectives and collaborative workspaces become more effective. Furthermore, evaluation fosters a culture of transparency and accountability, which strengthens trust among the stakeholders and ensures that the actions undertaken respond efficiently to the needs identified.

2.3. ELEMENTS THAT CHARACTERISE COMMUNITY ORIENTATION

2.3.1. What is community?

Although there are various meanings and interpretations of the word *community* that refer to spatial frameworks (local, regional, national, European, international, etc.) or to shared characteristics among human groups or collectives (values, interests, customs, languages, cultures, etc.), for the Always Supported programme the community is always local (neighbourhood, district, area, town, city) and is made up of four structural elements: territory, population, resources and needs (Marchioni, 1987).

Based on this framework, the concept of *community* refers to smaller human collectives with certain affinities that help their members to identify with one another and with other people, or are usually linked to a manageable space or territory where community relationships play a significant role in their structure and, ultimately, in their constitution (Vega et al., 2018).

2.3.2. Who are the local stakeholders?

Local stakeholders can be classified in various ways and their scope can be individual, group-based or collective (associative or neighbourhood networks, public services, economic and commercial agents, private entities, informal groups, individuals, institutional representatives, etc.). To establish a typological criterion within the democratic framework that governs contemporary society, these different stakeholders can be identified according to the role they play in the community (Marchioni et al., 2015).

» **Citizen role.** This refers to the individuals who live, work, study, etc., in the local community in question. Citizenship can be considered on an individual basis or as a collective agent (associations, informal groups, platforms, etc.).

» **Professional technical role.** This involves professionals from public administrations or private entities who work – or whose work has an impact – in a given territory. These professionals are essential both in addressing the specific needs of individuals and groups and in meeting local demands from a more integrated and community-focused perspective.

» **Institutional decision-making role.** This includes people who represent administrations at different levels as decision-makers of public policies. In this context, the institutional role played by those who represent private entities that are strategic to the programme is equally important.

These different roles of local stakeholders are, in turn, connected to the role that each of them plays in the Always Supported programme, considering the following: lead entities, other local stakeholders and volunteers. We will now examine each of them in more detail.

2.3.2.1. Lead entities

The *lead entities* are those that promote and coordinate the development of Always Supported in a specific area: the local administration, the managing entity and the "la Caixa" Foundation. The relationship between these agents, as well as their levels of responsibility and involvement, is established by means of a collaboration agreement that encourages joint efforts and outlines the contributions and commitments of each party to achieve shared objectives effectively and in a coordinated manner. Each of them is represented by key contacts at both the technical and institutional levels.

» **Local administration.** The city council has a public responsibility to address social demands: ensuring access to essential services and the overall well-being of all citizens. It acts as a pillar in promoting a fair and cohesive community by ensuring that policies and resources are effectively directed towards meeting the needs and improving the quality of life of the population, especially the most vulnerable. The local administration also has a key role to play because of its knowledge of the area, its relationship with the different stakeholders in the municipality and its ability to coordinate across its various departments and policies (social services, volunteering, centres for older adults, participation, sports and culture, etc.), a coordination that will be essential to provide the most integrated intervention possible at both the community, individual and group levels. It should be noted that, in some areas, the agreement is also signed with the regional autonomous administration.

» **Entity that drives the rollout of the programme.** An entity with experience and a strong track record in the local area, through which the professional team of Always Supported is organised. Knowledge of the area, local roots, influence and the recognition it receives from the different stakeholders are fundamental when it comes to establishing partnerships and collaborative relationships.

» **The "la Caixa" Foundation.** An entity that contributes by providing resources for the proper implementation and development of the programme. These include:

  – A scientific management that provides the theoretical and methodological framework underpinning the programme, offers training to professionals, develops tools and techniques to improve detection and care, monitors the intervention both in the area and within the programme, designs and conducts evaluations to assess the progress of individuals and the quality of care for the continuous improvement of the programme, etc. It also constantly updates advances in the field of ageing and loneliness and seeks to adapt the programme and its methodology to new requirements, presenting new challenges in terms of content, care profiles, programmes and more.

  – An online platform that makes it possible to monitor relevant aspects of the work process with tools accessible to the Always Supported teams. Its capability for systematising and measuring care makes it a useful instrument for managing and evaluating the programme, as well as for scientific research on loneliness in later life.

  – The financial resources necessary for hiring staff and covering general expenses, which include the allocation of two full-time professionals for each team. However,

the number of professionals and their degree of dedication may vary according to the characteristics and size of the area, the population and the needs of the entity, among other factors.

– Similarly, the "la Caixa" Foundation, through the programme for the Elderly, uses its resources to monitor and develop the Always Supported programme. This includes more individualised support to the professionals in the Always Supported teams, as well as the promotion of communication campaigns, addressing more formal aspects such as the online work platform, legal issues like GDPR compliance, etc. These resources are invaluable both for the local area and for the programme as a whole.

2.3.2.2. Other local stakeholders

» **Other public administrations** operating or with impact in the area (regional, provincial, district). Their collaboration is essential for coordinating responses aimed at people's needs. This promotes the involvement of primary healthcare professionals, specialised social services, centres for older adults, and others managed by these institutions.

» **Third sector entities that carry out actions in the social field or for older adults.** Their collaboration contributes to broadening the scope of the programme, as well as to combining efforts and resources to address the different situations of loneliness (Caritas, Red Cross, Friends of the Elderly Foundation, etc.).

» **Third sector entities that do not work specifically with older adults**, but focus on areas such as youth, gender and equality, social exclusion, etc. Their collaboration allows for broader and more diverse responses to different situations and needs.

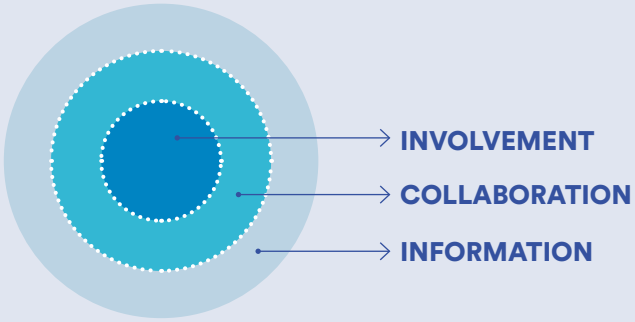
» **Citizenship**, through both individuals and informal groups or existing organisations (associations for older adults, cultural or neighbourhood groups, business associations, mutual support groups, volunteer organisations, caregiving groups, bereavement groups, etc.).

» **Volunteering.** Volunteers are also an element in fostering reciprocal relationships. Their willingness to support people experiencing loneliness creates opportunities for mutual help and reciprocal care, as well as for personal growth and development. This desire to help and support others requires empowered individuals who possess the necessary resources, tools and skills to ensure their work is meaningful.

2.3.3. Levels of involvement: the three circles theory

One of the guiding principles of the community methodology is that the levels of commitment and participation should be open and flexible to adapt to the context and the varying capacities and possibilities of local stakeholders. Marchioni (1989) proposes the three circles theory to represent this adaptability, openness and flexibility.

Figure 2.
Three circles theory



Source: Compiled by the authors, based on Marchioni (1987).

The three circles theory is based on the possible degrees of people's involvement, represented as concentric circles varying in intensity from highest to lowest.

» **Circle 1 (involvement).** This includes stakeholders who actively and continuously participate in the initiatives and spaces created for the development of a project, programme, etc. In this circle, due to the level of commitment required, the number of stakeholders is limited.

» **Circle 2 (collaboration).** This includes stakeholders who are not usually part of the collaboration spaces, but participate occasionally or partially through specific initiatives by providing resources, etc. The number of stakeholders included in this circle is larger, as their level of contribution or connection to the shared objective is lower and varies widely.

» **Circle 3 (information).** This includes the stakeholders with whom contact is established to inform and, if possible, create situations of mutual engagement. Thus, if any of them wants or is able to participate actively, they have the necessary information. This circle also represents the large and diverse number of local stakeholders who are aware of the project or programme and contribute to raising awareness of it and amplifying its impact. It is essential to maintain this flow of information to sustain a certain level of connection.

As observed, these three circles form an open, permeable and dynamic organisation, designed to encourage a variety of engagement situations. This structure allows mobility between the circles, as it makes it easier for a stakeholder to move from one circle to another, for example, from Circle 1 to Circle 3, or from Circle 2 to Circle 1 or from Circle 3 to Circle 2, depending on their level of involvement and commitment.

By way of example, considering the variability that can exist across the different areas, the application of this theory to the Always Supported programme is reflected in the following:

» **Circle 1 (involvement).** In this central circle, in which the intensity of engagement and commitment is highest, are located the lead entities and other organisations and stakeholders that actively participate in the Social Action Group or in the working groups or committees (see section 2.4.2, p. 74), for example: municipal social services;

nursing or social work professionals from health centres; centres for older adults; volunteer organisations; entities, programmes, associations or groups that directly impact the population that Always Supported is aimed at, etc.

» **Circle 2 (collaboration).** This intermediate circle, where there is less commitment or involvement, includes entities or stakeholders that collaborate occasionally with the programme. Examples include: local initiatives, providing premises or other resources; local pharmacies or businesses, for outreach; existing working groups related to health, ageing, etc., to structure and coordinate various actions. Additionally, associations of different types that welcome individuals supported by Always Supported to participate in their activities; sports or cultural groups or resources that collaborate by creating activities that take into account the characteristics and needs of the people served by the programme; local media outlets, to develop initiatives discussing ageing, loneliness and so on. And so on.

» **Circle 3 (information).** This broader circle, which does not involve situations of commitment, includes numerous stakeholders from different fields and sectors that are contacted by the Always Supported team to inform them of the care provided by the programme and to propose collaboration whenever it is possible or deemed appropriate. These stakeholders may include a council of older adults or a food bank programme, a neighbourhood or women's association, or an educational centre that carries out service-learning activities, a professional association of psychologists or a parish centre. However, as mentioned, these examples can vary considerably depending on the context and resources available in each area. For instance, this circle could also hypothetically include a health centre that receives regular updates, but with which no stable collaboration mechanisms have yet been established. This is often seen as a first step, with the aim of strengthening relationships and opening feasible channels of collaboration so that the primary care team, or part of it, can move from Circle 3 to Circle 2 or, preferably, to Circle 1.

As the programme is implemented, depending on the resources available in the local community and the relationships that are generated, the composition of the circles will evolve. In this way, a network of local stakeholders is built up in which participation can be either active or occasional, all with the shared aim of providing more coordinated and integrated responses to loneliness in later life.

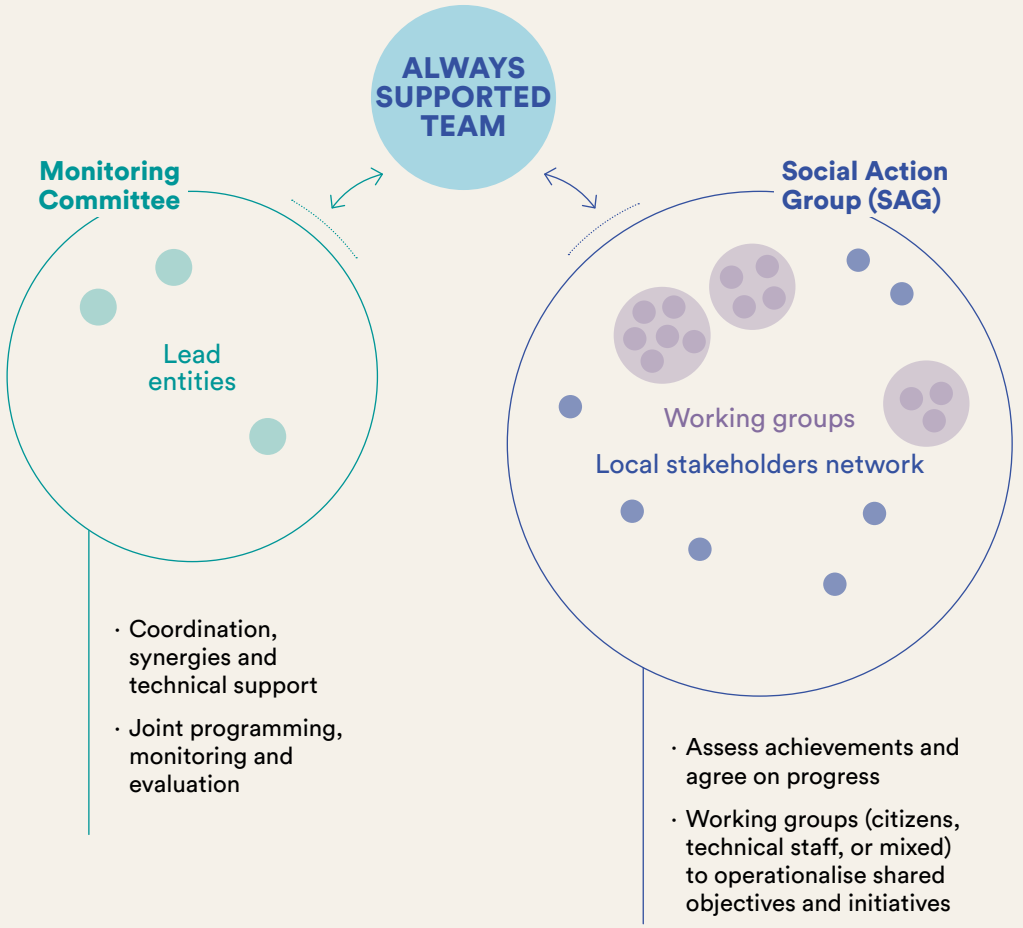
In this process, the role of the Always Supported team, besides providing information, knowledge and methodology, is to create or facilitate – and sustain – spaces for collaborative work and joint reflection. These spaces enable stakeholders to plan and execute actions for the identification and support of individuals in need, with each stakeholder contributing according to their role and capabilities.

2.4. COMMUNITY ORGANISATION

All work in and with the community should aim towards building shared responses, which requires partnerships, inclusive spaces for collaboration and the coordination of the different local stakeholders through various levels of involvement or cooperation.

The Always Supported programme proposes an organisation of the lead entities and the network of local stakeholders that must adapt to the characteristics of each area and its existing resources. This organisation includes creating the Monitoring Committee and the Social Action Group.

Figure 3. **Always Supported programme community organisation**



Source: Compiled by the authors.

2.4.1. Monitoring Committee

What it is

This is a space for relationship-building and collaboration dedicated to implementing and monitoring the programme, evaluating its progress and making decisions to ensure the fulfilment of its goals and objectives.

Who is involved

It is composed of the stakeholders that drive the programme through the signing of an agreement that outlines the collaboration: the local administration, the private entity or third-sector organisation in the area, the regional government (if applicable) and the "la Caixa" Foundation.

How it is organised

To organise and operate effectively, the following is planned:

» **Political-institutional level.** Regular meetings (at least once a year) in which a joint evaluation is made based on the collaboration agreement signed to promote effective and coordinated teamwork. These meetings address various aspects:

- The achievements in terms of the number of people supported, the quality of care provided or the level of engagement and support from the network of local stakeholders.
- The difficulties encountered and the improvements needed to address them, for example, in relation to available resources, whether offices are needed for individualised attention, or how to improve, if necessary, coordination with certain services or the involvement of other departments under the local administration in identification or attention, etc.
- The planning of local communication and outreach campaigns or the various aspects of involvement in campaigns at the national level.
- Proposals, objectives and agreements for the following year to improve care, carry out training and awareness-raising actions, extend the area of intervention or address other aspects that will depend on the needs of each context.

» **Technical level.** Regular meetings (quarterly or four-monthly) to ensure compliance with the mutual agreements outlined in the collaboration agreement, as well as the coordination and operational efficiency of the programme. These meetings are attended by the designated representatives specified in the agreement (heads of services, directors of basic services, etc.), with whom there is also regular communication to guarantee quality care at both the individual and group levels, as well as in all matters related to community work. These meetings address a wide range of operational aspects, as they aim to respond to needs or technical requirements that have to be solved or that require close coordination with the local administration, for example: collaboration with other departments or programmes to carry out the territorial project; coordination to respond to specific needs or manage highly complex situations; joint organisation and the provision of resources (facilities, logistics, communication, etc.) for a training session aimed at municipal professionals; planning a meeting of the Social Action Group; and so on.

2.4.2. Social Action Group (SAG)

What it is

The space for mutual relationships and collaboration among the most engaged stakeholders or those who collaborate on a stable basis with the programme is called the *Social Action Group* (Moya and Costa, 2007). It is a space that fosters shared knowledge, reflection and joint work.

Objectives

Its purpose is to promote cooperation to carry out strategies and initiatives that respond to the challenges posed by the multidimensionality and complexity of loneliness in older adults in the local environment:

» Collaborate in identifying individuals who are experiencing or at risk of loneliness.

» Share resources to develop personal and relational strategies that promote empowerment and the building of relationships, new bonds and a sense of belonging.

» Encourage more integrated care (coordination between sectoral interventions) to respond to specific needs, particularly in situations of high complexity or those requiring professionalised coordination.

» Contribute to raising awareness, voluntary action and the training of those involved.

» Participate in promoting and developing social innovation experiences to generate local responses to the new challenges posed by longevity.

Who is involved

It is composed of the entities that drive the programme and other local stakeholders who are more engaged or who collaborate with it on a stable basis.

Its composition and number of members will depend on the specific characteristics of each area. Since it is a mixed space (professionals + citizens), it can include professionals from the public administration (social services, healthcare, participation, older adults, etc.) and local third-sector entities, as well as organised citizens and individuals.

The key is that it is a group open to new members, changes in their involvement, and new challenges.

Organisation and operation

In each area, an organisation and structure are established in accordance with its idiosyncrasies or unique characteristics to ensure effective information flow and efficient management of time and resources.

In addition to motivation and training, one of the premises for effective and sustained operation over time is to avoid an inflexible organisation, as the internal dynamics, objectives and level of involvement of its members constitute a dynamic process that evolves as the programme itself evolves and takes root in the area.

Some key elements that guide its operation are:

» Dialogue and equal relationships (without role confusion) among its members.

» Cooperation to jointly build a new model of ageing that emphasises the relational aspect and engages older adults with the challenges of society, recognising them as active stakeholders in their community.

» Meetings focused on agreement and the shared achievement of operational objectives. Meetings that are agile and effective, held only as needed, combining both formal and informal aspects.

» Distinction between general meetings or gatherings, in which all members of the SAG participate, and meetings for specific groups or working committees, in which only some of its members participate.

Groups or committees

Based on the objectives set and the composition of the SAG, in order to encourage more effective involvement it can be organised into working groups, commissions, committees, etc., in which participation is based on possibilities, interests or affinities with the proposed objectives.

These groups need not be permanent or static. At the local level, and particularly regarding loneliness in later life, the solutions are not always obvious and it is necessary to "learn by doing" in an experimental way to try to find shared responses.

Depending on their temporal nature, different types of groups or committees can be identified:

» **Ad hoc groups.** These are formed with the aim of achieving specific objectives or initiatives at a given moment. For example, a care group to attend to a complex situation of a person who requires, on a temporary basis, the support and care of a close circle formed from primary relationships and, as far as possible, secondary relationships such as good neighbours, friends, family, or similar, facilitated by a formal public or private organisation.

» **More stable groups.** These are established to develop recurring objectives or initiatives throughout the year or once a year. For example, a working group to organise the annual community event held every year on the International Day of Older Persons. Several months beforehand and drawing on the experience of previous editions, this group works collaboratively, alongside the lead entities, to plan the various activities required for the event.

And based on their composition and objectives, the following distinctions can be made:

» **Technical groups.** These involve only professionals who work to achieve technical or professional objectives. For example, a technical committee might address issues such as case detection, case analysis, coordination, training, etc., based on the commitments acquired by the service or department to which they belong.

» **Citizen groups.** These involve only citizens (organised groups or individuals) who take on objectives or initiatives in which they play a more prominent role. For instance,

organising a one-off or recurring activity in the fields of leisure, culture or sports to create opportunities for meeting new people or maintaining connections. A concrete example night be organising a game of pétanque and holding tournaments in the neighbourhood park two afternoons a week.

» **Mixed groups.** These groups involve both professionals and citizens who work together on shared objectives or initiatives. Examples might include setting up an urban garden as a collective space for connection and socialising, which also promotes environmental sustainability and fosters knowledge about local crops; or a working group that, in collaboration with a university, creates an accessibility map of the neighbourhood and draws up proposals for improvement.

However, this relational and organisational framework is not an exact science. The multiplicity of possibilities and aspects that can be addressed is diverse and constantly evolving.

Table 1. **Examples of SAG working groups**

SAG groups	BASED ON THEIR TEMPORAL NATURE: Ad hoc	BASED ON THEIR TEMPORAL NATURE: Stable
BASED ON COMPOSITION: Technical	Working group to organise and conduct a training session for professionals	Technical committee for more integrated care and stable coordination between professionals
BASED ON COMPOSITION: Citizen	Care group to address a complex, though temporary, situation involving an individual through a close-knit circle	Pétanque group to organise and conduct a sports activity that fosters regular or periodic social gatherings
BASED ON COMPOSITION: Mixed	Working group to analyse risk factors related to neighbourhood accessibility and develop improvement proposals	Working group to run an annual Summer Programme aimed at meeting the needs and demands of older adults during the summer season

Source: Compiled by the authors.

The technical committee

This is a working space aimed at achieving professional objectives such as case detection, case analysis, coordination, training, etc. It is generally composed of personnel from social services, primary healthcare centres and other specialised services under different administrative bodies.

Its organisation, functioning and operational objectives are agreed upon by its members to ensure it remains are agile, flexible and effective, allowing it to adapt to emerging opportunities and needs.

2.5. METHODOLOGY OF THE COMMUNITY ORIENTATION

The various interventions carried out in the local context, combined with the networked nature of community dynamics, require building relationships of trust by considering what already exists and taking into account the idiosyncrasies of the area. For this reason, Always Supported does not propose replicating identical community approaches from one local reality to another. Instead, it proposes starting from the same conceptual and methodological premises and applying them with flexibility, that is, recognising the diversity and heterogeneity of the location where the connections and bonds of the people being supported are rooted.

All this takes place within a continuous process of updating knowledge, as existing collaborative relationships are consolidated and new ones are formed, advancing in the sustainability of the network of local stakeholders, whose role evolves and is strengthened through experience and learning.

2.5.1. General aspects of the implementation phase

The area is selected at the proposal of the city council based on criteria such as the number of older adults, risk factors for loneliness, the context of community life and the social fabric, as well as available local resources and services, among others. Once the basic premises have been agreed with the local administration through a collaboration agreement and the entity that will develop the intervention has been selected, the deployment of Always Supported begins.

The implementation phase begins with the training and organisation of the team, as well as strategic planning in coordination with the local administration. Once the resources, services and stakeholders considered most significant in this phase have been identified, the first steps are taken in and with the community to understand it better and establish the initial components of the local stakeholder network. At the same time, outreach campaigns need to be developed aimed at identifying individuals in situations of loneliness, as well as to raise visibility around these situations, promoting the need for supportive relationships of well-being and mutual support.

Table 2. **Implementation phase**

INTERNAL WORK	WORK IN AND WITH THE COMMUNITY
· Always Supported team training and work organisation	· Establishment of relationships and situations of engagement
· Planning and relational strategies	· Formation of the Social Action Group (SAG) or integration into a similar existing network
· Preliminary knowledge: analysis and community file	· Awareness raising and outreach

Source: Compiled by the authors.

The deployment phase of the programme is generally spread over a period of approximately one quarter or four months. Planning the timeline of this phase is crucial, as the sequence of the different actions may vary depending on community dynamics. It will therefore be necessary to adjust the timings (for example, speeding up or slowing down certain actions to take summer into account) to ensure they do not negatively affect engagement with local stakeholders or the building of trust and collaboration relationships.

Table 3. **Example of a timeline for the implementation phase distributed over one four-month period**

ACTIONS	Jan	Feb	Mar	Apr
Always Supported team training and work organisation	■			
Planning and relational strategies	■			
Preparation of the analysis and the community file	■	■	■	
Establishment of relationships and opportunities for engagement		■	■	■
Formation of the Social Action Group (SAG) or integration into a similar existing network				■
Awareness raising and outreach		■	■	■

Source: Compiled by the authors.

Specifying the actions and setting them out in a timeline ensures that the action plan unfolds in a more efficient and organised way. Without this timeframe and concrete objectives, the implementation phase may take longer because there will always be stakeholders who have not yet been contacted or additional insights that could enrich the analysis.

In this regard, it is essential to bear in mind that knowledge and relationships are always in progress. There is no definitive understanding, because reality changes and it will always be necessary to remain attentive to new situations or demands. Likewise, relationship-building does not end with this phase; ongoing outreach and invitations to collaborate with other local stakeholders will always be necessary.

To avoid delaying the process, it is important to clearly define what we need to know to begin the intervention and whom we want to invite to form the Social Action Group or to support the goals promoted by Always Supported in this initial stage.

If individuals experiencing loneliness are identified during the implementation phase, support can begin immediately. There is no need to wait for the SAG to be formed, as it is likely that the person may be going through moments of helplessness and frustration that should not be prolonged.

Starting individual or group support as soon as possible also allows the Always Supported team professionals to begin applying the techniques and methods they have learned, to better understand what the intervention entails, and therefore to more effectively communicate the objectives of the Always Supported programme.

2.5.2. Always Supported team training and work organisation

2.5.2.1. Always Supported team training

In this phase, the initial training of the Always Supported team (see chapter. 4, section 2, p. 221) is fundamental. Professionals are provided with resources that include programme-specific materials and specialised literature, to help them understand the conceptual and methodological elements that define the support offered by Always Supported. This initial training, which is complemented and enriched by continuous training and follow-up, provides the necessary foundation to begin both individual and group interventions with a more community-oriented approach. To this end, the Scientific Management of the programme provides contents and a training itinerary to support the teams in this ongoing process of learning and enhancement of their personal and professional resources.

In general terms, the aspects covered by the initial training are as follows:

» Conceptual approaches to ageing and the different situations of loneliness in later life.
» Specific situations such as bereavement, loss, loneliness among carers, etc.
» Content, methodology and tools for intervention based on support profiles: loneliness profile, preventive profile and network profile.
» Conceptual and methodological elements related to community orientation.
» System for recording, monitoring and evaluation.
» Communication and outreach.

2.5.2.2. Internal organisation and action plan

In this phase it is also essential to establish an organisational structure and assign roles, defining the objectives, responsibilities and tasks of each member of the Always Supported team.

Other aspects that should be taken into account in these initial stages include:

» Internal communication planning, that is, the procedures and spaces for internal coordination among the Always Supported team, the designated representative of the entity and the local administration.

» Provision of the necessary resources to ensure professionals have the tools needed for efficient execution. This includes, for example, training in the use of the online work platform and other instruments for systematising their work, both in terms of the support provided to individuals (loneliness assessment tools, case analysis instruments, etc.) and the work they carry out with the network of local stakeholders (analysis of detection and profiles, record of stakeholders and meetings, etc.).

» Preparation of the physical office and work centre, as well as the provision of a safe and reliable space for attending to individuals with appropriate privacy.

2.5.3. Planning and relationship strategies

It could be said that implementation of the programme really begins when the community is explored with a focus on older adults and the environmental factors that affect the different situations of loneliness. This also includes the start of introductory meetings and relationship building with identified stakeholders.

For this preliminary relational work, there is no established script, but there are planned steps and recommendations on ways of doing things, some more operational and others more substantive.

Figure 4. **Steps for engaging with local stakeholders in the implementation phase**

Source: Compiled by the authors.

2.5.3.1. First step. Identification and prioritisation of local stakeholders. Strategic planning

The intervention area is not only defined by its geographic, economic or sociocultural characteristics, but also by its organisation and social and institutional dynamics. Understanding how it is organised administratively (districts and neighbourhoods, health zones and areas, basic social services areas, etc.), the internal organisation chart of administrations and entities and the social dynamics that characterise the community not only saves time and energy, but also allows for "starting off on the right foot".

The local council or entity typically has lists or databases of resources and associations, a portfolio of services, etc., which will serve as a starting point for understanding the area and identifying stakeholders. Using this basic information, the Always Supported team will begin to build its community file.

Identification and prioritisation must be carefully planned, as initial contacts require time. The professionals of the Always Supported team should manage this timing within their work schedule.

With regard to prioritisation, the aim is not to exclude certain stakeholders who may also be important, but rather to go step by step, prioritising according to the relevance or influence of the stakeholder for that particular moment. However, it is essential not to overlook any resource, group, association or individual who, although initially considered not to be significant, should not be dismissed due to their leadership or influence.

Generally, for this initial phase, it is considered that the following stakeholders may be priorities:

» Primary healthcare and social services support (social work, emotional well-being contacts, nursing, etc.).

» Centres for older adults focused on participation, volunteering, leisure and recreation, etc.

» Associations for older adults, neighbourhood groups or women's groups with significant influence or relevance. This may also include associations of carers or those focused on bereavement.

» Existing committees or working groups related to older adults.

» Active ageing programmes, age-friendly city initiatives or other loneliness-related programmes in the area. Other programmes run by the entity that serve older adults.

» Key individuals who, because of their role in the community, should be taken into account from the outset.

Strategic planning also refers to the organisation of introductory meetings taking into account the nature of the different community agents, as well as the necessary willingness to cooperate among all the stakeholders engaged, including organisations and public administrations.

The following are examples of situations to be considered during initial contacts:

» **Social services.** Generally, these answer to the municipal administration and their collaboration is secured through the agreement that already exists for the programme. However, communication with those responsible for managing basic areas and the frontline professionals must be coordinated by the designated representative of the local council. Based on this communication, the professionals of the Always Supported team and frontline staff – or as otherwise agreed – will establish more fluid relationships for collaboration in detection, coordination of support, and so on.

» **Primary health care teams.** Managed by the regional administration, they are crucial for detection and for providing more integrated care. Naturally, there are various initial circumstances and options for collaboration (more or less formal), but it is essential to emphasise that these relationships must be built taking into account the timeline, rules and dynamics (both explicit and implicit) that govern the ways in which primary health care centres operate. Initial contact with the primary health care team management by the designated municipal representative and the entity (accompanied by the Always Supported team if deemed appropriate) can be an effective way to begin these relationships. Once collaboration is agreed upon, the Always Supported professionals will hold introductory meetings with various team members. There is also the possibility of an introduction to the entire team, which does not prevent meetings being held later with the professionals most directly involved, to explore further opportunities for joint work and cooperation.

» **Other organisations.** Service providers, those that manage public resources, NGOs, etc. Once again, the first contact should be at the institutional level (with the representative, management, department director, etc.), led by the local council or the designated representative of the entity, is a necessary step. This approach facilitates the establishment of ongoing, cooperative relationships at a more technical or grassroots level later on.

2.5.3.2. Second step. Preparing and arranging meetings

To hold an in-person meeting, it is first necessary to make prior contact by telephone or email to arrange an appointment with the individual or group, specifying the place, day and time. Additionally, having programme outreach material and basic information about the area, which will have already been worked on for the analysis report, will be helpful.

In other words, when visiting a service provider or the office of an association or organisation, it is not only a matter of presenting what we do, but also why we do it. This requires data to support the conversation, such as indicators from the Map of Loneliness in Spain (Yanguas, 2021), together with the demographic characteristics and comparisons of the older population in the area, risk factors, the impact of loneliness on people's health and well-being, the negative consequences of situations of loneliness, the target audience of the programme and the proposed support plan, etc. In short, it is necessary to prepare the meeting in order to foster a dialogue that enables sharing points of view and achieving situations of mutual commitment.

2.5.3.3. Third step. Introductory meeting to build relationships and propose commitments

As mentioned, these initial meetings with local stakeholders are ultimately aimed at establishing collaborative, long-term relationships. It is essential to create an atmosphere of trust from the outset, where people feel encouraged to exchange viewpoints, knowledge and objectives to reach mutual commitments. They need to understand and share the vision that the support provided by the Always Supported programme relies on the involvement of other local stakeholders to reach older adults experiencing loneliness and help them feel part of, and actively engage in, their community. Moreover, they should see that we all improve when we share challenges and complement each other's contributions.

In summary, the objectives of these initial meetings, which can serve as guidelines, are as follows:

» To understand not only their aims and what they do, but also their day-to-day reality.

» To share knowledge and perceptions about older adults and situations of loneliness through various experiences and perspectives, from an ageing paradigm that emphasises the importance of social relationships and interdependence.

» To provide more detailed information on the characteristics of the Always Supported programme's care model and its approach to organising and collaborating with other stakeholders in the community.

» To explore and discuss what Always Supported – with its specific focus and resources – can contribute to their service, entity or association, and how they, in turn, can contribute to the programme's goals of identifying and addressing different situations of loneliness among older adults in their community.

» To invite them to join the SAG (Social Action Group) or collaborate with it to the extent they are able and willing.

» To agree on operational aspects, such as communication channels, inform about possible dates for the first SAG meeting to check availability, etc.

The information gathered during these in-person meetings will also help complete the analysis report and the community file.

Finally, it is important to note that if a significant amount of time passes between this initial meeting and the first SAG meeting or other initiative to be shared, it is advisable to provide a brief update – by means of a call or email – on the steps taken so far, to keep relationships active. From the outset, individuals, entities or associations invited to participate should feel that their involvement will be supported by a team that values their contribution and keeps them informed.

2.5.4. Planning and monitoring instruments

2.5.4.1. Analysis report

The analysis report is a working tool with a twofold objective:

» To establish a dialogue and trust-based relationships with local stakeholders in order to foster commitments built on knowledge.

» To guide the programme's implementation actions in line with the idiosyncrasies of the area and focusing the planning on identification and intervention.

This is not merely an organised or exhaustive collection of data, but rather a concise description that helps to understand the local reality, as well as to identify the area's main strengths and challenges with regard to addressing loneliness at the individual, group and community levels.

Some recommendations for preparing the analysis report:

» Much of the required information can be sourced from the local council's documentary database or the National Institute of Statistics, from other existing reports or analyses, etc. Often, data disaggregated by neighbourhood is not available; in such cases, municipal or regional data will need to be extrapolated.

» The goal is not to include numerous data points or charts, as these could hinder understanding, but rather to provide a clear and concise analysis focused on key trends and conclusions related to demographic, economic, sociocultural and environmental risk factors, among others.

» Naturally, creating this report also requires travelling around the area at different times to gain first-hand knowledge of its characteristics. The documentary record is one thing, but "getting out on the street" is another. For instance, a list might indicate a certain number of parks or facilities, but when visited in person it could become apparent that they are "lifeless", or that they lack urban furniture or shade. Conversely, there may be "hidden" corners or facilities that host community activity or offer opportunities beyond their intended purposes and could serve as mediating factors in promoting social support and engagement.

» To facilitate dissemination of the analysis findings and raise awareness of the programme, an executive summary and a visual presentation with the most relevant conclusions should be prepared.

The foundational documentary part should be completed within the first few weeks of the programme's implementation. This initial information will serve as a basis for the initial meetings with key stakeholders. Later, with the insights gained from these meetings, the report, executive summary and presentation can be completed and shared in the first SAG meeting.

Table 4. **Proposed outline for preparing the analysis report**

Cover	Title: Name of the municipality and intervention area Date: month and year Footer: logos of the lead entities
Contents	By sections with page numbers
Introduction	Purpose of the programme, lead entities, objectives of the analysis report, methodology
Executive summary	Brief summary providing quick and visual information on the main characteristics and conclusions concerning older adults and the factors that affect situations of loneliness
Contextualisation	Concise description of the area, geographical location, administrative organisation, characteristics, and connections with the rest of the municipality (other districts, etc.)
Population	Identification of the most relevant data on the municipality or area: · General population (total number of inhabitants by age range and gender) · Disaggregated data on the population over 60 by age range and gender: – Older adults living alone (single-person households) – Educational and socioeconomic level – Diversity of origin
Physical environment	Identification of the main difficulties or advantages: · Urban structure (condition, habitability, presence or absence of lifts, etc.) · Accessibility to health services, leisure activities, etc. · Mobility and transport
Community life	Identification of the main difficulties or advantages: · Social fabric: associations, ongoing participatory processes, support networks, volunteering, formal and informal moments and spaces for participation, etc. · Availability of resources and services in fields such as older adults, caregiving, volunteering, religion, culture, sports, centres for older adults, etc. · Local shops · Community cohesion or conflict situations particularly affecting older adults, if applicable
Social policies	Identification of public policies and programmes related to ageing, loneliness, health, volunteering, participation, etc., that impact or complement the support provided by the programme
References	Reference materials and bibliography used

Source: Compiled by the authors.

2.5.4.2. Community file

The community file is a working tool for the Always Supported team, consisting of a database or system for storing information collected about the various entities, organisations and individuals in the community identified as key stakeholders with whom collaborative relationships are gradually established (Vecina-Merchante, 2024).

It includes the name and department or area of the administration, organisation, association, etc., as well as the contact person or persons with address, telephone number, email, social networks and website, along with a section for notes on other data or possible incidents, conflicts, etc.

This file may also incorporate community facilities or resources that are relevant for the development of the action plans of those receiving care (sports, cultural facilities and others, such as a community garden).

It does not include specific projects or activities carried out in the community, as this information is constantly changing, and including it would require revisions and updates that the Always Supported team may find difficult to maintain. To gather this type of information, other tools or a shared SAG agenda can be used, in which each entity or institution regularly updates its information.

The information in the file can be organised in various ways: by level of involvement, by sector or by type of stakeholder or role within the community. Here are some example criteria.

Table 5. **Examples of classification criteria for recording in the Always Supported team's community file**

Sectors	Environment, social area, citizenship, community, sports, economic and commercial sector, education, public spaces, information and communication, interculturality, leisure and culture, participation, religious sphere, health, security, urban planning and housing, volunteering, etc.
Stakeholder typology	· Local government areas (social services, services for older adults, health, participation, etc.) · Regional government areas (social, older people, health, etc.) · Sector councils or committees, centres for older adults, other services for older people, primary healthcare centres, other health resources, organisations for older people, volunteer organisations, other entities, educational institutions (primary, secondary, university, etc.), civic centres, cultural centres, sports centres, libraries, associations (neighbourhood, older adults, women's, youth, bereavement, carers, voluntary, religious, cultural, sports, commercia, etc.), informal groups, collectives, individual citizens, establishments (local shops, pharmacies, etc.), and so on.
Role in the community	Institutional, technical or citizen-based, with a specific section for volunteers if needed
Level of engagement	Participate in the SAG, collaborate with the SAG, receive information

Source: Compiled by the authors.

The information in the community file can be employed for other purposes if the Always Supported team needs it or if the SAG intends to use and share it. In such cases, the team may share any data which is public. Some resources that may emerge from this file include:

» Portfolio of services – structured as a profile for each service or area – which organises and provides information on the basic structure and services specific to councils, centres and entities.

» Community map using Google Maps or other platforms to facilitate information and location details for SAG entities, citizens, etc. (Community Project, 2020).

The community file is a living document that is updated as the programme progresses and as the team becomes more familiar with the community and local stakeholders. It also evolves as services and resources change (contact persons, location, etc.).

2.5.4.3. Monitoring tool for detection based on intervention profiles[4]

Monitoring the detection and number of individuals experiencing loneliness or at risk of loneliness, whether identified by stakeholders of the SAG or its collaborators, or through awareness-raising activities, is essential for planning improvement or training initiatives. For this purpose, it would be necessary to collect the information detailed in table 6 (p. 88).

» Month and year: fields to indicate the month and year when the request for assistance reaches the Always Supported team.

» Stakeholder or detection channel: dropdown field to specify through which channel or stakeholder the individual is detected or the request reaches the Always Supported team.

» Description of stakeholder or channel: open field to include information on the person, professional, service, etc., that identifies and refers the request to the Always Supported team.

» Profile: dropdown field to assign the intervention profile or to indicate that no profile is applicable.

» Criteria: characteristics of the profile according to the criteria established by the programme.

» Observations: open field for additional considerations.

This detailed information and its tracking over time allow for analysing where the detection challenges or opportunities lie and enable the planning and specific training of stakeholders if needed, measuring the impact of awareness-raising activities on detection, etc.

4. For further information, see chapter 3, p. 138.

Table 6.
Fields for monitoring and planning detection according to intervention profiles

Day	
Month	
Year	
Stakeholder or detection channel	· Social services · Centre for older adults · Health · Managing entity · Pharmacies · Establishments · Volunteers · Other SAG entities · Other community stakeholders · Individuals assisted by Always Supported · Meeting space · Group activity · Information point · Other outreach and awareness-raising action · Others
Description of stakeholder or channel	
Profile	· Loneliness · Preventive · Network · Does not meet profile
Criteria	· Preventive · Preventive and declines to participate · Existential and/or emotional and/or social loneliness · Existential and/or emotional and/or social loneliness with highly complex factors · Loneliness and declines to participate · Network: meeting spaces, open group activities · High dependency, other health factors, cognitive deterioration, etc., that prevent participation in the programme
Observations	

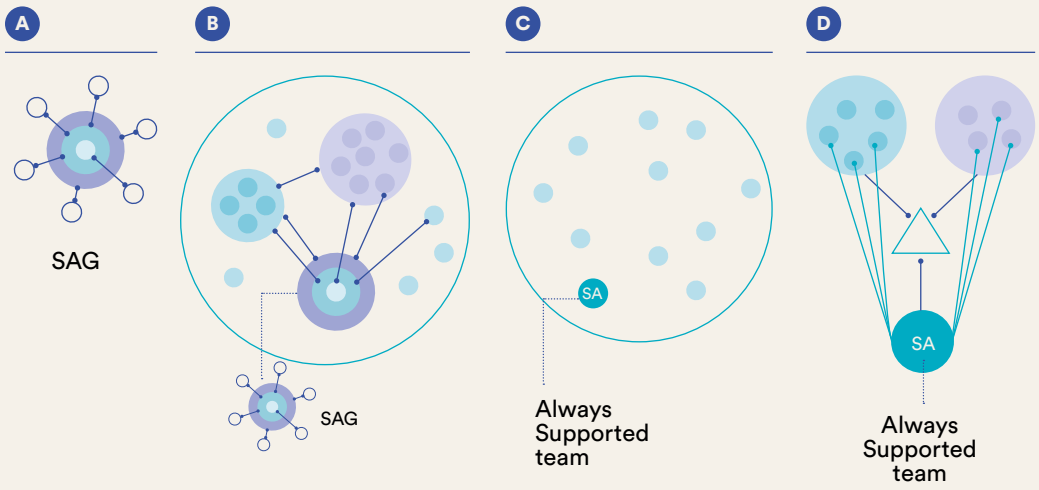
Source: Compiled by the authors.

2.5.5. Starting point and steps for the consolidation of the SAG

2.5.5.1. Starting point

In the planning and community assessment stage, the Always Supported team will analyse the various possibilities for establishing the SAG, identifying the most appropriate mechanisms for each situation, as well as its challenges and opportunities. This analysis will be based on what already exists in the area regarding older adults and loneliness in a broad sense.

Figure 5. **Possible starting points for setting up the Social Action Group (SAG)**



Source: Compiled by the authors, based on Marchioni et al., 2015.

These possibilities can be grouped into the following four categories:

A. **Absence of community organisation, networks or relational spaces and joint work, which is why the SAG is created.** The composition, objectives, organisation and operation are defined according to each stage of the programme (implementation, development and consolidation).

B. **Existence of community organisation, networks or relational spaces and joint work, within which the SAG is established.** Considering the specificities and limitations of the programme, the SAG operates with a certain autonomy to complement and enhance the existing community structure, and to enrich the synergies and complementarity among the different groups and areas of this structure.

C. **Existence of community organisation, networks or relational spaces and joint work into which the programme is incorporated, but a SAG is not created.** The Always Supported team is integrated as an additional member to enrich and improve this structure with the vision, objectives and resources of the programme.

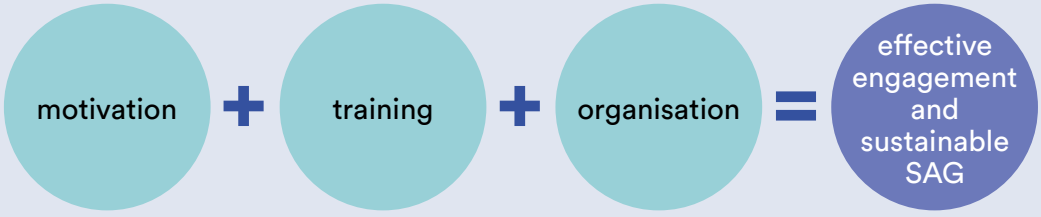
D. **Existence of various initiatives, networks or working spaces, although challenges of differing nature prevail, making it difficult to create a SAG or for the Always Supported team to integrate into existing structures.** In such cases, the Always Supported team seeks to foster mutual understanding, build trust-based relationships, improve coordination and support joint initiatives wherever possible.

Moving forward, the possibility of creating a SAG with autonomous operation will be developed, as the other options depend on numerous variables and context-specific details that are difficult to fully outline here.

2.5.5.2. Forming the SAG

When forming the SAG, it is essential for its members to have a clear understanding of the reasons for joining and the contributions they can make. It is equally important for individuals to feel – and indeed be – capable of carrying out the tasks and initiatives involved in meeting the common objectives. For this reason, the initial meetings, which will be held more frequently, are generally dedicated to getting to know each other and providing training. In fact, the connections between the different interests (*motivation*) and ensuring that members understand how they can contribute to the shared goals and participate in them (*training*) will require a significant portion of the Always Supported team's efforts within the SAG, particularly in the early stages. Following this, individuals need opportunities and resources to *be able* to genuinely engage, that is, to have the spaces, time and resources necessary to channel and structure their participation effectively (De la Riva and Moreno, 2019).

Figure 6. **Basic premises for effective and sustainable involvement in the SAG**



Source: Compiled by the authors, based on De La Riva and Moreno, 2020.

There is extensive literature and online resources available for techniques to energise SAG meetings and the relationships among its members. Any of these techniques is suitable if the following is taken into account:

» **Adaptation to local dynamics and the programme's needs.** Needs and objectives are not always the same. Naturally, they will revolve around issues such as identifying situations of loneliness, raising awareness or integrating actions; however, the experience gained and the context will vary, as will the structure and ways of operating within the SAG.

» **Flexible, efficient and agile organisation and operation.** Meetings should be only as many as necessary, balancing formal and informal elements, with durations and frequencies that are practical and manageable for all members.

» **Preparation of content and dynamics.** The objectives of the meetings should be clear, with dynamics that facilitate their understanding and with a breakdown into specific tasks, so that by the end members do not feel time was wasted and that each member understands and takes on the tasks they need to complete within the agreed and shared planning.

» **Systematisation of agreements and tasks. The minutes:**
  – **General meetings of the SAG.** The minutes should simply record the date, location, participants, agreements and tasks, as well as the date and time of the next meeting. At the end of the meeting, the agreements should be read and approved, and the minutes sent to all SAG members (whether they attended or not) through the established channels. These minutes will be used to follow up on the agreements and set the agenda for the next meeting.
  – **Other meetings.** In the case of informal meetings, working groups, coordination sessions, etc., a formal record is not necessary. An email (or a message through the agreed channel) informing the Always Supported team and the participants of the agreements will be enough to provide them with the necessary information.

The purpose of the Always Supported programme is not to create activities specifically for the people it serves; rather, its goal is to connect with them and encourage their involvement in what already exists within their community. However, the Always Supported team may encourage alternative approaches and actions to address emerging shared challenges, working alongside SAG members and other local resources or entities.

Initial meetings of the SAG

As mentioned above, the initial meetings should be oriented towards training and understanding the purposes of the SAG, as well as fostering mutual understanding and group cohesion:

» The analysis report drawn up by the Always Supported team on the specific situation of older adults and the different factors in their community that affect loneliness is shared.

» Knowledge is provided on the types of loneliness and how to detect these situations, as well as different levels of support, etc.

» Each entity, individual or institution's contributions are structured to aid detection and provide more integrated support of individuals (connecting or reconnecting older adults with their community based on different ages, capacities, possibilities and interests; promoting relationships, bonds and cooperation; encouraging active participation; etc.).

» Operational objectives are set with a view to detection, awareness raising, support, etc.

» Basic organisational and operational agreements are reached on the basis of these objectives:
  – Detection protocol and channels, distinguishing whether it originates from a technical or community profile (see Appendix 1, p. 254).
  – Support protocol for highly complex situations (see Appendix 2, p. 262).
  – Working groups or committees, in particular, the technical committee.

The programme provides protocol templates that each SAG must adapt according to its characteristics and existing resources in order to improve and enrich them as members incorporate experiences and learning.

2.5.5.3. Towards the stability and consolidation of the SAG

Once the functioning of the SAG has been established and various experiences, etc. have been shared – in most cases after the first year, in others it will take a little more time – it is recommended to hold a maximum of three general meetings per year, focusing on the following points:

» **Review and programming.** Sharing the results of the previous year and defining the objectives for the current year. It is important to highlight achievements and results, so that SAG members feel a sense of ownership. From there, jointly plan ways to move forward in a continuous and sustained action to achieve shared objectives over time.

» **Monitoring.** Tracking the progress of planning and the established objectives, with the option of making adjustments. This process can also be managed by the working groups.

» **Evaluation.** Assessing the objectives and actions shared by the SAG. Joint analysis of what worked well and the aspects needing improvement to learn from experience, correct mistakes, enhance successes and improve future stages, etc.

Since the aim is to maintain this shared work space over time, it is essential that the SAG remains a flexible group adapting to change and evolving, and that it be open to varying levels of involvement and new members.

Member rotation or the departure of original participants may occur, but by encouraging new additions the group can maintain its strength and capacity even with changes in composition. Opening it up to new members enhances knowledge diversity and perspectives, revitalises energy and motivation, and broadens its scope and participation.

To ensure sustainability, it is not essential to have a large number of fully engaged members (Circle 1), though this may vary depending on the intervention area. It is preferable to have a large number of individuals or entities that collaborate occasionally or on a regular basis (Circle 2); even if they do not attend some of the meetings, their support can be invaluable at various times and in different ways (see the three circles theory in section 2.3.3, p. 69).

2.5.6. Territorial projects

In order to encourage participation and the establishment of support networks, it is essential to promote the involvement of citizens and other local stakeholders through the organisation and development of what we call *territorial projects*.

A territorial project is defined as a set of planned actions that, with the involvement of local stakeholders who are part of or collaborate with the SAG, set out to raise awareness of the importance of social relationships or promote community gatherings, among other aspects. They may also aim to collectively respond to identified but unmet needs.

While most of these territorial projects are common initiatives across all areas, they are adapted and implemented according to the possibilities and specific characteristics of each location. Broadly speaking:

» They represent a community-based response to the various situations of loneliness experienced by older adults or other identified needs.

» They are promoted either as a one-off or recurring initiative, depending on the needs and local resources available, and are aligned with the possibilities and motivations of both the people supported and those driving the initiatives.

» They require a certain level of organisation to mobilise a group of people beyond the Always Supported team.

» They acknowledge the diversity of the different local realities and aim to have a greater impact by involving not only the administrations and lead entities of the programme, but also other local stakeholders.

» They encompass various territorial areas: a neighbourhood, part of the city, an entire locality, etc.

» They contribute to promoting positive social values, such as care, solidarity, interdependence and both intergenerational and intragenerational relationships.

The following is a framework that may be useful for the planning and implementation of a territorial project, based on the 9-questions technique (Ander-Egg and Aguilar, 2006).

Table 7. **Framework for planning and developing a territorial project**

Why?	Foundation	Reasons for carrying out an intervention
What for?	Objectives	Intended outcomes of the project
How?	Methodology	Approach to achieving the proposed objectives, considering feasibility, tasks, roles and work to be carried out
What?	Actions	Basic project definition and actions to be implemented
For whom?	Target audience	People to whom the actions are addressed; main participants of the project
When?	Timeline	Schedule with activity deadlines (Gantt chart)
Where?	Location	Physical space, scope and area of the project. City, locality, neighbourhoods... Place where it will take place and/or area of influence
With whom?	Participants in its development	Individuals, entities, administrations, associations, etc., responsible for carrying out the actions
With what?	Resources	Necessary material resources (anticipated) and costs
How is it disseminated?	Outreach	Specific dissemination actions planned for the project; communication plan
How is it evaluated?	Evaluation	Planned project evaluation method; indicators, instruments

Source: Compiled by the authors, based on Ander-Egg and Aguilar, 2006.

2.5.6.1. Summer Programme

One of the territorial projects carried out wherever Always Supported is developed is the Summer Programme. Over the years, it has been verified that the different situations of loneliness (and other situations of difficulty associated with it) become more acute in summer, as the cities empty, family and friends go on holiday and many services, facilities, activities and even local shops hang up the "closed for holidays" sign. In addition, there is a lack of places suitably equipped to provide relief from the warmer weather, and so on.

All of this exacerbates the perception of loneliness, leading many people to feel more isolated, bored or sad, and it can negatively impact on their health. It especially affects people who are more vulnerable due to a lack of financial resources, health issues, or because their homes are not equipped to cope with the heat, and so on.

For these reasons, Summer Programmes have been promoted with the aim of responding to the demands and needs of individuals over 60 in the community during the summer months, through actions designed and developed collaboratively by the network of local stakeholders. These initiatives, which emphasise the relational aspect, focus on strengthening the sense of sharing, enabling people to feel they are active agents in their community and fostering commitment to both personal care and the care of others (Yanguas, 2023).

In the implementation of the Summer Programme, it is necessary to align various stakeholders, so it is essential to build it jointly on content that is meaningful to all of them.

The most common approach involves moving forward progressively, edition by edition, through dialogue and exchange:

» **Dialogue.** The complexities of ageing, the various forms of loneliness and the limitations of conventional approaches and procedures are highlighted, as these may not be suitable for shared projects that require flexibility and collaboration.

» **Exchange.** The exchange of perspectives and resources among different local stakeholders to find joint solutions.

Ultimately, the underlying objective is to drive a change in ways of working and foster collective intelligence. These processes can only be built experience by experience, with consistency and continuity in actions, and through relationships based on trust and collaboration (Brugué-Torruella, 2018).

2.5.7. Awareness raising

One of the objectives of the Always Supported programme is to make visible, inform and raise awareness of the phenomenon of loneliness by highlighting the importance of maintaining strong and meaningful social relationships. In addition, it aims to promote community participation and engagement in creating connections and support networks capable of detecting and collectively addressing the various situations of loneliness in later life.

Through an educational approach, the main objectives of awareness raising are:

» **Visibility.** Loneliness is a hidden reality for many people. Raising awareness helps bring these situations to the forefront of public conversation.

» **Changing perceptions.** Fostering a deeper understanding of loneliness can change attitudes and behaviours to promote inclusion and social support.

» **Strengthening support networks.** An informed community is more likely to engage in initiatives and support networks that enhance the overall well-being of older adults.

To achieve these objectives, the Always Supported team, with the support of the lead entities and members of the SAG, can undertake the following actions:

» Communication campaigns through social networks, media or informational materials.

» Information points in health centres or centres for older adults, etc., with the support of professionals from these centres to facilitate engagement and contact with potential interested individuals.

» Events such as workshops, talks or citizen laboratories, and participation in local or community actions taking advantage of special days like the International Day of Older Persons (1 October).

These actions will require careful planning – a communication plan – to focus efforts and maximise impact. Some key considerations include:

» Starting from the context in which you are working. Adapting awareness-raising strategies to the cultural characteristics, customs and idiosyncrasies of the location.

» Identifying target audiences. Determining the different interest groups and tailoring the messages and awareness-raising methods to each of them.

» Defining objectives. Establish clear and measurable objectives, ensuring they align with the various goals of the programme and clearly defining whether it is a campaign or a detection action, or if the aim is to disseminate and raise awareness of the programme, etc.

» Focusing the messages. Emphasise the "positive side of life": relationships, life projects, personal capabilities, etc. It is also important to include individuals who have been supported by the programme, volunteers or members of the SAG as direct witnesses.

» Organising. Establish the frequency, division of tasks (editing of contents, photographs, monitoring of impacts, supervision, publication), internal communication, and follow-up of the communication plan.

To delve deeper into these communication-related aspects, professionals have access to a manual that provides key insights for conveying clear information to both older adults and the programme's advocates. This manual includes specific tools and strategies that enable stakeholders, both professional and non-professional, to understand the proposal of the Always Supported programme, how it works, the value it brings, and how it can support older individuals (*Manual de comunicación para los equipos del programa Siempre Acompañados*, Communication Manual for the Always Supported programme teams, 2024).

3.
PROGRAMME PROFILES: DEFINITION AND INTERVENTION PROPOSAL

3.1. INTRODUCTION

Loneliness, says Christina Victor (Victor et al., 2000; Victor and Sullivan, 2015), is an experience that exists in the form of multiple realities (each person experiences loneliness in a different way) and is constructed and reconstructed by each person in the context of their life.

Supporting people in situations of loneliness therefore requires a personalised perspective. There is not a single loneliness, but different types of loneliness; even if we classify them – social, emotional, existential, etc. – each experience of loneliness is unique and also dynamic: what begins as a lack of people to share with, for example, can end up affecting a person's life project.

Alongside this personalised perspective, understanding other variables, such as the degree to which the person feels loneliness or various related factors – social network, social support, losses and transitions, perceived health, quality of life, coping strategies, sense of purpose, etc. – can help establish a line of work that ensures a more effective intervention while also optimising resources.

Nevertheless, bearing in mind the variability among individuals, the Always Supported programme has defined different loneliness profiles (characteristics and traits shared by different people), based on the criteria outlined below, with two objectives: to tailor the intervention to the needs and characteristics of those experiencing loneliness, and to make the intervention more efficient and effective.

The profiles defined in the programme, which will be explained in detail later, are:

» **Loneliness profile.** These are individuals in different situations of loneliness.

» **Preventive profile.** Refers to individuals who are not experiencing loneliness, but have accumulate risk factors (for example, they have a limited social network, are carers of older adults, are going through a period of transition, have recently experienced a loss, etc.) that warrant preventive intervention.

» **Network profile.** Corresponds to individuals in need of connection.

For proper organisation of the information presentation, we will first outline the procedure and tests used for including individuals in the programme, as well as the subsequent matching of the person to the corresponding profile. Following that, we will provide a comprehensive overview of the set of traits and characteristics that define each profile.

3.2. ASSESSMENT OF THE ENTRY PROFILE

When the person contacts the programme and the initial interview is conducted, the profile into which the individual is placed within the programme is defined. It should be borne in mind that the profile is not a static assignment; rather, as the person progresses through the process their profile may change due to various circumstances. In other words, profiles are tools that facilitate the appropriate intervention, but it is guided by the individual and their situation of loneliness.

Throughout the time that the person participates in the programme – ranging from six months to three years, depending on their personal and evolving situation – regular evaluations are conducted to adjust the intervention (and, obviously, the profile) with the aim of offering them the most appropriate support for their situation at each moment.[5]

As mentioned earlier, the assignment to the most appropriate profile is established during the initial interviews, following the criteria of suitability and profile assessment (see chapter 3, section 2, p. 174 and Appendix 3, p. 267).

This matching of each person to a specific profile is carried out in a face-to-face interview using two tests selected for the purpose: the CEL tool (*Campaign to End Loneliness Measurement Tool*) and the *UCLA 3-item loneliness scale*.

When choosing these two tests, we take various factors into consideration:

» The length of the scale, that is, how many questions an initial screening scale should contain.

» The language used, that is, whether the questions posed to the individual are phrased positively (for example, if they are happy with their relationships) or negatively (for example, if they miss certain people).

» The reason for which the scale was designed: screening, research, service development, etc.

» Whether the scale asks directly about the word "loneliness" or addresses the issue of loneliness without naming it (using the word "loneliness" can be distressing for some people who feel lonely, because it forces them to acknowledge their situation).

» Psychometric characteristics of the tests: validity, reliability, etc.

The CEL Tool was developed during the 2014 campaign to end loneliness in the United Kingdom and was created in collaboration with older adults, service providers and others, with the aim of better understanding and addressing loneliness. The tool uses validated items from the UCLA Loneliness Scale (Austin, 1983) and the De Jong Gierveld Scale (De Jong Gierveld and Van Tilburg, 2006). It was designed to be user-friendly and adaptable to a variety of contexts.

5. This chapter details the process that individuals follow in the programme, specifying when and how they are evaluated, and whether they can change profile based on evaluation results.

The second test included in the initial profile assessment is the UCLA 3-item scale (Austin, 1983; Hugues et al., 2008), a brief instrument widely used for the assessment of loneliness. It was developed from the 2004 20-item scale (Russell et al., 1978) with the purpose of being used in surveys that could be conducted by telephone. Validation tests concluded that it effectively measures feelings of loneliness and is a robust measure of loneliness for telephone or self-administered questionnaires.

Using both tests within a structured interview, the individual is assigned to the profile based on the following scoring system:

Table 1. **Scoring for profile assignment**

	CEL loneliness measurement tool	UCLA 3-item scale
PREVENTIVE PROFILE	Responds to 1 or more questions with "I agree".	Score of 3 points or lower.
LONELINESS PROFILE	Responds to at least 1 question with "I do not agree".	Score of 4 points or higher.
NETWORK PROFILE[1]	A person with a need for connection and participation regardless of their situation of loneliness. The "network profile" is a space focused on fostering social relationships, connection and participation through projects and activities.	

1. The characteristics and criteria of this profile are detailed in section 3.3.3, p. 115.

Source: Compiled by the authors.

One last point: loneliness is a complex phenomenon that is still highly stigmatised. Often, although it may seem paradoxical, it is not easy for people suffering from loneliness to participate in a programme aimed at empowering them to combat their own loneliness: the pain caused by suffering can also be paralysing.

The creation of the network profile is aimed at providing experiences of connection, bonding, belonging, closeness and intimacy. It is intended to make people feel useful and valued by others, which in turn will help them perceive themselves as valuable. Empirical evidence (Hall et al., 2023) underlines the importance of these connections and recommends recognising and not underestimating the power of meaningful conversations. In the ten years of experience with this programme, it is common to see individuals included in the network profile subsequently feeling capable of confronting their loneliness and participating in the programme.

3.3. TYPES OF PROFILE

3.3.1. Loneliness profile: people experiencing loneliness

3.3.1.1. Definition

This profile is made up of people with certain characteristics:

» They have few social relationships.

» They suffer from a lack of meaningful relationships, which leads to a deficit of emotional support.

» They generally lack deep bonds and people to confide in.

» They miss the company of others.

» They experience feelings of exclusion and the absence of a reference group.

» They perceive a lack of meaning or purpose in their life, which hinders their motivation, among other issues.

» They often have feelings of isolation and disconnection from the world around them and do not find anyone who understands their situation or their feelings and emotions.

The profile also includes people with the following characteristics:

» Feeling of loneliness that causes them distress and suffering.

» Lack of personal resources (knowledge, skills, strategies, etc.) to cope with it.

» Absence of a social network and social support.

» Lack of meaning.

» Manifestation in their narrative of one or more of the following situations:[6]

- Losses. For example: "Since I lost my daughter, I've stopped going out; I don't even feel like going out with my husband any more."
- Transitions (retirement, moving house, etc.). For example: "I came to live here to be near my daughter, but now I don't have anyone and she works all day."
- Absence of trusting relationships, without meaningful bonds. For example: "I know there are people I can meet up with, but I can't talk about what's worrying me; nobody cares about the problems I have with my daughter."
- Lack of motivation to take charge of their life. For example: "I feel low on energy, I don't feel like doing anything; it's an effort, and I don't do anything I used to enjoy."
- A certain existential emptiness. For example: "Since my husband died, nothing makes sense; I don't even feel like getting dressed up to go out."

The causes of these situations can be numerous and varied, as many as there are people. Based on the definition of possible causes made by John Cacioppo (Cacioppo and Patrick (2008), Christina Victor (Victor et al., 2000; Victor and Sullivan, 2015) and Robert Weiss (Weis, 1973), we can distinguish them as:

6. The phrases in quotation marks refer to cases from the Always Supported programme.

» Causes related to factors external to the individual.

» Causes related to internal factors of the individual.

» Causes that are a combination of both types of factors (in a high percentage of people).

External factors can be defined as those related to the socio-environmental context, that is, the geography where the person is located, their surroundings, and factors associated with the experience of feeling lonely.
These include:

» Inadequate physical environment (lack of accessibility): housing, neighbourhood, access to services, etc.

» Insufficient financial conditions: poverty.

» Community with limited resources or difficulty in accessing those resources.

» Occurrence of life events: losses, transitions, changes in family structure, etc.

» Limited social relationships.

» Poor supportive relationships.

By *internal factors* we refer to intrapersonal, psychological and emotional aspects that influence the subjective perception of loneliness.

» Sadness (and depression), anxiety issues, etc.

» Low self-esteem, self-concept and self-efficacy.

» Low tolerance to stress.

» Past experience related to traumatic situations.

» Subjective assessment of poor living conditions and health.

Therefore, the loneliness profile is broad, heterogeneous and diverse, encompassing people who feel lonely regardless of other objective factors, such as living with others or having a social network.

3.3.1.2. Types of loneliness profile

Loneliness is usually classified into three different typologies, emotional, social and existential, which are not mutually exclusive (Weiss, 1973; De Jong Gierveld, 1998). This classification provides a reference framework for understanding the phenomenon of loneliness and its characteristics. However, it is crucial to recognise that the reality of experiencing loneliness is much more complex and does not always fit neatly into these categories. Bearing in mind the great complexity of the loneliness phenomenon, distinguishing between these three types – social, emotional and existential – is helpful in understanding the needs of those experiencing it.

Below, we outline the most relevant characteristics of each type of loneliness and the needs that may accompany them.

Social loneliness

» Characteristics: little or no social network, lack of a sense of belonging to a community, perceived lack of social support. Factors such as social isolation, migration and changes in social and family structure may contribute to this type of loneliness.

» Needs: integration and a sense of belonging to a group or community; building a network of friends, family members or acquaintances; frequent opportunities to interact with others and to be part of a community where they feel valued and accepted.

Emotional loneliness

» Characteristics: absence of an intimate, close and deep relationship. Perceived abandonment, lack of attachment or absence of secure relational bonds; this may be marked by a feeling of emptiness. Causes can include the loss of a loved one, difficulties in interpersonal relationships or an inability to form deep bonds due to psychological or emotional factors.

» Needs: creation or reconstruction of meaningful relationships with emotional connection; to feel supported and understood by someone with whom they can share feelings, fears and joys.

Existential loneliness

» Characteristics: awareness of being separated from people and the universe, regardless of having family, friends or other loved ones. It is related to a lack of purpose and meaning in life. Causes, which may vary, include existential crises, identity issues and personal experiences of suffering or alienation.

» Needs: engaging in activities or projects that bring meaning to life; exploring beliefs and values; connecting with activities that foster a sense of belonging and transcendence, and contributing to the common good; feeling validated and recognised; and being able to share experiences with others.

3.3.1.3. Complexity factors and high-complexity protocol

The experience of loneliness occurs within a situational and cultural context that cannot be ignored when dealing with it. This context refers to the circumstances and conditions in which the person is living and which, in the case of loneliness, are influencing the way the person is experiencing it. The context can either mitigate or intensify the perception and effects of loneliness.

When we refer to the situational context we are talking about factors of complexity, which are usually conditions related to the following situations and which exacerbate the experience of loneliness:

» Precarious housing situation: lack of basic resources (water, electricity), unsanitary conditions, dampness, lack of ventilation, being located in unsuitable or risky environments.

» Precarious financial situation: people at risk of poverty or lacking financial resources to meet basic needs.

» Mental health: depression, anxiety, complicated grief, etc.

» Situations of mistreatment, abuse or lack of protection.

» Suicidal ideation.

» Chronic medical conditions that may limit mobility, such as Parkinson's disease.

» Acquired disabilities that limit mobility, such as severe visual impairment.

» Others.

The intervention model of the Always Supported programme takes context into account by conducting a comprehensive assessment based on the person's life story and the evaluation (see chapter 3, section 1, p. 139, and sections 1.3-1.5, pp. 150-170) to identify the complexity factors that are intensifying the person's experience of loneliness. Once identified, these situations need to be addressed in order to respond to the needs that have highlighted. The community-focused approach, an essential component of the programme (see section 2, p. 61), will enable us to tackle the situation in a comprehensive way and in collaboration with specialised stakeholders in the community.

These stakeholders are professionals from public administrations and local organisations that carry out social, health or community interventions. Thanks to the work carried out with the community in establishing collaborative networks, these stakeholders and organisations are also part of the Always Supported programme framework, enabling an integrated and coordinated response to the needs of the people served by the programme. This inter-institutional and multi-stakeholder collaboration is essential.

Some of these professionals include:

» Social workers from social services.

» Social workers and healthcare staff from health centres.

» Mental health specialists.

» Associations specialising in disability, volunteering, Parkinson's disease, mental health, etc.

» Food bank managers and volunteers.

» Others.

Once a complex situation is identified, the protocol for complex or high-complexity cases is activated (see Appendix 2, p. 262). This protocol aims to facilitate the creation of a technical space for interdisciplinary coordination among professionals, enabling a swift and organised response to these situations by placing the individual at the centre and enhancing the support provided through the different institutions and technical stakeholders in the area that collaborate with the programme. This coordinated approach serves as the link between person-centred intervention for the individual and the role of the community in tackling loneliness. In other words, it highlights the role of the community in improving the experience of loneliness and, therefore, builds that relational "architecture" within the community that is essential in the response to situations of loneliness.

The protocol establishes the basis of coordination to address these situations swiftly and efficiently, specifying the roles of the professionals involved and the way in which they should communicate.

The procedure for handling a complex case is divided into the following phases:[7]

Phase 1. Prior assessment and activation of the protocol

The Always Supported team activates the protocol when it detects a complex situation during the initial assessment or at any point in the intervention, based on the situations mentioned above.

Activating the protocol means that the team will contact the professionals who can address the identified need or needs. Each case requires unique coordination tailored to its specific circumstances. Ad hoc multidisciplinary teams are formed according to the needs presented by the case.

Phase 2. Joint and integrative assessment

A joint assessment is conducted by all the professionals involved to identify needs, risk factors, available resources, etc., taking into account the wishes and opinions of the individual and establishing coordinated action guidelines.

Phase 3. Intervention plan

A coordinated plan of intervention and approach to the case is drawn up, including the distribution of responsibilities, working guidelines and the timeline assigned to each action.

Phase 4. Monitoring the intervention plan

The professionals involved report on progress according to the agreed proposals. The intervention, the work of team members and the assigned timeframe are jointly evaluated.

Phase 5. Case closure

Once the objectives have been achieved, the coordinated intervention is concluded by mutual agreement. In general terms, each case should be resolved as quickly and efficiently as possible.

7. Although the protocol includes the same phases, its implementation depends on the location where it is applied.

Example of a case with complexity factors and protocol activation

Presentation of the case

Antonia[8] is 87 years old. She lives alone and is estranged from her daughter. Over the past six months, she has lost two close friends with whom she shared hobbies, walks, chats and rest on a park bench. Now she does not know what to do.

She owns her home but has limited financial resources. She says she feels ashamed of her home because "it's falling to pieces". It is the flat she moved into after her husband passed away nine years ago, because she could not afford to stay in the home where she had lived with him and her daughter. It is a 25 m^2 mezzanine with very little ventilation; it has a small window in the kitchen and another in the dining room. The walls are damp, causing the paint to peel off and exposing the brickwork. Occasionally, she leaves the door open to let some air in. There is a bathroom with a small shower, but no hot water due to a lack of installation. Antonia says with resignation that she has got used to cold water. She does not have the financial resources to make even minimal repairs or regularly pay for the utilities.

During the visit, she presents with a poor personal appearance, dishevelled and wearing clothing in poor condition, though clean; it is not dirty, just old and worn.

Antonia says that she has felt sad and anxious for years. These feelings have been intensified by her living conditions and, in particular, by the lack of a support network, as her social interactions are very limited. Her episodes of anxiety have become more frequent and her ability to manage daily activities is deteriorating. She stopped attending the mental health service years ago, saying they did not help her. Occasionally she goes to the community centre for older adults.

She was referred to the programme by the health centre after attending a follow-up appointment for "some spots on her skin". The nurse noticed that she was alone, without any support, and told her about the Always Supported programme.

Analysis of the situation

The results of the evaluation tests are as follows:

» She presents with very severe loneliness on the De Jong Gierveld scale. She scores 6 in emotional loneliness and 5 in social loneliness (a total of 11 points).

» On the Duke scale, she scores low in perceived social support.

» According to the Lubben scale, there is a risk of social isolation and a clear need to improve close emotional relationships.

» In terms of loss, she scores a 6, and in transitions, also a 6, as she is going through a delicate period and has experienced significant losses in the past year

» Her perceived health scores a 4, meaning she believes she is in poor health. Quality of life scores a 2, indicating she perceives her quality of life to be poor.

» In assessing existential loneliness, she expresses that she does not feel she means anything to others and that her life has no purpose.

8. Antonia's case is a real one, adapted to protect her privacy and rights.

» Regarding the typology of loneliness, she scores high in the following areas: frequency of feelings of loneliness, rumination, stereotypes such as "it's normal for older people to be lonely", family loneliness, and loneliness due to loss.

» Her predominant coping strategies are:
  – Resignation to her current situation.
  – Lack of activation of her social network (reaching out to people); she stays alone at home.
  – Occasionally tries to manage her emotions: "I try not to feel sad".
  – Does not ask for help.
  – Dislikes being alone.

» In the assessment of the meaning of life, the most notable values are:
  – Perception of meaning: Sometimes I feel completely bored (2).
  – Perception of meaning: Life seems completely routine to me (1).
  – Existence of tasks and goals: I have no goals or aspirations in life (2).
  – Experience of meaning: Every day is exactly the same (2).
  – Experience of meaning: My life feels empty (3).
  – Experience of meaning: When I think about my life, I find no reason to live (2).
  – Existence of tasks and goals: I have realised that I have no purposes (2).

» Regarding daily life: the times of day when she feels the saddest or most alone are in the afternoon and at night.

In addition, she presents the following **complexity factors**:

» Poor housing: constant concern for safety and physical discomfort, which increases her stress and sense of helplessness.

» Untreated diagnosis of depression and anxiety: Antonia's depression and anxiety complicate her ability to seek out and maintain social connections.

Intervention. Activation of the protocol for complex cases

In this case, with the person's consent, the Always Supported team activates the protocol for complex cases to coordinate an approach to Antonia's situation, following the different action guidelines and involving her at all times:

» The Always Supported professional will work on alleviating her loneliness by developing her social network and engaging her in meaningful activities, following the loneliness intervention framework (see section 3.3.1.5, p. 107).

» The social services professional will address her precarious housing situation and explore the possibility of activating home support services.

» The mental health professional will schedule an appointment and attempt to reconnect her with the mental health network to assist with her depressive and anxiety symptoms.

Closure of the action protocol in Antonia's case

Following the case, once the complexity factors have stabilised, the protocol is deactivated with the commitment that each service will continue supporting Antonia within their respective areas. In this case, the Always Supported programme will continue working to improve her situation of loneliness by strengthening her social network and meaningful activities, following the guidelines established in the intervention model.

In conclusion, the definition of the loneliness profile is broad, as it includes three types of loneliness, existential, social, and emotional, which are not mutually exclusive and may also involve additional complexity factors. Therefore, within the loneliness profile, we may find people experiencing only one type of loneliness, as well as people feeling all three types and presenting one or more additional complexity factors.

3.3.1.4. Criteria

Taking into account the characteristics of individuals with a loneliness profile, the criteria that these people meet are as follows:

» Loneliness with a prolonged duration (chronicity).

» Moderate, severe, or very severe score in the De Jong Gierveld test.

» Predominance of negative emotions and feelings:
  – Sadness.
  – Hopelessness.
  – Low self-esteem.
  – Lack of motivation.
  – Feeling of not fitting in (sense of alienation).
  – Feeling of lack of control.
  – Experience of emptiness.
  – Lack of interest, apathy, boredom.
  – Perceived lack of recognition.
  – Shame.
  – Loss of identity.

» Lack of trusted relationships or only superficial connections, with no-one for intimate bonding.

» Relationships: limited social network, little support.

» Lack of purpose or meaning, limited daily life, with no meaningful activities.

» Presence of various risk factors: widowhood, chronic illnesses, etc.

» Established perception of isolation.

3.3.1.5. Intervention proposal

Intervention for the loneliness profile is a multi-component approach that combines personalised individual support, psycho-educational group intervention (for example, to improve coping with vulnerability, emotion management, social skills development, etc.), and the establishment of new meaningful relationships. All of this aims to create a support network that encourages participation in community spaces with which the individual can feel connected.

The following outlines the factors targeted in the intervention for the loneliness profile, **taking into account each person's individuality and specific situation**.

» Focus on modulating variables:
- Increase the size of the social network by expanding interactions with groups that may include acquaintances, friends or family.
- Enhance social support by developing trusting and supportive relationships, both perceived and provided.
- Improve personal resources to manage loneliness by learning to handle emotions and loss, develop healthy coping styles and manage vulnerability, etc.; influence and work towards the life they would like to lead in terms of meaning and purpose, etc.

» Focus on mediating variables:
- Strengthen engagement and participation in formal activities, such as volunteering, involvement in community associations or groups, etc., and informal activities, such as staying in touch with friends by phone and in person.
- Incorporate healthier habits, routines and lifestyles, including balanced diets, regular physical exercise, etc.

» Minimise risk factors where possible. Some examples:
- Connect with health and social services.
- Include family in the process with the individual's consent.
- Engage with local neighbourhood services (libraries, pharmacies, home support services, associations, etc.).

In summary, the primary objective of the intervention proposal is for the person to transform their daily life and become empowered to make decisions that lead to an improvement in their feelings of loneliness by transforming relationships, enhancing modulating variables and minimising risk factors.

3.3.1.6. Example of a case with a loneliness profile

Presentation of the case

Luis is 83 years old. Happily married to Maria for 54 years, he was widowed two years ago. They had two children, who now live in different cities and visit him occasionally. Since his wife passed away, he feels lost and unsure of what to do after a lifetime together.

He lives alone, in the same house he has lived in all his life, fortunately close to the Always Supported office, but far from his friends and family.

Luis always socialised with friends from work, which was on the other side of the city and, unfortunately, he has hardly any connections in his neighbourhood. He mentions some neighbours with whom he used to play cards from time to time when he was younger; they were fellow parents from his children's school, but that was a long time ago.

Financially, he has a good pension that allows him to live comfortably.

Luis, who suffers from arthritis, is physically frail and has mobility difficulties. His daily routine is somewhat disorganised. He gets up late and skips breakfast to avoid overlapping it with lunch. Most of his time is spent in front of the television or reading. He describes his days as monotonous and boring. Talking about the past, he mentions that he used to enjoy taking walks in a nearby park but has stopped, partly for fear of falling and partly because of the pain he feels when walking. He does not pay much attention to his diet; living alone, he often eats whatever is convenient for dinner, frequently ready-made food.

Regarding relationships, his children phone him every weekend. The conversations are brief and focused on daily routines. He has lost contact with his work friends due to distance and lack of mobility. He has a few neighbours who greet him, but he does not have a close relationship with them. He feels he has nothing in common with them, that he does not fit in anywhere. He describes his life as sad.

Analysis of the situation

The results of the evaluation tests are as follows:

» He presents with severe loneliness on the De Jong Gierveld scale. He scores 4 in emotional loneliness and 5 in social loneliness (a total of 9 points).

» On the Duke scale, he scores low in perceived social support.

» On the Lubben scale, he is at risk of social isolation and has a clear need to improve close emotional relationships.

» He scores 2 for loss (no significant losses in the past year). In transitions, he scores 6, indicating he is going through a difficult period.

» Perceived health and quality of life each score 4, since he considers his health and quality of life to be neither very good nor very bad, remaining at an average score (range 1-7).

» Regarding existential loneliness, he feels existential loneliness related to purpose and meaning. However, in terms of the meaning of relationships, he does perceive that he matters to his children.

» In terms of loneliness typologies, he scores high on frequency of feelings of loneliness, rumination, family loneliness and loneliness due to loss.

» His predominant coping strategies are:
  – Reflection and changing his thought patterns.
  – Lack of activation of his social network (reaching out to people); he stays alone at home.
  – Emotion management (he tries not to feel sad).
  – Does not ask for help.
  – Dislikes being alone.

» In the assessment of the meaning of life, the most notable values are:
  – Perception of meaning: Sometimes I feel bored (3).
  – Perception of meaning: Life seems routine to me (3).
  – Experience of meaning: Every day is new and different (5).
  – Experience of meaning: My life feels empty (3).
  – Existence of tasks and goals: I have goals or aspirations in life / I have discovered that I have purposes in life (6).

» Regarding daily life: the time of day when he feels the saddest or most lonely is at night.

Based on the results of Luis's tests and the information gathered from the interview and life story, it can be concluded that he presents the following strengths and weaknesses:

» His strengths and personal resources are:
  – Favourable coping strategies: reflection and changing thought patterns, and emotion management.
  – Occasional contact with neighbours.
  – Contact with his children.
  – A sense that life has purpose.

» His weaknesses and areas for improvement are:
  – Loneliness with a prolonged duration (chronicity).
  – Severe loneliness score on the De Jong Gierveld test.
  – Limited social network and few meaningful relationships, with little support.
  – Predominance of negative emotions and feelings:
    · Feeling of not fitting in.
    · Feeling of lack of control.
    · Boredom.

– Risk factors: widowhood and arthritis, which makes mobility difficult; unhealthy daily routine (food and sleep hygiene). Does not ask for help.
– Pain makes mobility difficult.
– Few hobbies or meaningful activities.
– Unhealthy routine: eating and sleeping.

Intervention proposal

On the basis of the above analysis, the following objectives are proposed:

» Improve his routine by going out every day (focusing on the mediating variable).
How will he do this?
– Stabilise his schedule and mealtimes.
– Go out every day to a different destination related to exploring the neighbourhood where he lives (destinations can be repeated).
– Keep a diary of the places he visits and assess this routine, as well as a subjective assessment of his mood (before and after going out).
– Attend the meeting point organised by the Always Supported programme on Tuesdays.

» Improve social and support relationships (focusing on the modulating variable):
How will he do this?
– Expand his social network:
· Attend the group intervention organised by the Always Supported programme to improve social skills.
· Practise the skills he has learned at the meeting point intervention that the Always Supported programme organises on Tuesdays.
– Improve his supportive relationship with his children:
· Show more interest in them during conversations.
· Learn to ask for help by practising assertiveness.
· Practise expressing gratitude towards his children.
– Take care of his health and seek assistance for daily living activities (reducing risk factors).

How will he do this?
· Contact the health centre to request follow-up for pain management.
· Look into assistive devices that may be available to help reduce the risk of falls.
· Contact the district social services to inquire about home help options.

The intervention agreed upon with Luis to achieve the specific objectives mentioned above combines, on the one hand, individual work to monitor the action plan and agreed actions, and on the other, his participation in the group intervention and meeting points organised by the programme.

3.3.1.7. To summarise

The intervention for the loneliness profile is an individualised approach aimed at the following:

» Personal work to focus on modulating and mediating variables, as well as risk factors.

» Changes in the individual's daily life.

» Group interventions to address specific aspects.

» Participation in meeting spaces organised by the programme.

3.3.2. Preventive profile: people with risk factors

3.3.2.1. Definition

The preventive profile refers to those individuals who, although they are not currently experiencing loneliness or may feel only mild loneliness (after all, who does not feel lonely from time to time!), display risk factors that could lead them to experience loneliness in the future and could therefore benefit from a preventive intervention. These people may be on the verge of feeling lonely due to recent changes in their lives, such as retirement, the loss of loved ones, health problems, reduced mobility, etc. This profile also includes those who have a limited social network or little social interaction, or lack trusting and supportive relationships.

These are individuals who exhibit one or more of the following characteristics, indicating a potential risk of experiencing loneliness:

» Significant life changes: retirement, loss of loved ones, changes in family structure (divorce, empty nest, etc.), moving house.

» Health or mobility issues.

» Limited or sparse social network; infrequent relationships.

» Lack of relationships with trusted people to share with.

» Low participation in the community or in meaningful activities.

» Low self-esteem or lack of self-confidence.

» Lack of a meaningful life project.

3.3.2.2. Criteria

By way of summary, and taking into account the characteristics of this profile, the general criteria defining individuals included in this profile are as follows:

» People who are not lonely or experience only mild loneliness.

» With a high or very high level of autonomy.

» Who need or show interest in:
  – improving their personal resources;
  – expanding or adjusting their network, both in structure and in the qualitative elements – emotional closeness and support – of their relationships;
  – having a more meaningful daily life;
  – increasing their participation in the community.

» With various risk factors that are expected to trigger future loneliness or potential chronic loneliness.

» With no or a very limited social network or significant relationships.

» With some presence of intermittent or occasional negative emotions and feelings:
  – Sadness.
  – Hopelessness.
  – Low self-esteem.
  – Lack of motivation.
  – Feeling of not fitting in (sense of alienation).
  – Feeling of lack of control.
  – Experience of emptiness.
  – Lack of interest, apathy, boredom.
  – Perceived lack of recognition.
  – Shame.
  – Loss of identity.

» Lack of trusted relationships or only superficial connections, with no-one for intimate bonding.

» Lack of purpose or meaning, limited daily life, with no meaningful activities.

» Others.

3.3.2.3. Intervention proposal

Preferably, the intervention for this profile is group-based, with each person also having individual improvement objectives. In other words, a personalised approach developed, if possible, within a group setting. In any case and depending on the person's needs, the option of offering an individual intervention in addition to the group approach is always considered.

We will now outline the group intervention for the preventive profile, followed by the individual intervention.

» **Group intervention.** As mentioned above, for the preventive profile, priority will be given to the group intervention (see section 4, p. 120). The interventions are designed with a specific itinerary and objectives. However, each person is encouraged to pursue their own development. In other words, alongside the group work and its benefits, each participant will set their own objectives and decide how to work on the different aspects and actions outlined in the chosen itinerary according to their life experience and interests.

» **Individual intervention.** For the preventive profile, an individual intervention may also be considered when the need is identified. The criteria for offering individual intervention to someone within the preventive profile are:
  – Reluctance to share personal issues in a group: the individual expresses discomfort with discussing private matters with others.

– Difficulty being in a group: not respecting others' opinions, not listening, needing to speak without allowing space for others, etc.
– Identification during the group intervention of an area that would benefit from individual work.
– Other reasons for which the team deems individual intervention appropriate.

The following are the key factors targeted in the intervention for the preventive profile, both in group and individual settings:

» Empowerment.

» Increasing the quantity and quality of relationships.

» Improving mediating variables (lifestyle, etc.).

» Learning skills, strategies and tools to prevent feelings of loneliness.

» Enhancing emotional management.

» Working on life projects and sources of meaning.

» Developing skills to manage situations of fragility and vulnerability.

» Seeking ways to contribute to the common good.

3.3.2.4. Example of a case with a preventive profile

Presentation of the case

Pepa is a 69-year-old woman for whom retirement marked a drastic change in her life. She worked for more than 40 years as a teacher and identified strongly with her profession; educating and being part of children's lives gave her a sense of purpose.

Since retiring, she says she is enjoying her free time, but at the same time feels disoriented without the anchor her job provided. She lives alone in a small flat since her husband passed away five years ago. She has two children, with whom she has a very good relationship. They see each other every week and speak on the phone daily, although she says, "I don't want to worry them with my problems".

Pepa makes an effort to maintain her daily routines. She engages in activities she enjoys, such as yoga and walking with her friends in the park. She has a stable social network, though she feels it is limited, that if her friend is not available she will have no-one to talk to. She does interact with a few neighbours she chats with occasionally, but is unsure how to take the next step to build deeper connections. She says it used to be easy, but since retiring she feels she has nothing to offer. She misses the school, the classes, the children.

Pepa participates little in community activities and rarely attends social events or local groups because she feels embarrassed to go alone. When she does go, it is because her friend or one of her children accompanies her. She would like to have the courage to go by herself and start meeting new people, as she believes that such a change would help make her days better.

Analysis of the situation

The results of the evaluation tests for the preventive profile are as follows:

» On the De Jong Gierveld scale, she does not exhibit loneliness.

» On the Lubben scale, she scores 4 in the areas of emotional closeness and frequency of contact, and perceived support scores 3. This needs attention.

» In the assessment of meaning of life, the most notable values are:
  – Sometimes I feel completely bored.
  – Life seems routine to me.
  – I have goals in life (scores in the mid-range).
  – Every day is exactly the same.
  – My life has some exciting aspects (scores in the mid-range).
  – When I think about my life, I find reasons to live.
  – I have discovered that I have purpose in life (scores in the mid-range).

Based on the results of Pepa's tests and the information gathered in the interview and life story, it can be concluded that she does not experience loneliness, and has a high degree of autonomy.

In addition, she displays the following strengths and weaknesses:

» Her strengths and personal resources are:
  – Enthusiasm for her profession, along with all the skills and knowledge she has developed over her lifetime.
  – Her passion for children and teaching.
  – Independence in managing her life (she lives alone).
  – She maintains an interest in community activities.
  – She expresses a need to:
    · have a more meaningful daily life;
    · increase her participation in the community.
  – She has support from her children, with whom she maintains a very good and regular relationship.
  – She has occasional interactions with her neighbours.

» Her weaknesses and areas for improvement are:
  – Retirement has led to a loss of identity, role and purpose.
  – She perceives her social network as limited.
  – Due to low motivation and self-esteem (related to the loss of role), she finds it difficult to start new relationships.
  – She has self-limiting beliefs about going to new places on her own ("I feel embarrassed").

– Predominance of negative emotions and feelings:
  · Sadness.
  · Boredom.
  · Shame.
– Low participation in community activities.
– Risk factors: widowhood and retirement.

Intervention proposal

The objectives proposed for Pepa are:

» Discover meaningful activities and redefine her life project.

» Improve social relationships by strengthening social skills.

» Strengthen her self-esteem and confidence.

To work on these specific objectives, she will be encouraged to:

» Participate in the group intervention "Life Project and Meaningful Activities".

» Engage in relational spaces designed by the team.

» Undertake individual intervention over a set period to address limiting beliefs that hinder the creation of new relationships.

3.3.2.5. To summarise

The intervention for the preventive profile would include:

» Group intervention as a framework for working on individual development.

» Option for individualised preventive support.

» Option to participate in relational spaces created for the network profile.

3.3.3. Network profile: people needing connection

3.3.3.1. Definition

The network profile is designed for people who want to have social connections, to experience support and to build networks. People in this profile need opportunities for connection, bonding and belonging; they want to feel useful and valued by others, with a special emphasis on the need to have regular small conversations because of their impact on improving well-being, as previously mentioned.

This profile includes three situations:

1. People who long for connection, bonding and support (even if they do not necessarily have objective deficits in these areas).
2. People who, due to their situation, are reluctant (do not want to commit, do not feel capable, etc.).
3. People who have participated in the programme, either in the loneliness or preventive intervention, and continue to need connections.

Below, we present the characteristics of each group:

1. Regardless of whether or not there is an objectively identified issue in the evaluation of the Always Supported programme, there are individuals who want (or need) more contact with other people and long for greater bonding, to feel useful and recognised. The Always Supported programme offers them this possibility, which obviously has a preventive nature that requires a lower intensity of intervention than the preventive profile analysed above.
2. People who decline another intervention. As mentioned in the chapter introduction, these are individuals who, for whatever reason, dismiss the possibility of being included in the other programme profiles, but could benefit from attending these relational spaces.
3. People who need continuity in the programme. These are individuals who have made an individual or group journey in Always Supported and have improved their situation, but need a space to continue building connections and a sense of belonging.

3.3.3.2. Criteria

In summary, the criteria met by individuals in this profile are as follows:

» Individuals not experiencing loneliness and who do not seek high involvement with the programme but have a need for connection and relationships.

» Individuals experiencing loneliness who decline participation in an individual programme yet have a need for connections and relationships.

» Individuals who have completed the initial proposed intervention and remain connected to the programme through the spaces designed for the network profile.

3.3.3.3. Intervention proposal

We have long known that both the quantity (number of contacts) and the quality of social interactions significantly influence feelings of loneliness (Pinquart and Sorensen, 2001). Therefore, the intervention for the network profile focuses on providing opportunities for individuals to increase their relationships, feel useful, and experience connection, bonding, a sense of belonging, closeness and intimacy.

The aim is to encourage conversations and provide opportunities for people to share, tell stories, joke and catch up, in other words, to create a space where individuals can enhance their sense of belonging and social relationships.

The intervention for the network profile is embedded in the community orientation of the Always Supported programme (see section 2, p. 61). The relational spaces are designed in collaboration with community organisations and are conducted jointly by the team and a volunteer organisation or individual. In each area, these spaces are defined with the specific characteristics of the community and the stakeholders involved in mind.

3.3.3.4. Example of intervention proposal

» Coffee spaces or café gatherings: open meetings held at a frequency ranging from weekly to monthly. These are facilitated in collaboration with volunteers and community organisations. Formats vary, but most combine talks or presentations on topics of interest with activities that promote cohesion and facilitate relationships.

» Walks: organisation of walks through areas of interest in the community, with a frequency ranging from weekly to fortnightly. These are open proposals, with no need for prior registration.

» Summer Programme: this programme aims to address the needs of people who are at higher risk of experiencing loneliness during the summer, when the intensity of the activities on offer decreases and relationships are often interrupted due to holidays, if people relocate (see section 2.5.6.1, p. 94).

» Volunteering: volunteering opportunities are offered for actions organised by the Always Supported programme, such as information points or community activities to raise public awareness (see chapter 4, section 3, p. 237).

» Others.

3.3.3.5. To summarise

The intervention for the network profile focuses on both increasing the number of social interactions and improving the quality of existing relationships, as well as fostering a sense of belonging, etc. This is achieved by facilitating relational spaces designed by the team in collaboration with community stakeholders and by creating new social connections.

3.4. SUMMARY TABLE OF PROFILES

The following table summarises the typology of the programme profiles, their definition and the proposed intervention.

Table 2. **Summary table of typologies and interventions**

LONELINESS PROFILE

Key words

People experiencing loneliness

Typology	Characteristics	Type of intervention
Social loneliness Emotional loneliness Existential loneliness *With/ without complexity factors	*a.* Loneliness with a prolonged duration (chronicity). *b.* Moderate, severe, or very severe score on the De Jong Gierveld test. *c.* Predominance of negative emotions and feelings: · Sadness · Hopelessness · Low self-esteem · Lack of motivation · Feeling of not fitting in (sense of alienation) · Feeling of lack of control · Experience of emptiness · Lack of interest, apathy, boredom · Perception of lack of recognition · Shame · Loss of identity *d.* No trusting relationships or only superficial connections, with no-one for intimate bonding. *e.* Relationships: limited social network and little support. *f.* Lack of purpose or meaning, restricted daily life, with no meaningful activities. *g.* Various risk factors: widowhood, chronic illnesses, etc. *h.* Established perception of isolation.	1. Personalised individual work process. 2. Group intervention to address specific issues. 3. Participation in social spaces created by the programme (meeting spaces).

PREVENTIVE PROFILE

Key words
People with risk factors

Typology	Characteristics	Type of intervention
	a. Individuals without loneliness or with mild loneliness. ***b.*** High or very high level of autonomy. ***c.*** Individuals who need or show interest in: · improving their personal resources; · expanding or adjusting their network, both in structure and in the qualitative aspects of their relationships (emotional closeness and support); · having a more meaningful daily life; · increasing their participation in the community. ***d.*** With various risk factors that could lead to future loneliness or possible chronic loneliness. ***e.*** No or limited social network, or no meaningful relationships. ***f.*** Some presence of intermittent or occasional negative emotions and feelings: · Sadness · Hopelessness · Low self-esteem · Lack of motivation · Feeling of not fitting in (sense of alienation) · Feeling of lack of control · Experience of emptiness · Lack of interest, apathy, boredom · Perception of lack of recognition · Shame · Loss of identity ***g.*** No trusting relationships or only superficial connections; no-one for intimate bonding. ***h.*** Lack of purpose or meaning, limited daily life, with no meaningful activities.	**1.** Preferably group intervention. **2.** Possibility of individual preventive support. **3.** Possibility of participating in the relational spaces designed by the team (network profile spaces).

NETWORK PROFILE

Key words: People in need of connection

Typology	Characteristics	Type of intervention
Decline another intervention. Continuation of the process from other programme interventions.	*a.* Individuals not experiencing loneliness who do not want high involvement with the programme but have a need for connection and relationships. *b.* Individuals experiencing loneliness who are uncertain about participating in an individual programme but have a need for connections and relationships. *c.* Individuals who have completed the initial proposed intervention and remain connected to the programme through the spaces designed for the network profile.	Typical meeting spaces: · Coffee spaces or café gatherings · Walks · Summer Programme · Volunteering

Source: Compiled by the authors.

4.
GROUP INTERVENTION

4.1. INTRODUCTION

A group intervention can be defined as a set of structured and systematic procedures implemented within a group of people who share a particular situation, characteristic, problem or need. Its purpose is to induce changes in behavioural, emotional or cognitive variables through interaction and group cohesion. This approach aims to optimise the psychological and social functioning of participants by facilitating processes of self-exploration, feedback and mutual support (Corey et al., 2006).

In the specific case of loneliness, group interventions have been widely used in various formats. Thus (Pinazo, 2020):

» Cattan and White (1998) identified four types of health promotion interventions aimed at reducing loneliness or social isolation: group activity interventions, one-to-one interventions, service provision and targeted interventions.

» Findlay (2003) repeated the review for the period 1998-2002 and, while questioning their efficacy, identified four types of interventions, quite similar to the previous ones: group activity interventions, one-to-one interventions, service provision, and information and communication technology interventions (Internet).

» Cattan et al. (2005) conducted a new systematic review in which they identified and categorised 31 studies: 17 group interventions, 10 one-to-one interventions,

three service provisions and one community development initiative. Of the effective interventions, nine out of 10 were group interventions, specifically, support or educational groups. The authors drew two key insights from the study: first, the benefits of group interventions, namely that educational and social group interventions targeting specific groups can alleviate social isolation and loneliness in older adults; and second, the lack of proven effectiveness of interventions focusing on home visits and befriending.

» Dickens et al. (2011) identified various types of interventions: group activities (19 studies) and one-to-one interventions (11 studies), dividing them into those offering social and physical activities, those providing support through different strategies or methods, internet training interventions, home visits and service provisions. Their review of interventions to reduce social isolation found that supportive group interventions have proven effective in improving health levels, reducing loneliness, and increasing participants' social activity.

» One of the most insightful reviews is that by Masi et al. (2011), which proposed four types of actions to address loneliness in older adults: 1) programmes that enhance social skills (assertiveness, communication skills, etc.); 2) programmes that provide social support through companionship, usually from a volunteer, commonly known as befriending; 3) programmes that increase opportunities for social interaction; and 4) programmes that modify maladaptive social cognitive patterns, that is, those that change unhelpful social cognitions (Pinazo and Donio, 2018).

» Cohen-Mansfield and Perach (2015) classified interventions into five types: educational (24 studies), with shared activities (six studies), with individual activities (one study), with specific therapeutic or intervention techniques (two studies), and with sensory technological aids (one study).

» Finally, a number of validated interventions have been found in addition to those already mentioned. For example, Banks and Banks (2002) worked using animal-assisted therapy; Winningham and Pike (2007) used cognitive interventions; Tse (2010) worked with group gardening; Chiang et al. (2010) used reminiscence; and Tsai et al. (2010) with video conferencing, to name a few.

In any case, group interventions with an educational component that guide individuals toward behavioural activation, improve their sense of control and include social activities have proven to be effective (Cattan et al., 2005; Dickens et al., 2011). The authors observed that, after participating in the group, older adults gained a greater sense of control over the activities they engaged in. A comprehensive review of these studies can be found in Pinazo (2020).

4.2. OBJECTIVES OF GROUP INTERVENTIONS

In general, group interventions aim to increase participants' self-awareness (referred to as *personal resources* in the Always Supported programme) and help them clarify the changes they want to achieve by providing them with the necessary tools to reach these goals and offering support to make them happen. Additionally, the interaction among group members provides an opportunity to share experiences of adopting new behaviours and to receive mutual support.

In the case of loneliness, group interventions pursue the following objectives, in summary:

» To give and receive support and feedback among people who are dealing with similar "symptoms" (Thompson et al., 2000).

» To increase awareness of the individual resources that people have or develop to cope with loneliness or reduce the risk of feeling it.

» To accept and normalise shared experiences by providing support and a sense of belonging (Correa, 2016).

» To serve as a source of support, learning and improved well-being.

» To provide personal resources (skills, strategies, etc.) that empower each person to address their own loneliness.

Each of these interventions can, in turn, be classified according to the psycho-educational component it addresses. For example:

» Improving coping with vulnerability.

» Optimising emotion management.

» Developing social skills.

» Learning healthy habits.

» Expanding personal resources for adapting to change.

» Raising awareness of the value of meaningful activities and increasing them.

» Delving into the meaning of life.

4.3. CHARACTERISTICS OF GROUP INTERVENTIONS

Group interventions are defined not only by the objectives they aim to achieve, but also by other aspects, both "methodological" and substantive:

» **Group dynamics.** The group intervention focuses on the interaction and dynamics among participants. Relationships, roles, communication patterns and group interactions are explored and developed. The group itself becomes a resource and a learning environment.

» **Social support.** Groups provide an environment of mutual support and understanding. Members can share similar experiences, provide emotional support and learn from

each other, which encourages the reduction of isolation, the promotion of empathy and the development of a sense of belonging.

» **Multiple perspectives.** Groups are made up of individuals with different life stories, experiences and perspectives. This provides the opportunity to interact with other points of view and alternative solutions to common challenges (for example, increasing social connections). The diversity of perspectives enriches the process and fosters both the acquisition of new knowledge and personal development.

» **Social learning.** Groups provide a shared learning environment. Participants can learn from each other, share effective coping strategies and offer relevant information and resources. Social learning can be a powerful catalyst for change and personal growth.

» **Group feedback and reflection.** In group intervention, participants have the opportunity to receive direct and honest feedback from others, which provides new perspectives and increased personal awareness. In addition, group interaction allows for reflection on one's own thoughts, emotions and behaviours through the lens of the group and by observing what happens to other group members (a kind of vicarious learning).

» **Normalisation and validation.** By sharing their experiences within the group, members can realise they are not alone in facing their challenges. Normalisation and validation of these experiences can reduce stigma, ease emotional burdens and foster a sense of acceptance and understanding, both towards oneself and others.

4.4. SKILLS REQUIRED TO FACILITATE GROUP INTERVENTIONS

The person leading the intervention process must have the necessary training to facilitate effective communication, promote empathy and encourage collaboration among participants. Apart from this training, particularly in addressing loneliness – as well as in dealing with related issues such as grief, the meaning of life and similar topics – a certain level of both professional and personal experience is essential.

In addition to the points mentioned above, it is crucial to create safe and confidential spaces where group participants can confidently share their experiences, thoughts and emotions.

To ensure success, the group facilitator should develop the following skills:

» **Communication skills.** To lead effectively, the facilitator must possess strong communication skills. They should be able to actively listen to group members, demonstrate empathy, ask clear questions and encourage open and respectful communication among participants.

» **Group management.** The facilitator must be capable of managing group dynamics and maintaining a safe and welcoming environment. They should establish and enforce group rules and norms, manage conflicts and ensure that all members have the opportunity to participate.

» **Theoretical knowledge.** Group intervention relies on a deep understanding of the concepts being addressed. For example, how can one facilitate a group on coping with loss without a solid grasp of well-being, affective processes, the meaning of loss, vulnerability or purpose?

» **Empathy and cultural sensitivity.** Leading a group intervention requires demonstrating empathy and understanding towards group members by acknowledging and respecting their experiences, perspectives and cultural differences. It demands sensitivity to diversity and the ability to foster an inclusive environment.

» **Problem-solving skills.** As challenges and conflicts arise in the group, the facilitator must possess strong problem-solving skills and be able to identify and address issues effectively, while fostering collaboration and commitment among members.

» **Flexibility and adaptability.** The facilitator must be able to adapt to changing needs, adjust their approach with cognitive flexibility and be willing to explore new strategies or techniques, as necessary.

» **Self-awareness and self-reflection.** A strong sense of self-awareness and the ability to self-reflect are essential. The facilitator should be open to receiving feedback, examining their own reactions and biases, and ultimately be committed to their own professional growth and development.

4.5. GROUP INTERVENTIONS IN THE ALWAYS SUPPORTED PROGRAMME

Group interventions in the Always Supported programme are defined as designed, structured and validated processes aimed at generating changes in participants' daily lives by facilitating their personal empowerment through group dynamics, fostering mutual learning and change.

As previously described, the Always Supported programme bases its theoretical model on the influence of risk factors and mediating and modulating variables on feelings of loneliness. Consequently, the design of the group intervention is based precisely on addressing some of these variables that may be contributing to the feeling of loneliness – social relationships and mediating and modulating variables – by focusing on one or more of them to equip participants with personal resources to address these challenges.

4.5.1. Design of the interventions

The scientific literature supports that loneliness programmes combining different types of interventions have proven to be the most effective in alleviating loneliness (Masi et al., 2011; Dikens et al., 2011). Group interventions are among the range of approaches offered to enhance the likelihood of reducing loneliness in older adults, as we have already discussed. The Always Supported programme combines various strategies to address loneliness, with group interventions being a key component.

Initially, the programme began by working with the interventions proposed by the "Live well, feel better" programme (Yanguas et al., 2016), part of the "la Caixa"[9] Foundation's Older Adults programme. The initiative consists of four itineraries aimed at helping older adults develop strategies that contribute to their personal growth and development, and alignment with a life project that enhances their personal well-being. The first itinerary, "Living as I wish", lays the foundations for personal change; the second, "Living positively", develops key personal resources for change; the third, "Living is self-discovery", applies change in everyday situations; and the fourth, "Living with purpose", deals with losses and the search for meaning. Although not specifically designed to address loneliness, the topics covered in each of the itineraries are closely related to the factors and variables that may influence an individual's experience of loneliness. Consequently, someone participating in the programme can benefit from the work undertaken in them to improve their situation.

Subsequently, based on the experience of the almost 2,000 participants supported over the 10 years of the programme, the need was identified to design interventions tailored to the specific situations of Always Supported participants to improve existential loneliness, emotional loneliness and social loneliness.

Various groups were set up to guide these interventions:

» Focus groups with participants to explore their needs and the feasibility of working in a group setting.

» Working groups with professionals from the Always Supported programme to share the recurring areas of focus or variables identified in the action plans and to determine whether there were common issues among participants that could be addressed through group interventions.

From the factors that were identified, it was decided to start with those that were most relevant for group intervention aimed at improving feelings of loneliness, based on the following psycho-educational components:

» **Improving social skills.** The main idea is that by enhancing social skills, the quality of social, interpersonal and intrapersonal relationships can improve, facilitating social networks and promoting social inclusion for older adults (Stojanovic et al., 2016; Masi et al., 2011). Skill-training interventions have proven effective when conducted in groups with individualised objectives for each participant (Delgado and Alonso, 2019).

» **Emotion management.** Healthy ageing is closely linked to the ability to understand our emotions and take advantage of what they bring us to take the most appropriate actions (Díaz-Veiga et al., 2009). It is crucial to highlight the importance of emotions and their impact on people's health and well-being. When individuals develop adequate levels of emotional management (emotional intelligence), enabling them to recognise, understand and act on their own emotions and those of others, their well-being and personal and social adaptation improve (López-Pérez et al., 2008).

9. The "Live well, feel better" programme of the "la Caixa" Foundation can be consulted at this link: https://fundacionlacaixa.org/es/personas-mayores-atencion-soledad

» **Developing routines and a healthy daily life.** Education in healthy habits is essential to promote the health, well-being and autonomy of older adults, as it improves their quality of life while empowering them to take an active role in their own health. It can also contribute to disease prevention (Amador and Esteban, 2015). In the context of the Always Supported programme, developing routines and a healthy daily life also act as variables that "mediate" feelings of loneliness.

» **Enhancing empowerment against loneliness.** Empowerment in later life is often influenced by negative self-perceptions, and loneliness directly impacts the feeling of not being in control and the ability to make decisions, leading individuals to "disempower" themselves. Feeling empowered is crucial for improving well-being and quality of life, strengthening self-concept and self-esteem, and facilitating social participation (Iacub and Arias, 2010).

» **Coping with vulnerability.** As described in previous chapters, all human beings are inherently vulnerable simply by existing, as there is always the possibility of being "wounded". Feeling vulnerable is a fundamental human condition. Developing healthy ways to cope with vulnerability involves acquiring strategies to strengthen self-esteem, self-confidence and resilience, while creating a supportive and secure network of relationships (Rowe and Kahn, 1997). Connecting with our vulnerability offers the opportunity to live in a way that is more connected to the present and enables us to face life's challenges in a healthier way.

» **Reconnecting with meaningful activities, purpose and meaning.** Existential loneliness is linked to a lack of purpose and meaning, and can have a major impact on people's psychological health by increasing the risk of suicidal ideation. Sutin et al. (2018) conducted a longitudinal study in which they found that people who felt their lives had purpose reported fewer feelings of loneliness over time. It is essential for individuals to identify and explore their sources of meaning and meaningful activities, and to develop personal resources to build their life project and put it into practice. For example, this could involve fostering social commitment, self-awareness and self-fulfilment or participating in volunteer activities in which they can care for others in need.

To ensure its effectiveness (Dickens et al., 2011), each intervention is structured with a defined theoretical foundation from which specific objectives and an action plan are developed, depending on the focus areas.

The group interventions offered in the programme undergo a validation process that ensures:

» The quality of the process, ensuring that the methodology and tools used are appropriate.

» Effectiveness, confirming that the intervention meets the objectives and expected outcomes.

» Acceptability, ensuring that the approach is well-received by the participants.

4.5.2. Target audience

Group interventions are aimed at individuals who are being supported by the programme, both in the preventive profile and in the loneliness profile, who meet the specific criteria defined for each intervention.

4.5.3. Example of a group intervention

An example of a typical intervention within the programme is described below.

4.5.3.1. Introduction: life project and meaningful activities

A considerable percentage of the individuals supported by the Always Supported programme experience existential loneliness. These are people who have lost connection with the meaning and purpose of life, with what brings them satisfaction, which leads to an identity crisis in many cases. This disconnection from life can result in feelings of hopelessness, worthlessness and sadness, leaving individuals feeling unmotivated.

The intervention analysed in this section aims to reignite participants' motivation, that is, the inner strength that drives people to seek a "good" life, one with meaning and purpose, aligned with their values and beliefs, where they become active stakeholders in their own life story.

This group intervention focuses on helping older adults connect with their life project by rediscovering or identifying meaningful activities that contribute to the common good, thereby fostering greater emotional well-being and a more fulfilling life.

The inner strength required to connect with meaning and purpose involves becoming aware of and enhancing personal resources that modulate feelings of loneliness, such as managing loss, coping with vulnerability, developing healthy coping strategies and reconnecting with one's own values. It also includes working on engagement, commitment and social participation.

Through a collaborative and mutually supportive approach, participants will explore their values, interests and goals with the aim of building an action plan that will enable them to integrate these elements into their daily lives. This approach seeks to empower older adults to identify and sustain meaningful activities, thereby fostering a more fulfilling and satisfying life that reduces feelings of existential loneliness and brings meaning and commitment to their lives.

4.5.3.2. Objectives

» Reconnect with their life project by facilitating a connection with what gives them purpose and meaning.

» Identify and commit to activities that provide satisfaction and encourage participation.

» Explore activities and actions that contribute to the common good.

» Identify personal values and motivations.

» Create a supportive environment that helps build and strengthen social relationships.

4.5.3.3. Target audience

This group intervention is designed for older adults experiencing feelings of loneliness, predominantly existential, and who exhibit one or more of the following characteristics:

» Have lost their sense of purpose or life project and feel empty.

» Have lost significant social connections.

» Lack opportunities to establish social relationships.

» Have stopped participating in activities they once enjoyed.

» Want to explore new activities.

4.5.3.4. Methodology

The intervention, based on therapeutic and educational approaches, employs techniques from cognitive-behavioural therapy, acceptance and commitment therapy (ACT) and humanistic approaches. The group structure fosters mutual support, collaborative learning and the creation of a social support network.

The sessions are designed to provide participants with a comprehensive and transformative experience by combining various components to facilitate learning and personal development. Different elements are introduced in each session:

» **Theoretical component.** Provides a foundation for understanding existential loneliness, meaningful activities and related concepts.

» **Individual reflection exercises.** Includes self-reflection exercises to explore values, beliefs and experiences in order to foster self-awareness that helps participants connect with their purpose and meaning.

» **Practical activities and tasks between sessions.** Practical activities are included aimed at introducing specific changes in participants' daily lives, such as planning and engaging in meaningful activities, promoting social interaction, implementing new coping strategies and so on.

4.5.3.5. Sessions

The following is a brief overview of each session, including the objectives and the focus of the main activities proposed.

SESSION 1. PRESENTATION AND START OF THE JOURNEY

Professor Ramon Bayés (2020) once said that "a person is a journey, and no two journeys are the same". In other words, a person is always the final result – always, as long as their brain functions (we are vulnerable!) – of their unique interactive history shaped within specific physical, cultural, social and emotional environments, through language and other forms of communication. In short, a person is the singular product of their biography. Without interactions in specific contexts, the person, as such, would not exist. The professor likens a person to a unique and unrepeatable journey, constantly evolving from birth to death. While the past cannot be changed, the journey itself can be transformed, especially the future. It is precisely this journey into the future that the intervention seeks to influence.

This session marks the start of the journey, where participants connect with the other group members, are introduced to the individual journey that is initiated through the proposed intervention, and explore individual expectations.

Objectives:

» Introduce the programme and group members.

» Define personal objectives.

» Raise awareness of the importance of the present moment.

Main activities:

» Pair activity for getting to know each other.

» Group activity to identify expectations and personal goals.

» Activity on the importance of the present moment using Tolstoy's story *The Emperor's Three Questions*, followed by individual reflection.

This story symbolises the importance of the present moment. It tells of an emperor who seeks the answers to three key questions, believing that if he knew them, he would always have everything under control: What is the right time? Who are the right people? What is the most important thing? A hermit helps him find and understand the answers for himself. The best time is the present, the most important person is the one you are with now, and the most important thing is to help others.

After reading the story, a reflection begins with the participants on "the importance of my moment" to analyse the three questions in the story in relation to the life of each of the participants.

SESSION 2. EXPLORATION OF PERSONAL VALUES AND MOTIVATIONS

This session aims to uncover what drives each of us, what attracts us, what connects us to life, that is, what motivates us, so that personal development can revolve around these aspects. The key idea for connecting with values and motivations is self-determination, the notion that each individual is an active agent of what happens to them and that they are in control of their own life. Self-determination is about making choices and living the life that one desires. It is therefore related to motivation – the reasons that drive us to do something. Engaging in activities or actions aligned with our intrinsic motivation is essential for connecting with a sense of purpose.

Objectives:

» Identify the values, interests and motivations that are still important to each participant.

» Understand intrinsic motivations and recognise the importance of feeling competent in pursuing them.

Main actions:

» Brief introduction to the concepts of self-determination and intrinsic motivation.

» Group exercise to create a list of motivating activities for the group members: "What motivates me".

The steps of the activity are as follows:

» Each participant writes on sticky notes five things that motivate them (one thing per note, along with their name) and shares them with the whole group.

» The notes are placed on a wall mural and sorted into categories.

» The implications of each category in relation to well-being and values are discussed.

» A reflection takes place, with participants sharing personal experiences about the connection between the categories, well-being and values.

SESSION 3. MANAGING LOSS

This session focuses on understanding that the experience of loss and transitions are crucial moments of change and personal identity reconstruction, and that the attitude adopted towards that experience is key to healthy management. We need to be sensitive, approach the pain, and learn to live with it. Loss, according to Neimeyer (2002), encompasses any diminishment of personal resources (losing people through death, break-ups, arguments, etc.), material resources (money, home, etc.), or symbolic resources (youth, children leaving home, etc.) with which we have an emotional connection. Loss, therefore, is intrinsically linked to attachment and to what is meaningful or important to each person. In the face of loss, people experience grief, which is a natural adaptive reaction that includes a process of adjustment and adaptation. This process, which involves emotional pain and suffering, varies in intensity depending on each individual's experience. Losses are part of the human condition and, as we age, they tend to accumulate. While we cannot control what may happen to us, we can manage the attitude we adopt when it does.

Objectives:

» Explore the nature and significance of losses and transitions as deeply vulnerable experiences for individuals.

» Describe and understand the emotions and thoughts that arise when experiencing a loss.

» Delve into experiences of loss and transitions, and "normalise" them.

» Develop coping strategies.

Main actions:

» Reflection on loss through readings from chapter 4 of the book *Quicksand* by Henning Mankell.

In 2013, Swedish author Henning Mankell learned he had cancer. An unexpected neck pain following a car accident revealed he was suffering from lung cancer with metastasis in the neck. From that moment, the author, known worldwide for his series of crime novels featuring Inspector Kurt Wallander, faced the illness head-on. In his final book, *Quicksand* (Tusquets), he exorcises his fears, inviting readers on an urgent journey through his life and that of his entire generation.

The reflection is guided by the following questions:

» What is the concept of quicksand, and what does it represent?

» How does Mankell experience quicksand?

» How does he overcome it?

The reflection activity revolves around personal experiences of loss and the resources used to overcome them.

» Individual losses are explored and shared in a group.

» Each participant chooses a loss and reflects on it in depth:
  – What did I feel? What was my initial emotional reaction? What thoughts did I have?
  – What did I do to overcome it? Once I accepted the situation, what thought helped me face and overcome it? What did I do?

» The resources used to overcome the loss are shared with the group.

SESSION 4. RECONNECTION WITH MEANINGFUL ACTIVITIES

This session builds on the understanding of loss and the motivations explored in previous sessions, aiming to encourage individual reflection in order to connect with meaningful activities that bring satisfaction and purpose. Having a meaningful day involves planning tasks and activities aligned with one's life goals. It is based on the premise that goals keep us connected to life. Living with a purpose and engaging in activities in everyday life that are relevant, meaningful and reflective of who we are as individuals is essential for emotional and psychological well-being. Every activity is linked to an emotional state, which can be positive, aversive or neutral – all of which are part of life. These activities, when structured as part of a logically ordered set of goals, will enable us to achieve more complex life goals that require more time and effort to accomplish. These life goals are personal and, in a way, shape us as individuals. This session introduces techniques to inspire participants to identify life goals and plan for the future based on what they want, enjoy and find motivating.

Objectives:

» Identify activities that have been meaningful in the past and those that are meaningful in the present.

» Visualise and explore new opportunities for motivating and meaningful activities.

» Connect activities with value and purpose.

» Analyse the impact on mood of activities that give life meaning.

Main actions:

» Introduction to the relationship between personal values, activities and commitment.

» Activity: "The meaning of my activities":

- Individual reflection is conducted, and answers are written on a piece of card:
  - "Of what I've done in my life, what has brought me the most satisfaction or pride?"
  - "What things would I have liked to do but haven't?"
  - "If I could go back, what would I not to do again if given the chance?"

» These reflections are shared with the group.

» The actions or items mentioned are connected to sources of meaning and examined to see if they are currently present in each participant's life.

» An individual reflection follows, focusing on connecting daily life with meaningful activities, based on the previous discussion.

» Participants share insights about their sources of meaning and how they plan their daily lives. Are meaningful activities present or absent?

» A group discussion is held on new activities that could be meaningful and aligned with the values identified.

SESSION 5. PROMOTING SOCIAL RELATIONSHIPS

This session emphasises social relationships as an essential aspect of emotional well-being, given that humans are interdependent beings – we need one another. Engagement with others is introduced as a crucial attitude for fostering meaningful social connections. Building new relationships throughout life and connecting with others are fundamental needs. Social and behavioural sciences emphasise the importance of social functioning and its connection to multiple areas of life. While strong social functioning is synonymous with health and well-being, poor social relationships equate to illness and suffering. We cannot live without relationships. Friendships provide social support and are a source of satisfaction, especially for those with fewer family connections. However, social relationships are equally important for those who enjoy satisfying family ties, as they allow people to share similar life experiences, interests and common concerns. This is why maintaining and creating new relationships in daily life is so important.

Objectives:

» Reflect on the importance of the interpersonal environment for personal development.

» Encourage the creation and strengthening of meaningful and appropriate social relationships that provide support and well-being.

» Analyse the importance of cultivating new relationships and the challenges encountered in establishing these new connections.

Main actions:

» Presentation of the types of social relationships and their role in emotional well-being.

» Group activity: "Ways to nurture relationships":

- In pairs, participants share the different ways they nurture their relationships, and write them on a piece of card.
- Each pair shares them with the group.
- All suggestions are compiled into a single list.
- The group discusses the list, reflecting on the challenges of maintaining relationships, the skills needed to nurture them and other relevant aspects.
- An individual reflection follows, focusing on what participants currently do, and what they could do better to nurture their relationships.

SESSION 6. SHARING WITH OTHERS: THE COMMON GOOD

This session focuses on the benefits of spending time with others and doing things for others. These benefits are equally significant for the person receiving the help and the one giving it. Participating in voluntary actions, such as caring for others or improving the community, brings numerous advantages, particularly in terms of personal growth and development. Acts for the common good not only enhance collective and community well-being, but also help individuals find meaning and purpose in life. At the same time, people experience a stronger connection to the community, which generates personal satisfaction as they realise their actions have a positive impact on the world.

Objectives:

» Analyse the importance and motivations that lead us to spend time with others and do things for other people.

» Reflect on the key aspects and benefits of caring for others and doing things for others through community action.

» Identify the positive aspects of spending time with others and doing things for other people.

Main actions:

» Group activity to reflect on the importance of doing things for others or participating in activities that contribute to the common good.
  – Explore actions carried out or known by participants that contribute to the common good.
  – Share participants' personal experiences.
  – Conduct a group exercise to compile a list of actions that contribute to the common good.
  – Reflect individually on how to connect personal values with contributions to others or the community, exploring their motivations for helping others.
  – Reflect individually on one's own participation in contributing to the common good.

SESSION 7. GIVING YOURSELF PERMISSION

This session focuses on the importance of the permission that each person gives – or does not give – themselves to do what they want or are interested in. "Giving yourself permission" is about being connected, about knowing, acknowledging and understanding your own desires, personal aspirations, ambitions and passions, emotions and feelings, both those you like and those you do not, those you accept as your own and those you find harder to embrace. When we give ourselves permission, it acts as a facilitator and driver of personal change by linking intention to action. It means seeing oneself as an active participant, as someone who is "doing something", which is a key part of initiating change. Precisely, one of the essential benefits of this session is that it offers an opportunity for participants to give themselves permission (in a supportive environment) to change (somewhat) the way they see things or to deal with some aspects of their life in a different way from how they have done previously.

Objectives:

» Encourage individuals to lead the life they desire by fostering personal change.

» Transform ideas and beliefs that hinder change.

» Facilitate self-awareness of the need and desire to change one's life by connecting with meaning and purpose.

Main actions:

» Introduce the concept of *giving yourself permission* and reflect on its meaning through the analysis of a case study:

The case presents the difficulties of a 78-year-old woman who used to go dancing with her husband. Since his death eight years ago, she has not danced again. She has a friend who attends the dance and has invited her to join her, but she is unsure of what to do. She is grappling with several doubts: whether going to the dance would be a betrayal of her husband, and what her children might say.

» The following questions are posed:

– What might she be feeling inside?

– How can she give herself permission? What needs to change?

» Engage in individual reflection on whether or not one gives themselves permission to do things that bring satisfaction, exploring limiting beliefs.

» Conduct a group activity to share individual commitments to giving oneself permission to introduce changes in life.

SESSION 8. CLOSURE AND FUTURE PLANNING

In this session, the last of the journey, the aim is to reconnect with the lessons learned on the itinerary, the changes experienced and the participants' commitments for the future. Returning to Professor Bayés' initial concept of the journey, participants are invited to consider what journey they envision for themselves as they continue their process with a view to the future, incorporating the insights they have gained. It is a closure session with a focus on reflecting on the process and the learnings achieved.

Objectives:

» Reflect on what has been achieved and establish a plan of action to maintain these achievements.

» Evaluate the intervention carried out.

Main actions:

» Setting future goals and support resources:

– Individual reflection on what has been learned during the itinerary. "What do I intend to incorporate into my life?". Anticipated challenges are noted.

– Share these reflections with the group.

– Identify resources to help overcome the challenges mentioned.

– Individual reflection: "From now on...".

» Final acknowledgements:

– All participants, along with the facilitator, will express gratitude for something about the group and the time shared together.

4.5.3.6. Validation

The programme undergoes a validation process to assess its effectiveness regarding the mediating and modulating variables that influence feelings of loneliness and its acceptability among the target group. The validation process follows a pre-post study design, with evaluations conducted one month and three months after the intervention has concluded.

The pre-post assessments administered are as follows:

Table 1. **Evaluation scales used in the validation of group interventions**

Variable	Dimension	Test
WELL-BEING	· Self-perception · Positive relationships · Autonomy · Mastery of the environment · Personal growth · Purpose in life	**Ryff's Psychological Well-Being Scale** (Ryff, 1998)
LONELINESS	· Social loneliness · Emotional loneliness	**De Jong Gierveld Loneliness Scale** (De Jong Gierveld and Kamphuis, 1985); validated in the Spanish older population (Buz and Pérez-Arechaederra, 2014; Buz et al, 2014)
ENGAGEMENT WITH LIFE		**LET, Life Engagement Test** (Scheier et al., 2006)
SOCIAL NETWORK	· Family · Friends	**Lubben Social Network Scale (6 items)** (Lubben et al., 2006)
PURPOSE IN LIFE		**PIL, Purpose in Life Test** (Crumbaugh and Maholic, 1964 and 1969; Crumbaugh, 1968)

Source: Compiled by the authors.

The following questionnaire will be administered after the intervention to assess the participants' subjective perception of change and the insights gained (see Appendix 4, p. 268).

4.6. CONCLUSIONS

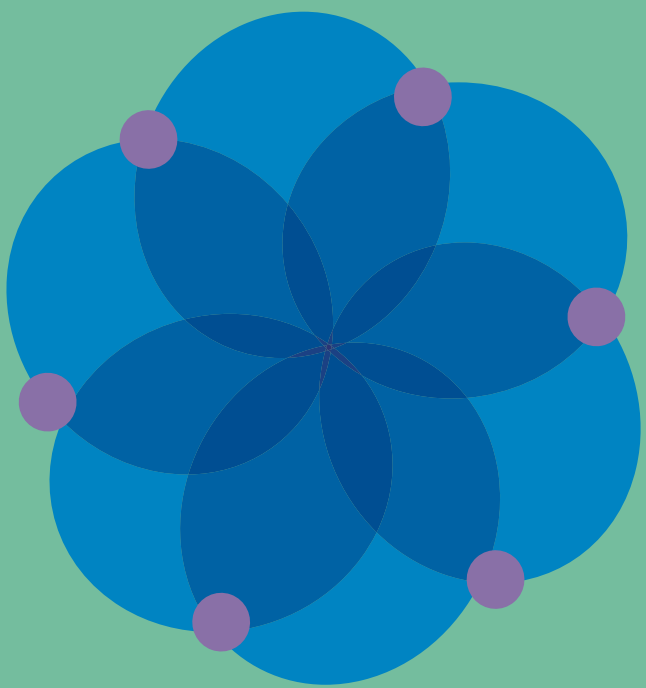
» Group interventions are an effective means of alleviating loneliness, as they provide opportunities for social connection, emotional support and the reinforcement of meaning and purpose. They create spaces where individuals feel understood and emotionally supported.

» Participating in a group fosters a sense of belonging and facilitates the creation of social and support networks. At the same time, encouraging participation and collaboration among participants helps improve their sense of achievement and reinforce self-esteem.

» Group interventions that include psycho-educational components promote personal development and empowerment by fostering a sense of autonomy and control and by developing skills and knowledge. These, in turn, enhance personal confidence, an essential quality for improving well-being and reducing feelings of loneliness.

Chapter 3

Evaluation and support process



1.
EVALUATION OF THE ALWAYS SUPPORTED PROGRAMME

1.1. INTRODUCTION

This chapter addresses the evaluation of the Always Supported programme. This evaluation encompasses two complementary perspectives:

1. The multidimensional evaluation of the person experiencing loneliness, through the assessment of variables such as social network, sense of purpose, loneliness, social support etc., as detailed below.
2. A second evaluation of the "satisfaction" of all those involved in the Always Supported programme (primarily individuals experiencing loneliness, professionals and experts) regarding the care and support provided for situations of loneliness by the Always Supported programme.

In any case, before addressing the purely evaluative aspects, the first instrument used by the Always Supported programme is the life story, which is only conducted with individuals included in the loneliness and preventive profiles (see sections 1.2-1.4, pp. 139-170).

The life story, detailed below and conducted exclusively with the loneliness profile, has two main objectives:

1. To get to know the individual.
2. To try to establish a meaningful connection between the individual and the professional from the Always Supported programme.

1.2. LIFE STORY: OBJECTIVES AND CONTENTS

Creating a life story for older adults is an enriching practice that provides multiple benefits for both the individual and their social and family environment.

At a stage in life when people may face challenges such as the loss of loved ones, declining physical abilities and feelings of isolation, creating a personal narrative becomes a powerful tool for enhancing emotional well-being.

Reflecting on past experiences and achievements can significantly reduce sadness and anxiety, while also providing a renewed sense of purpose and accomplishment. In addition, this practice helps preserve memory and personal identity, which are crucial to maintaining continuity and coherence in a person's life.

The use of the life story as a "therapeutic" and research tool has its roots in various disciplines and has evolved over time. In the field of social research, sociologists from the Chicago School used life narratives to gain a deeper understanding of the experiences of diverse social groups as early as the beginning of the 20th century (Thomas and Znaniecki, 1918-1920). In gerontology, Robert Butler introduced the concept of *life review* in the 1960s, emphasising the importance of reminiscence and reflection on

one's life in old age as a therapeutic process (Butler, 1963). In recent decades, the life story has been adopted as a valuable tool in the care of older adults, particularly within person-centred support models.

Life stories are proving to be valuable tools for providing personalised care, as they offer professionals a deeper understanding of the individual (McKeown et al., 2006). This approach not only improves the quality of care, but also facilitates the resolution of internal conflicts and the grieving process, helping older adults face death with greater peace and acceptance (Butler, 1963).

Creating life stories with older adults is a practice that goes beyond collecting biographical data. It is a process that can significantly strengthen the bond between the individual and the professional. Through the construction of a life story, a deep relationship is established between both parties, fostering empathy, understanding and trust – essential elements for providing quality, person-centred support. To develop a life story, it is crucial to create a safe space in which the person can share their biography with the professional, reinforcing the connection between them. According to McKeown et al. (2006), knowing personal stories enables professionals to look beyond the situation, symptoms and current behaviours to connect with all aspects of the individual.

Finally, documenting a life story promotes resilience by enabling older adults to recognise and celebrate their ability to overcome adversity throughout their lives, thereby strengthening their self-esteem and their ability to face current challenges (Ryff and Singer, 2003). Taken together, these benefits highlight the importance of creating a life story for older adults and emphasise its positive impact on emotional, cognitive and social well-being, as well as on the quality of the bond established between the professional and the person receiving care.

In addition to what has already been mentioned, the life story allows us, through the individual's life narrative, to understand what their fundamental values have been, the basis and manner in which they made decisions, how they acted and what their beliefs, desires, motivations and priorities were. The life story helps uncover what has been significant in their life and what has brought them meaning and purpose.

It also helps to understand the historical context a person has lived through, as well as the fundamental positive and negative events in their life. Additionally, it provides an opportunity to learn about the coping and resilience mechanisms they may have developed in response to traumatic experiences. All of this enables a deep knowledge of the individual, which is key to truly understanding their current situation and guiding the intervention.

In the face of loneliness, it is essential to be able to talk, share experiences and feel heard. The descriptions, explanations and evaluations that are part of the experiential stories we tell convey meaning and often connect with the emotions surrounding them. Narrating our life and recounting it requires organising our discourse and reconstructing our story to make it intelligible both to ourselves and to the person listening. In this

process of recollection, introspection and reflection, new meanings or interpretations often emerge as memories are revisited in the light of the present, and are therefore always reconstructed and reinterpreted.

As Bonafont (2020) reminds us, "In what we narrate and how we narrate it, our way of thinking, our values, our feelings or emotions, our way of positioning ourselves in relation to events that concern us and our way of dealing with them appear – implicitly, more or less subtly, or explicitly. Through dialogue with others, our expectations, desires or motivations may also emerge."

Two final notes, partially mentioned already:

» The attitudes of the listener are essential, as they either facilitate or hinder the narration. Demonstrating honest and sincere interest in discovering the uniqueness of the other person, as well as showing a genuine willingness to listen attentively and empathetically, fosters interpersonal relationships and creates a communicative space. As professionals, we need to be sensitive, respectful, discreet and worthy of the trust of those who open themselves up to us. We must recognise their uniqueness, create an atmosphere of dialogue and enable both words and silences to flow freely.

» The interpersonal relationship is essential; we must create an intersubjective space built on trust, mutual commitment to collaboration, acceptance of the relationship and recognition that the person sharing their story is willing to delve into their inner world, while the listener is prepared to receive it without judgment.

Objectives of the life story

Creating a life story has two fundamental objectives:

1. To gain a comprehensive understanding of the individual.
2. To establish a secure and trusting bond.

Contents of the life story (see Appendix 5, p. 270)

The following outlines the content that should be addressed when creating a life story, always bearing in mind that it is a dynamic and open process. As previously mentioned, it is not about simply "filling in" sections of a script, but rather using this framework as the basis for a conversation aimed at achieving the aforementioned objectives and supporting the individual in their uniqueness. The content is divided into two sections: *a*) getting to know the biography, and *b*) understanding the current and future life.

1.2.1. Getting to know the biography of the person

This section aims to provide an overview of the individual's life; the biographical data offer a general idea of their life story and context.[10]

1.2.1.1. Life stages

The aim is for the individual to recount their early years, childhood, adolescence, youth and maturity, sharing both significant memories and their personal identification with each stage, as well as the most relevant aspects of each. This may include their family of origin and the social, cultural and historical context.

> *I was born in Vilafranca del Bierzo (León), but since my mother was captivated by the idea of Barcelona and we needed work, we moved here and eventually settled in Badalona. My father came first to look for a job and a home, and a month later, my mother, my sister and I followed; I was eight years old at the time.*
>
> *I remember that I had to address my parents formally. They were very strict and stern; back then, parents were respected much more than they are now. I never lacked anything, although I missed having more closeness, trust, love, affection, or even just a smile at times... those things I have given to my three sons and my daughter.*
>
> *I always attended a religious school. I remember that when I was seven, the nuns used to say I was a disaster because I couldn't remember the lessons, memorising has always been something I've struggled with. Thursday afternoon was the only time we didn't have classes, as back then we had lessons every day, even on Saturdays, and every afternoon. Well, on that particular day, they wanted me to memorise a text, and I was punished all afternoon. In the end, they let me go because it was impossible for me to memorise what they were asking.*
>
> *I am the eldest of three sisters. When I was 17, my mother fell ill, and as I was the oldest and my youngest sister was only two years old, I was forced to leave school to take care of her (I would take her to and from school, feed her, put her to bed, bathe her...). I was like her second mother. I had a happy childhood with my sisters and friends, and I was sad to stop studying. I enjoyed learning. But at that time, I couldn't go against my mother and father. Everything was done for the family.*
>
> *Later, I got married and continued to have a relationship with my family and my sisters. I have nephews and nieces, and we see each other occasionally, though less and less over time. My sister passed away five years ago from cancer. Before she died, we had a big argument over an issue with my father's inheritance, which disappointed me a lot, and from that moment, my relationship with her changed. That hurt me, and I carried that pain inside. We still talked, but it was never the same. Now she's gone.*

10. The text in italics corresponds to the narrative of a person participating in the Always Supported programme.

1.2.1.2. Periods

This includes the formation of one's own family unit and life development over time: marriage, parenting, the empty nest and so on.

> *I got married later in life. My husband was very handsome. I met him in a village near where we lived, where my father would go some weekends. One time, I convinced him to let me join him along with a friend of mine. There, in the square where we were going to spend the afternoon, he was also there with some friends.*
>
> *At first, I didn't notice him; he didn't catch my eye. But he noticed me immediately. I saw him a few more times, and on one of those occasions he asked for my phone number. It was a very special moment because I couldn't believe he had taken an interest in me.*
>
> *We stayed in touch for a while and, eventually, we started dating when I turned 20.*
>
> *He was studying at the time, so I didn't marry him until I was 27. I remember my father telling my mother that she needed to teach me how to cook, because I was going to get married soon and didn't know how to cook at all. In the end, I learned to cook after I got married, using recipes from my mother-in-law or my mother and experimenting on my own. And so far, no-one has complained about my cooking or my food.*
>
> *When we were newly married, we went to live with my mother-in-law in the neighbouring village. She was a widow. My relationship with her was excellent, I was her favourite daughter-in-law and I got along with her almost better than with my own mother. My mother-in-law was very kind and affectionate toward me.*
>
> *My husband was a very good person. We had a good marriage, with many happy moments and the occasional difficult one, but he was well-loved by everyone. Thanks to him, I started to have a social life, and every now and then we would take trips to Portugal, Andorra and the Basque Country – especially once our children grew up and had their own lives.*
>
> *During my marriage, I had four children: three boys and one girl. The youngest came unexpectedly, and he's my pride and joy. None of them wanted to study, but all four have good jobs. I have four grandchildren, and I'm very happy with them. Every week, I see the little ones from one of my sons. I see the others less often because they don't live nearby. My youngest son decided not to have children, he says he has a dog instead. It makes me a bit sad, but I understand that raising children nowadays is very difficult.*
>
> *I worked when I was young but later gave it up for my family. When my children grew up and started school, I would accompany my husband, who ran a churro shop, and help him out. I really enjoyed chatting with the customers. The shop was in the heart of the old village, and everyone would stop by daily for their churros.*

1.2.1.3. Transitions

This section covers life changes that have marked a transition or loss: changes in employment, divorce, retirement and so on.

> *My life was shaped by moving from the village to the city. Leaving the village environment allowed me to meet different people and move in more open circles. It was like being able to breathe, I had more autonomy.*

Changing jobs also marked milestones for me, as it meant I was progressing and improving. First I worked as an administrative assistant. After three years, I was made shop manager. I kept advancing until I stopped working when my husband suggested it. At the time, I didn't mind because it allowed me to spend more time with my family, and I often visited the village to see my parents and siblings.

Another significant moment was when I got married, as it gave me more of a social life. We went out often, something I didn't do before I got married.

1.2.1.4. Losses

This section focuses on the significant losses the individual has experienced throughout their life: family members, friends and so on. It is not only about listing them, but also expressing what they meant to the person, how they coped, and whether they felt their life or sense of self was transformed by the loss.

> *Talking about my husband makes me very sad. When he passed away three years ago, I cried a lot. He fell ill, and I cared for him for two years. Now, I face it with resignation, as he made my life very enjoyable. The things he used to say to me are things no-one will ever say to me again. Since he died, I don't go out as much.*
>
> *When my mother passed away, it was very hard* (gets emotional). *She died on the day she turned 85. Although I didn't have the best relationship with her, when she died I realised I hadn't made the most of her final years. It feels like there were things left unsaid, even though I know there's nothing I can do about it now.*
>
> *Lately, I've been losing many people close to me: neighbours, friends... It makes me feel anxious and sad. I feel more and more alone.*

1.2.1.5. Life events

Significant or critical events that have been important in one's life; challenges and difficulties faced, notable problems that required overcoming obstacles and dealing with uncertainties; successes and failures, achievements attained or goals not accomplished.

> *When my son was little, he had an accident and was in a coma for a few days; they were the longest days of my life. At the time, I remember I had a very bad time, I could only think that he was going to die. But then I quickly told myself that he wouldn't, I stayed strong and held on. Thankfully, everything turned out well, although his recovery afterwards was very slow.*

1.2.1.6. Life review

This may include a life balance assessment: whether the individual feels satisfied with how they have balanced the different moments of their life, whether they feel they can view their life positively, or if there are aspects that prevent them from doing so. It also explores how their sense of meaning has evolved over the course of their life.

> *In general, I would say I've lived a life filled with both joys and sorrows, but I'm happy with what I've experienced. The thing is, now I feel like I've lost everything, including my energy, and I don't know which way to turn. My grandchildren bring me joy, but I struggle to find meaning in my day-to-day life. Until a few years ago, things were going more or less fine; dealing with aches and pains since losing my husband, but I managed to keep going. Now, I feel like I can't carry on.*

1.2.1.7. Geography of life

Places where the individual has lived.

> *I've lived in Vilafranca del Bierzo (León), Badalona, Barcelona and Santa Coloma; but the place I truly feel connected to is Badalona, where I spent my youth with my husband. Later in life, we moved to Santa Coloma.*

1.2.2. Understanding the current and future life

This section aims to have the individual describe how they feel about their life at present, identifying the most important or relevant aspects that define their current situation, as well as their vision of their life in the future.

1.2.2.1. Relationships and significant people

The individual should describe their network of relationships, the frequency of contact and how they feel about the quality of these connections; the significant and most trusted people, whether friends or family, including any professionals they trust.

> *My children care a lot about me; they're always worrying about me. They all call me constantly to check how I'm doing, and even those who live far away make sure I spend time with them. But I don't like staying too long, they have their own lives. Besides, I prefer being in my own home.*
>
> *I've always been good at interacting with people, but I find it very difficult to meet people to share time or go for a walk with.*
>
> *I usually spend time with a friend who's very supportive, we support each other. But I don't want to "burden" her because she has her own life; she still has her husband, and I don't like getting in the way.*

1.2.2.2. Loneliness

The aim is for the individual to share their subjective perception of loneliness or isolation; what they think and what they miss at times when they feel lonely or isolated; and whether they feel they have people to turn to when they need support.

> *There are many moments when I feel lonely, but I try to change my mindset by telling myself that things aren't so bad or by turning on the television to keep myself entertained. I try to stay strong and convince myself that I have to keep moving forward, as I have done all my life.*

1.2.2.3. Participation

The aim is for the individual to describe the associations or interest groups they belong to or have belonged to in the past, as well as the projects they have participated in, would like to participate in or find interesting.

> *I participated in the choir at the local parish and even took solfège classes. I really enjoyed singing.*
>
> *For many years, I've been a member of a book club at the library, where I also volunteered for a long time. But since my husband passed away, I hardly go anymore, and I've said I won't volunteer again. It's a shame, because I used to enjoy it a lot and felt very good and useful, but I don't feel up to it; I feel less and less like it every day.*

1.2.2.4. Fundamental preferences and habits

This involves reviewing the daily activities in their life that bring them satisfaction and also identifying those they dislike.

> *My daily routine is pretty normal. I get up at a reasonable time and start the day. Sometimes it's hard for me to get going with things. The morning slips by, and I haven't left the house unless I have an errand to run, which makes me get ready because I like to go out looking presentable. Lunch and dinner, especially dinner, are sad moments because I've never liked eating alone. I usually turn on the television to distract myself and avoid thinking too much. As for the afternoons, I try to go out for a bit every day. In winter, I go out before it gets dark, and in summer I wait until it's not so hot. Even if it's just a short walk. I take care of everything in the house myself. I don't like anyone coming into my home and, of course, it's getting harder for me, but I still manage. My children get lovingly annoyed about it, but it's my decision.*

1.2.2.5. Daily life

This section reviews fundamental aspects of their life that should be taken into account: best and worst moments, notable skills they can contribute, and so on.

> *Regarding my best moments, they're the ones I shared with my husband and those I enjoy with my sons, daughter, grandchildren and my friend.*
>
> *As for my worst moment, it was the passing of my husband and the disappointment I experienced with my sister.*

1.2.2.6. Significant activities

This involves describing the activities they engage in, their habits and interests (cultural, social, educational, recreational, sports or leisure-related), their priorities, activities that relax them or make them feel good, places they would like to visit or frequent, as well as significant aspects related to spirituality and sexuality.

> *Apart from the book club, I've always enjoyed attending talks or concerts held in the neighbourhood. I used to never miss a single one. I'm a believer, and from time to time I go to mass, but only when I feel the need for a moment of connection. Going to church brings me peace of mind.*

1.2.2.7. Satisfaction with current activities

The aim is to explore what brings them the most satisfaction from their current activities and identify their hobbies, such as music, cinema, radio or others. It is also important to review significant celebrations with friends or family, specifying whether they need support to participate with those they trust.

> *I really enjoy celebrations with my family. My children come to pick me up so I don't miss any of my grandchildren's or their own birthdays. I also really enjoy attending my grandchildren's activities. One of them does dance, and the other plays basketball; I've gone to watch them a few times.*

1.2.2.8. Emotional life

This section includes a self-description of their subjective life, fears, desires, worries and so on. It also covers perceived health, how they self-evaluate and whether they experience or perceive any limitations.

> *What I've noticed lately is that I feel very insecure and indecisive; I struggle to make decisions on my own. I miss the part where, in any decision-making, I used to share it with my husband. Even though I was the one who made the final decision, I liked being able to talk it over with him.*

1.2.2.9. Health

This section involves reviewing the symptoms and signs they perceive and how these affect their daily life.

> *Regarding my health, I feel very anxious and depressed. I had an episode of anxiety attack about two years ago, and it scared me a lot. I went to the emergency room and they gave me medication. On the other hand, I feel limited in my mobility; I'm afraid of falling, although I don't use any kind of support aid because I feel embarrassed. I know my children are worried about it, but I already know what I need to do.*

1.2.2.10. Future

This section aims to investigate and explore how the individual envisions and projects themselves into the future.

> *I find it very difficult to imagine. I see myself increasingly alone and struggling more, and I'm afraid that, in the end, I'll be completely alone and unable to do anything. I would like to have more acquaintances and feel confident enough to go to places where people in my neighbourhood gather, but I don't feel capable. Right now, I just don't see it happening.*

1.2.3. Summary table of the life story model

GENERAL FRAMEWORK

STARTING POINT	**1.** In the face of life's various challenges, we sometimes need help. The need for help and support is a disruptive event. It requires processing losses and transitions and readjusting life. **2.** The individual themselves is the key. **3.** We need to: *a*) process losses and transitions; *b*) integrate them into our life experience; *c*) give sense and meaning to our various situations; *d*) connect past, present and future; *e*) maintain, readjust or transform our life plan according to the context and circumstances.

4. The mission of professionals is:
   a) to provide support;
   b) to offer resources that enable individuals to develop their life plan, maximising their abilities;
   c) to create bonds of trust based on recognising each person's individuality;
   d) to ensure that the bond of trust connects the professional and the individual in a relationship of equality, dignity and symmetry.
5. We aim for:
   a) a gradual, progressive, open and dynamic process;
   b) a process that is continuously updated, reviewed and readjusted according to changing circumstances and individual will;
   c) an open process that also adapts to life's events and experiences.

WHAT WE SEEK WITH THE LIFE STORY

1. To understand the individual's life and biography to connect their past, present and future.
2. To empower the individual to become an active agent in their own story.
3. To promote their later life as a stage:
   a) of personal development;
   b) of enjoyment of life;
   c) of commitment to the common good within their community;
   d) of coherence with their values;
   e) grounded in their personal, cultural and social identity.
4. To identify their sources of meaning, values, preferences (likes and dislikes) and desires.
5. To equip them for the conscious generation and development of their life plan.

OBJECTIVE

To establish a qualitative methodology that supports teams and professionals in personalising interventions by understanding essential aspects of the individual's life, both past and present, as well as their expectations for the future.

CONTENT OF THE LIFE STORY

BIOGRAPHY

1. Life stages: early years, childhood, adolescence, youth, maturity...; memories, personal identification...
2. Periods: marriage, parenting...
3. Transitions: job changes, divorces...
4. Losses: parents, siblings, friends...
5. Life events:
   a) Significant (important in the individual's life).
   b) Critical (crucial, as they mark their life).
   c) Challenges and difficulties they have faced.
   d) Successes and failures.
6. Life review and balance:
   a) How what gave their life meaning has changed over time.
   b) Life balance assessment.
7. Geography of life: places where they have lived.

CURRENT AND FUTURE LIFE

1. Relationships (if any) and significant people:
- *a*) Network of relationships.
- *b*) Frequency of contact and quality of bonds.
- *c*) Significant, trusted or key people (family, friends, etc.).
- *d*) Professionals of reference or support whom they trust (if any).

2. Loneliness (subjective perception of loneliness or isolation):
- *a*) When they feel lonely or isolated.
- *b*) What they think about.
- *c*) What they miss.
- *d*) Social support: people they can turn to if they need support.

3. Participation:
- *a*) Associations they belong to (or have belonged to).
- *b*) Projects they would like to participate in or that interest them.

4. Fundamental preferences and habits in their life:
- *a*) Daily activities that bring them satisfaction.
- *b*) Daily activities they dislike.

5. Daily life:
- *a*) Fundamental aspects of their life that should be taken into account.
- *b*) Best and worst moments.
- *c*) Notable skills they can contribute.

6. Significant activities:
- *a*) Activities, habits and interests (cultural, social, educational, recreational, sports, leisure, etc.).
- *b*) Personal priorities.
- *c*) Activities that relax them and bring well-being.
- *d*) Places they would like to visit or frequent.
- *e*) Sexuality.
- *f*) Spirituality.

7. Satisfaction with current activities:
- *a*) Hobbies (music, cinema, radio, etc.).
- *b*) Important celebrations with friends and family.
- *c*) Support (if needed) to carry out activities that bring well-being.

8. Emotional life:
- *a*) Fears.
- *b*) Worries.
- *c*) Self-description of their subjective life.
- *d*) Description of their current situation.
- *e*) Desires.
- *f*) Perceived health.
- *g*) Self-assessment.
- *h*) Limitations.

9. Health: symptoms and signs they perceive that affect their daily life.

10. Future: how they envision it.

1.3. EVALUATION OF INDIVIDUALS INCLUDED IN THE LONELINESS PROFILE

The evaluation of individuals participating in the Always Supported programme aims to both understand the individual and comprehend their situation and context to provide personalised support in their process of empowerment in facing loneliness. The evaluation is always hetero-administered, although there may be assessments that can be self-administered.

The evaluation gathers information across different areas of assessment that interact and are integral to situations of loneliness, considering the various care profiles addressed by the programme (see chapter 2, section 3.3, p. 99). For instance, individuals who do not feel lonely (which we refer to as the *preventive profile*) but have a limited social network do not require the same evaluation as those experiencing a situation of loneliness.

The evaluation of individuals includes subjective variables (loneliness, purpose, meaning...), relational variables (social network, social support...), as well as contextual and situational factors, which are considered highly relevant in providing support and intervention for situations of loneliness, such as housing, living conditions and so on.

The evaluation is organised into sections and can be found in Appendix 6 (p. 273):

» Block 1: Fixed data and basic social information

» Block 2: Family living arrangements

» Block 3: Social network and social support

» Block 4: Assessment of loneliness and other subjective aspects

» Block 5: Health

» Block 6: Financial situation, housing and observations

1.3.1. Block 1. Fixed data and basic social information

This section collects, on one hand, administrative data such as the individual's code, name and surname, ID card number, address, etc., and on the other hand, information about certain risk factors, such as gender, age, residence and neighbourhood, level of education, marital status, etc.

It also gathers information about their connection to local government services (social services and health services) and their entry channel into the programme, that is, who "referred" the individual (social services, centre for older adults, healthcare, community agents, etc.), as well as the professional conducting the evaluation.

1.3.2. Block 2. Family living arrangements

In addition to creating a genogram, information is collected about the lifestyle and living arrangements of the individual coming to the programme, specifically whether they live alone or not, who they live with, who accompanies them to the programme and who might be one of their support people, among other details.

1.3.3. Block 3. Social network and social support

This block evaluates the characteristics of individuals' social relationships, specifically their social networks (family network and friends network), including both quantitative aspects (frequency of contact) and qualitative aspects (emotional closeness, support, type of support, etc.).

1.3.3.1. Social network

An individual's social network consists of the people (family, neighbours, friends, co-workers, etc.) who have a meaningful relationship with that person.

What defines a social network is its ability to provide help and support. It is made up of both the people with whom we share our lives, our projects, etc. – those who are significant and valuable to us, with whom we establish close relationships – and co-workers, professional colleagues, etc., who are also part of our relational world and with whom we have social connections.

The tool used to assess the social network is the 6-item Lubben Social Network Scale (LSNS-6). This scale, developed by Lubben et al. (2006), is a set of instruments designed to evaluate perceived social support and the risk of isolation in older adults. Specifically, the scale examines the size of an individual's social network, as well as the closeness and frequency of contact they maintain with different members of their network.

The Lubben scale consists of 6 items that are simple to administer, and in Spain is based on the Spanish translation of the LSNS-18 items carried out by Fernández-Ballesteros et al. (2008).

Through its items, the LSNS-6 scale addresses the relationships a person establishes both with family members (the first 3 items) and with non-family members (the following 3 items). According to its authors (Lubben et al., 2006), it provides two outcomes:

» Perceived social support: a single score (range 0-30) indicating a broader, closer and more frequent and intense social support network as the score increases.

» Risk of isolation: the LSNS-6 score indicates the risk of social isolation for values equal to or less than 12.

Table 1*a*. **LSNS-6 scale**

ITEM	SCORE
1. How many relatives do you meet or hear from at least once a month?	0 1 2 3 4 5
2. How many relatives do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
3. How many relatives do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5
4. How many friends do you meet or hear from at least once a month?	0 1 2 3 4 5
5. How many friends do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
6. How many friends do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5

Items 1, 2 and 3 assess the family network, while items 4, 5 and 6 evaluate the non-family support network (friends, neighbours, colleagues, etc.). Items 1 and 4 measure the frequency of contact; items 2 and 5 assess emotional closeness; and finally, items 3 and 6 evaluate the perception of support.

Source: Lubben et al., 2006.

This tool is coded as follows:

Table 1*b*. **Coding and scoring of the LSNS-6 scale**

CODING OF ITEMS 1-6	CALCULATION OF THE LSNS-6	RISK OF ISOLATION
0 = 0 **1** = 1 **2** = 2 **3** = 3 or 4 **4** = between 5 and 8 **5** = 9 or more	1 + 2 + 3 + 4 + 5 + 6	**LSNS-6 ≤12**

Source: Lubben et al., 2006.

1.3.3.2. Social support

Basically, social support can be understood as:

» The set of expressive or instrumental provisions (perceived or received) provided by the community, social networks and trusted individuals, which can occur in both everyday situations and crises (Lin et al., 1986).

» All forms of assistance transactions (emotional, informational or material) that we receive, whether from our informal or close networks, other groups or the wider community. This includes both actual transactions and the perception and satisfaction with the support received (Barron, 2003).

Social support, essentially the help we receive, is deeply linked to well-being, and there is a strong connection between social support and loneliness.

Moreover, social support has direct and positive effects on health, both in terms of mortality and physical and mental health. It is extremely beneficial in compensating for moments of vulnerability throughout the life cycle, such as losses, transitions, distress and, of course, loneliness.

The Duke-UNC 11-item scale has been used to analyse social support, capturing opinions on the availability of others to provide help and emotional support during difficulties.

The Duke-UNC Functional Social Support Questionnaire was designed by Broadhead et al. in 1988. Its aim was to measure "perceived functional social support". The quality of social support has been shown to be a better predictor of health and well-being than the number of friends or the frequency of visits, known as *structural measures*. Duke-UNC focuses on the qualitative or functional aspects of social support.

Initially, it was a 14-item instrument designed to explore four distinct areas: quantity of support, confidential support, affective support and instrumental support. The author excluded six items: three due to very low validity coefficients, and the other three (the first three items in the version presented here) because they were standalone items that could not be included in the scale's two main dimensions.

Our version, therefore, consists of a self-administered questionnaire with 11 items. Each question allows for five possible responses on a Likert-type scale. The original factor analysis reveals the existence of two dimensions: confidential support (items 1, 2, 6, 7, 8, 9 and 10) and affective support (items 3, 4, 5 and 11).

The scoring range is between 11 and 55 points, with the score obtained reflecting perceived support, not actual support. The lower the score, the lower the support. In the Spanish validation, a cut-off point at the 15th percentile was chosen, corresponding to a score below 32. A score of 32 or higher indicates normal support, while a score below 32 indicates low perceived social support.

In the Always Supported programme, we use the Bellón et al. 1996 validation.

Table 2. **Duke-UNC-11 Functional Social Support Questionnaire**

1. I receive visits from my friends and family.	1 2 3 4 5
2. I receive help with matters related to my home.	1 2 3 4 5
3. I receive praise and recognition when I do things well.	1 2 3 4 5
4. I have people who care about what happens to me.	1 2 3 4 5
5. I receive love and affection.	1 2 3 4 5
6. I have someone I can talk to about my problems at work or at home.	1 2 3 4 5
7. I have someone I can talk to about my personal and family problems.	1 2 3 4 5
8. I have someone I can talk to about my financial problems.	1 2 3 4 5
9. I receive invitations to go out and do things with other people.	1 2 3 4 5
10. I receive helpful advice about important things in my life.	1 2 3 4 5
11. I receive help when I am ill in bed.	1 2 3 4 5

Each item is scored as follows: 1 = much less than I would like, 2 = less than I would like, 3 = neither much nor little, 4 = almost as much as I would like, 5 = as much as I would like.

Source: Bellón et al., 1996.

1.3.4. Block 4. Assessment of loneliness and other subjective aspects

This section assesses the following variables using psychometrically validated tests, items from standardised tests and some formulated by the programme's professionals, as described below:

1.3.4.1. Losses and transitions

The life cycle is a succession of changes, transitions and losses that threaten the continuity of connection and meaning in our lives. It is essential to adapt to role changes, retirement, the loss of a partner or friends, changes in family structure, illnesses and more.

By transitions, we mean events such as retirement or empty nest syndrome. These affect our identity, self-concept and self-esteem. They involve stepping out of our comfort zone and readjusting values and goals. Losses, on the other hand, are life events, such

as widowhood, the loss of loved ones or roles, etc., that act as triggers for processes of emotional and behavioural disorganisation.

Successfully coping with these losses and transitions (empty nest, retirement, emotional losses, relocation, limiting illnesses, family conflicts, etc.) can lead to good adaptation or, conversely, to issues such as mental health problems and feelings of loneliness.

Using two purpose-designed items, we evaluate whether losses and transitions are present. The items are scored on a Likert scale from 1 (strongly disagree) to 7 (strongly agree), based on agreement or disagreement with the following statements: "In the past year, I feel that I have experienced significant losses" (losses) and "I am going through a delicate/complicated time in my life" (transitions).

Table 3. **Scale for losses and transitions**

	ITEM	SCORE
LOSSES	1. In the past year I feel that I have experienced significant losses.	1 2 3 4 5 6 7
TRANSITIONS	1. I am going through a delicate or complicated time in my life.	1 2 3 4 5 6 7

Each item is scored as follows:
from 1 = strongly disagree to 7 = strongly agree.

Source: Compiled by the authors.

1.3.4.2. Perceived health and quality of life

Perceived health refers to individuals' perception of their own health, considering physical, psychological and sociocultural aspects. It is a good predictor of life expectancy, mortality, the presence of chronic illnesses and the use of healthcare services. As for *quality of life*, a multifaceted concept if ever there was one, the World Health Organization (WHO) defines it as "an individual's perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns". Quality of life is therefore influenced by factors such as economic and social conditions, personal circumstances and an individual's satisfaction with themselves.

Both concepts are evaluated in a very straightforward way at the beginning of the assessment and more thoroughly using the EuroQoL-5D when assessing health-related quality of life (in Block 5). This is done through two items formulated in a methodologically similar way to the previous ones, which evaluate agreement or disagreement with the following statements: "In the past month, my health is..." from 1 = very poor to 7 = very good; "I think my quality of life is..." from 1 = very poor to 7 = very good.

Table 4. **Scale for perceived health and quality of life**

	ITEM	SCORE
PERCEIVED HEALTH	1. In the past month, my health has been...	1 2 3 4 5 6 7
QUALITY OF LIFE	2. I think my quality of life is...	1 2 3 4 5 6 7

Each item is scored as follows: from 1 = very poor, to 7 = very good.

Source: Compiled by the authors.

1.3.4.3. De Jong Gierveld Loneliness Scale

To measure social loneliness and emotional loneliness, the De Jong Gierveld Loneliness Scale is administered. It consists of 11 items divided into 2 subscales. The social loneliness subscale includes 5 positively worded items that inquire about feelings of belonging to a social group. The emotional loneliness subscale contains 6 negatively worded items that explore feelings of desolation and a lack of attachment relationships. None of the items explicitly use the word *loneliness*, and all have 3 response categories: 1 = no, 2 = more or less and 3 = yes.

According to the scoring criteria of the DJGLS (*De Jong Gierveld Loneliness Scale*) outlined in its manual (De Jong Gierveld and Van Tilburg, 2011), to calculate the emotional loneliness subscale, the number of times the individual responds "yes" or "more or less" is added to the items related to this dimension (2, 3, 5, 6, 9 and 10). The score for this subscale ranges from 0 to 6. The score for the social loneliness dimension is obtained by summing the number of times the respondent answers "no" or "more or less" to the other items (1, 4, 7, 8 and 11). The score for the social loneliness subscale ranges from 0 to 5. The total loneliness score is the sum of the values obtained in the two subscales and can range from 0 to 11 points.

The authors of the instrument have established cut-off points for the complete scale but not for its dimensions. This allows loneliness to be analysed as a categorical variable and subjects to be classified based on the presence or absence of the feeling and its intensity. Thus, individuals scoring between 0 and 2 are considered "not lonely"; those scoring between 3 and 8 are classified as experiencing "moderate loneliness"; those scoring between 9 and 10 are considered to experience "severe loneliness"; and those with the maximum score (11 points) are classified as suffering from "very severe loneliness".

The instrument demonstrates good psychometric properties, with a Cronbach's alpha coefficient of 0.84 for the full scale, 0.88 for the emotional loneliness subscale and

0.88 for the social loneliness subscale (De Jong Gierveld and Van Tilburg, 2006). It is a reliable and valid tool and is particularly useful for research involving samples of older adults (Penning et al., 2014). It is the most widely used instrument in Europe for measuring loneliness.

Table 5. **De Jong Gierveld Loneliness Scale**

	NO	MORE OR LESS	YES
1. There is always someone I can talk to about my day-to-day problems.	1	2	3
2. I miss having a really close friend.	1	2	3
3. I experience a general sense of emptiness.	1	2	3
4. There are plenty of people I can lean on when I have problems.	1	2	3
5. I miss the pleasure of the company of others.	1	2	3
6. I find my circle of friends and acquaintances too limited.	1	2	3
7. There are many people I can trust completely.	1	2	3
8. There are enough people I feel close to.	1	2	3
9. I miss having people around me.	1	2	3
10. I often feel rejected.	1	2	3
11. I can call on my friends whenever I need them.	1	2	3

Each item is scored as follows: 1 = no, 2 = more or less, 3 = yes.

Source: De Jong Gierveld and Van Tilburg, 2006.

1.3.4.4. Existential loneliness

Following the recommendations of Van Tilburg (2021), we proceeded with the evaluation using items drawn from some of the factor analyses in that publication and through consultation with experts. This evaluation assesses whether individuals feel they spend "too much time in poor relationships" to avoid feeling lonely, whether they believe they "matter to others", whether they feel their life "has a purpose", and finally, whether they feel their life "has meaning". The measurement scale is similar to the De Jong Gierveld Loneliness Scale.

Table 6. **Items about existential loneliness**

	ITEM	SCORE
REGARDING RELATIONSHIPS	1. I spend too much time in poor relationships to avoid feeling lonely.	1 2 3
	2. I matter to others.	1 2 3
REGARDING THE MEANING OF LIFE	3. My life has meaning.	1 2 3
	4. I feel life has little meaning.	1 2 3

Each item is scored as follows: 1 = no; 2 = more or less, 3 = yes.

Source: Van Tilburg, 2021a.

1.3.4.5. Other aspects related to loneliness

To complete the analysis of loneliness, various items were developed, each scoring between 0 (never or completely disagree) and 10 (always or completely agree). These aim to capture important nuances of each individual's experience of loneliness. The following questions are addressed:

» The frequency of feelings of loneliness.

» Positive loneliness: captures the experience of not feeling lonely, even when objectively alone.

» The time a person spends thinking (ruminating), in this case, about loneliness.

» Various stereotypes about later life and loneliness that are common and may play a negative role in coping with loneliness, such as believing that "it is normal for older people to be lonely".

» Three different types of loneliness not previously assessed:

– Family loneliness.

– "Sentimental" or romantic loneliness (loneliness in a relationship).

– Loneliness due to the loss of loved ones.

Table 7. **Scale on types of loneliness**

VARIABLE	ITEM	SCORE
FREQUENCY OF FEELINGS OF LONELINESS	1. How often do you feel lonely?	0 (Never) ..... 10 (Always)
POSITIVE LONELINESS	2. Do you feel good when you are alone?	0 (Never) ..... 10 (Always)
RUMINATION OF LONELINESS	3. Do you often think about loneliness?	0 (Never) ..... 10 (Always)
STEREOTYPES OF LONELINESS - I	4. To what extent do you agree with the following statement? "It is 'logical/normal' for older people to be lonely."	0 (Completely disagree) ..... 10 (Completely agree)
STEREOTYPES OF LONELINESS - II	5. To what extent do you agree with the following statement? "Young people (who are not elderly) think it is normal for older people to be lonely."	0 (Completely disagree) ..... 10 (Completely agree)
FAMILY LONELINESS (ASKED ONLY IF THE INDIVIDUAL HAS FAMILY)	6. To what extent do you agree with the following statement? "I miss sharing life, joys and time with my family."	0 (Completely disagree) ..... 10 (Completely agree)
"SENTIMENTAL" LONELINESS	7. How much do you identify with the following phrase? "I miss having a romantic or meaningful relationship."	0 (Completely disagree) ..... 10 (Completely agree)
LONELINESS DUE TO LOSS (GRIEF)	8. How much do you identify with the following phrase? "Since I lost X, I feel lonely or less motivated to do things."	0 (Completely disagree) ..... 10 (Completely agree)

Source: Compiled by the authors.

1.3.4.6. Strategies for coping with loneliness

Coping strategies are the cognitive and behavioural efforts each person makes to manage, reduce, overcome or tolerate external or internal situations that cause them distress. These strategies are considered fundamental for regulating our emotions and maintaining our well-being. Each individual develops and uses different strategies to cope with loneliness.

Research shows that there are many diverse ways individuals choose to cope with loneliness. Over two decades ago, Rubenstein and Shaver (1982) described some behavioural coping strategies, such as reading, listening to music or reaching out to friends, as responses to feelings of loneliness. According to these authors, there are four main types of responses to loneliness: passive sadness (crying, sleeping, thinking, doing nothing), active solitude (working, listening to music, exercising), spending money, and having or seeking social contact.

Rokach and Brock (1998) expanded this range by describing six types of coping: reflection and acceptance, self-development and understanding, social support network, distancing and denial, religion and faith, and increased activity.

A distinction is usually made between problem-focused coping (actively making efforts to manage, in this case, loneliness), such as increasing social relationships, and emotion-focused coping, such as managing the feelings associated with loneliness.

Kharicha et al. (2018) suggests that coping styles can be organised along two dimensions where strategies may be represented: from prevention and action to acceptance or endurance, and from coping alone to coping with others or in reference to others.

Based on the existing literature, in the evaluation of the Always Supported programme, we formulated 10 items corresponding to various possible coping strategies. These items assess the degree of agreement or disagreement each individual has regarding their use. Scoring is based on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) and is used to understand the efforts individuals make, to expand coping strategies if necessary and to incorporate them into intervention plans.

The different coping strategies used are as follows:

» Acceptance.

» Reflection and change (active).

» Expanding the social network (active).

» Seeking activity (active).

» Managing emotions (active).

» Avoidance (passive).

» Asking for help (active).

» Using hobbies (active).

» No need for coping strategies.

» Using solitary activities (active).

Table 8. **Scale for coping with loneliness situations**

1. If I feel lonely, I accept my situation, resign myself and do nothing.	1 2 3 4 5 6 7
2. If I feel lonely, I reflect and try to change how I think.	1 2 3 4 5 6 7
3. If I feel lonely, I seek out people to spend time with.	1 2 3 4 5 6 7
4. If I feel lonely, I join activities.	1 2 3 4 5 6 7
5. If I feel lonely, I try to change how I feel and at least avoid being sad.	1 2 3 4 5 6 7
6. I avoid feeling lonely; I don't even want to think or talk about my loneliness.	1 2 3 4 5 6 7
7. If I feel lonely, I ask for help.	1 2 3 4 5 6 7
8. If I feel lonely, I distract myself with my hobbies and make an effort to keep up with my routine.	1 2 3 4 5 6 7
9. I feel comfortable with myself; I enjoy being alone.	1 2 3 4 5 6 7
10. I do many things alone (reading, walking, household tasks...) and feel good about it.	1 2 3 4 5 6 7

Each item is scored as follows:
from 1 = strongly disagree to 7 = strongly agree.

Source: Compiled by the authors.

1.3.4.7. Purpose in life

The PIL test, or *Purpose in Life* test (Crumbaugh and Maholick, 1964 and 1969; Crumbaugh, 1968), is a widely used instrument for assessing purpose in life from a logotherapeutic perspective, specifically its Part A, a 20-item Likert scale with seven response categories.

Noblejas de la Flor (1994) identified four factors explaining 54% of the total variance: perception of purpose (items 4, 6, 9, 10, 11, 12, 16, 17 and 20; 35.9% of the variance); experience of purpose (items 1, 2, 5, 9, 17, 19 and 20; 6.8% of the variance); goals and tasks (items 3, 7, 8, 13, 17, 19 and 20; 5.8% of the variance); and dialectic between destiny and freedom (items 14, 15 and 18; 5.5% of the variance).

For the evaluation of purpose, we selected, through expert input, 7 items from the three fundamental dimensions we aimed to assess for the intervention:

» Items 9 and 11, which correspond to the perception of purpose.

» Items 1, 2 and 5, which correspond to the experience of purpose.

» Items 3 and 20, which correspond to the presence of tasks and goals.

The meaning of life is connected to existential loneliness (see chapter 1, section 3, p. 21), and this is the main reason for its evaluation.

Table 9. **PIL or Purpose in Life test**

1. Sometimes I feel…	completely bored	1	2	3	4	5	6	7	exuberant, excited.
2. Life seems to me to be…	completely routine	1	2	3	4	5	6	7	always exciting.
3. In life…	I have no goals or aspirations	1	2	3	4	5	6	7	I have many defined goals or aspirations.
4. Each day is…	exactly the same	1	2	3	4	5	6	7	always new and different.
5. My life is…	empty	1	2	3	4	5	6	7	full of exciting things.
6. When I think about my life…	I find no reasons to live	1	2	3	4	5	6	7	I find reasons to live.
7. I have discovered that…	I have no purpose in life	1	2	3	4	5	6	7	I have purpose in life.

Source: Noblejas de la Flor, 1994.

1.3.4.8. Daily life

Based on existing literature on the rhythms of loneliness experienced in people's daily lives (Victor et al., 2006; Victor and Yang, 2012; Danvers et al., 2023), two items were formulated: one related to the worst time of the day and another to the worst day of the week in terms of their perception of loneliness. Both are designed to focus the intervention within the programme on the most critical moments.

1.3.5. Block 5. Health

In addition to assessing difficulties in leaving the home, the following is also evaluated:

1.3.5.1. Health-related quality of life: EQ-5D-5L

The EQ-5D, developed by the EuroQol Group (*www.euroqol.org*), is a generic and standardised instrument designed to describe and assess health-related quality of life (HRQoL). This index has been recommended for use in cost-utility analyses of health technologies by the National Institute for Health and Clinical Excellence (NICE, *www.nice.org.uk*).

The EQ-5D was developed to provide a measure of self-perceived health that incorporates individual preferences regarding health states. The EQ-5D instrument consists of two parts: the EQ-5D descriptive system and the Visual Analogue Scale (VAS). The EQ-5D descriptive system comprises five dimensions: mobility, self-care, usual activities, pain or discomfort and anxiety or depression. In the VAS, the individual rates their health on a scale from 0 to 100, representing the worst and best imaginable health states, respectively.

The individual evaluates their own health status, first using the EQ-5D descriptive system to assess severity levels by dimension (Figure 1, p. 164) and then using the Visual Analogue Scale (VAS) for a more general evaluation (Figure 2, p. 165). The EQ-5D is a generic instrument for measuring health-related quality of life (HRQoL) that can be used for both relatively healthy individuals (general population) and groups of people with various pathologies. The descriptive system comprises five health dimensions: mobility, self-care, usual activities, pain or discomfort and anxiety or depression. Each dimension has five severity levels: "I have no problems", "I have slight problems", "I have moderate problems", "I have severe problems", and "I am unable to". In this part of the questionnaire, the individual selects the severity level that corresponds to their health status in each dimension, based on their condition on the same day the questionnaire is completed. In the Always Supported programme, one of the technicians assists the person in completing the questionnaire. For each dimension of the EQ-5D, the severity levels are coded as follows: 1 for "I have no problems", 2 for "I have slight problems", 3 for "I have moderate problems", 4 for "I have severe problems", and 5 for "I am unable to".

The second part of the EQ-5D-5L is a 20-centimetre vertical VAS, marked in millimetres, ranging from 0 (worst imaginable health state) to 100 (best imaginable health state). In this section, the individual marks the point on the vertical line that best reflects their assessment of their overall health status on the same day the questionnaire is completed. The use of the VAS provides a complementary score to the descriptive system, enriching the evaluation of each individual's self-perceived health status.

Figure 1. **EQ-5D descriptive system**

Below each statement, mark ONE box that best describes your health TODAY.

MOBILITY

I have no problems walking ☐
I have slight problems walking ☐
I have moderate problems walking ☐
I have severe problems walking ☐
I am unable to walk ☐

SELF-CARE

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES (e.g.: work, study, household tasks, family or leisure activities)

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN OR DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort. ☐

ANXIETY OR DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am very anxious or depressed ☐
I am extremely anxious or depressed ☐

Figure 2. **Visual Analogue Scale (VAS)**

- We would like to know how good or bad your health is TODAY.
- The scale is numbered from 0 to 100, where 100 represents the **best** health you can imagine, and 0 represents the **worst** health you can imagine.
- Mark an X on the scale to indicate your health status TODAY.
- Now, write the number you marked on the scale in the box.

Source: Spain (Spanish) © 2009 EuroQol Group EQ-5D™ is a trade mark of the EuroQol Group.

1.3.5.2. Perceived health

The Always Supported programme introduces three additional items in the evaluation of subjective health status and quality of life, specifically developed for this purpose:

» A health transition item in which we ask the person to compare their current health (health perception) with that of six months ago.

» Two items on the use of healthcare services: visits to the family doctor and use of emergency services.

Figure 3. **Items for evaluating subjective health status and quality of life**

1. Compared to your health status six months ago, your current health is:

- ☐ Better
- ☐ The same
- ☐ Worse

2. How many times have you been to the family doctor in the last three months?

- ☐ None
- ☐ From 1 to 3 times
- ☐ From 4 to 6 times
- ☐ From 7 to 9 times
- ☐ More than 9 times

3. How many times have you used the emergency medical services in the last 12 months?

- ☐ None
- ☐ From 1 to 3 times
- ☐ From 4 to 6 times
- ☐ From 7 to 9 times
- ☐ More than 9 times

Observations: Indicate the types of chronic illnesses, medication, ADLs, whether assistance is received for performing ADLs, other relevant health aspects (optional): .....

Source: Compiled by the authors.

1.3.5.3. Cognitive decline

When there is a suspicion of possible cognitive decline, the Montreal Cognitive Assessment (MoCA©) is administered before referring the individual to healthcare services. This tool is designed to assess mild cognitive impairments by examining the following abilities: attention, concentration, executive functions (including abstraction skills), memory, language, visuoconstructive abilities, calculation and orientation. The administration time required is approximately 10 to 15 minutes (though it varies significantly between individuals). The maximum score is 30, and a score of 26 or higher is considered normal.

With a cut-off point of <21 (sensitivity of 0.714, specificity of 0.745), it allows us to differentiate between individuals without cognitive impairment and those with mild cognitive impairment (MCI). With a cut-off point of <14 (sensitivity of 0.843, specificity of 0.710), it differentiates between individuals without cognitive impairment and those with dementia. It is a test with high internal consistency (Cronbach's alpha of 0.76). The results are reliable over time, with a test-retest reliability of 0.921 and an inter-rater reliability of 0.914 (Gallego et al., 2009).

The MoCA is a screening tool for MCI with good results and is also used to detect cognitive decline in various pathologies.

The original version of the MoCA assesses six cognitive domains, and its Spanish version has proven to be a useful instrument for diagnosing MCI as well as dementia. Created in 1996, it has undergone successive adaptations in different languages.

As previously mentioned, it explores six domains:

» Memory (5 points).

» Visuospatial ability (4 points).

» Executive function (4 points).

» Attention / concentration / working memory (5 points).

» Language (5 points).

» Orientation (6 points).

The score ranges from 0 to 30 points and the highest score (30) reflects better cognitive function. A score of 26 or higher is considered normal. In the correction, 1 point is added for persons with ≤12 years of education.

Basically, the cognitive domains are assessed as follows:

» **Memory.** Learning five words with free delayed recall after five minutes. It also allows for measuring facilitated recall using semantic cues and recognition (multiple choice).

» **Visuospatial ability.** Assessed using the clock-drawing test and the copying of a cube.

» **Executive function.** Evaluated through various tasks, including a graphic alternation task adapted from the Trail Making Test B, a phonemic fluency task, and two verbal abstraction items.

» **Attention / concentration / working memory.** Assessed using a sustained attention task, a series of subtractions and a digit span task.

» **Language.** Measured through three visual confrontation naming items involving three animals of low familiarity, the repetition of two complex sentences and the aforementioned fluency task.

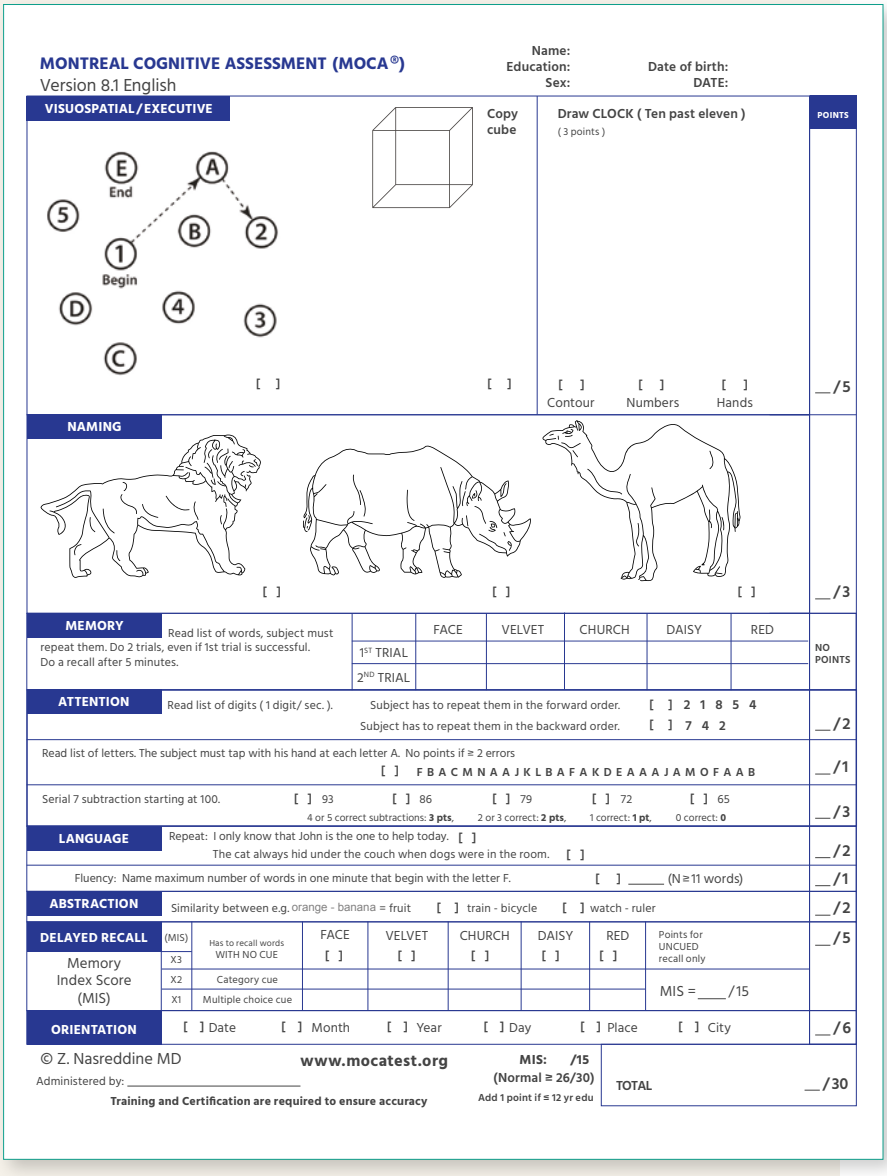
» **Orientation.** Evaluated through temporal and spatial orientation tasks.

For more information on its administration, we recommend reviewing the following websites and documents:

» https://mocacognition.com

» Nasreddine, Z. S. et al., 2005

Figure 4.
Montreal Cognitive Assessment



MONTREAL COGNITIVE ASSESSMENT (MOCA®)
Version 8.1 English

Name:
Education: Date of birth:
Sex: DATE:

VISUOSPATIAL/EXECUTIVE — POINTS

Copy cube [ ] [ ]

Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands __/5

NAMING [ ] [ ] [ ] __/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1ST TRIAL					
2ND TRIAL					

NO POINTS

ATTENTION Read list of digits (1 digit/ sec.). __/2
Subject has to repeat them in the forward order. [ ] 2 1 8 5 4
Subject has to repeat them in the backward order. [ ] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors __/1
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

Serial 7 subtraction starting at 100. [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 __/3
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0**

LANGUAGE Repeat: I only know that John is the one to help today. [ ] __/2
The cat always hid under the couch when dogs were in the room. [ ]

Fluency: Name maximum number of words in one minute that begin with the letter F. [ ] _____ (N ≥ 11 words) __/1

ABSTRACTION Similarity between e.g. orange - banana = fruit [ ] train - bicycle [ ] watch - ruler __/2

DELAYED RECALL __/5

		Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Memory Index Score (MIS)	(MIS)							
	X3							
	X2	Category cue						MIS = ____/15
	X1	Multiple choice cue						

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z. Nasreddine MD www.mocatest.org MIS: /15 (Normal ≥ 26/30) TOTAL __/30
Administered by: _____
Add 1 point if ≤ 12 yr edu
Training and Certification are required to ensure accuracy

Source: Obtained from https://mocacognition.com/paper#paper_form_full

1.3.6. Block 6. Financial situation, housing and observations

Living conditions play a decisive role in loneliness. In this final block of the evaluation, information is gathered on key aspects of these living conditions, such as:

» Financial situation and risk of poverty.

» Housing conditions.

The evaluation of the **financial situation** is carried out using the following items:

***a*) Do you have any financial difficulties in managing your day-to-day life?** ..... Yes ☐ No ☐

What is the reason?

.....

.....

***b*) Could you tell me which individual monthly income bracket you fall into?**

Income brackets:

- ☐ Income or pension equivalent to more than 1.5 times the minimum wage.
- ☐ Income or pension equivalent to the minimum wage or up to 1.5 times the minimum wage.
- ☐ Income equivalent to or less than the minimum pension.
- ☐ Income equivalent to or less than the non-contributory pension.
- ☐ No personal income or income below the thresholds outlined above.

Interpretation:

- Likely low-risk economic situation: Option 1 (more than 1.5 times the minimum wage).
- Likely intermediate economic situation: Option 2 (minimum wage to 1.5 times the minimum wage).
- Likely high-risk economic situation: Options 3, 4 and 5.

The assessment of the **housing** situation is carried out as follows:

***a*) Do you feel comfortable in your home?**

0 1 2 3 4 5 6 7 8 9 10

Not at all — Very much

***b*) Do you feel comfortable in your neighbourhood?**

0 1 2 3 4 5 6 7 8 9 10

Not at all — Very much

***c*) Do you have to negotiate any steps, ramps or uneven surfaces to access your home from the street?**

- ☐ Yes.
- ☐ Yes, but it can be avoided with a lift.
- ☐ No.

***d*) Are all the rooms in your home on the same level or are there different levels?**

- ☐ They are all on the same level.
- ☐ There are different levels.

Finally, the interview includes space for each professional to record qualitative aspects they consider significant and that are not covered in the assessment, as well as any additional observations.

***a*) General situation of the dwelling (if interview is conducted at home):**

- ☐ Not observable.
- ☐ Adequate, no modifications needed.
- ☐ Lacking sanitary conditions.
- ☐ Requires minor adaptations to improve mobility and accessibility.
- ☐ A room or installation needs refurbishment.
- ☐ Major renovation required.

***b*) Appearance of the person:**

- ☐ Well-groomed.
- ☐ Neglected. Lack of personal hygiene.
- ☐ Prostheses (hearing aids, dentures, etc.) and other supports (such as glasses, crutches, etc.) in poor condition.

Observations.....
.....
.....
.....

1.4. EVALUATION OF INDIVIDUALS INCLUDED IN THE PREVENTIVE PROFILE

People included in the preventive profile undergo the same evaluation as those in the loneliness profile (see Table 10, p. 170), although the assessment is less in-depth, given the needs of this profile and the requirements of the intervention (see Appendix 7, p. 289).

The evaluation begins by collecting personal data (name, surname, ID card number, address...) and then addresses the "entry channel" into the programme, that is, through which entity, public service, etc., the person has been referred to the programme.

Basic information about the individual is then collected, providing insight into some risk factors for loneliness, such as marital status, losses, etc.; lifestyle and living arrangements (whether they live alone or with others); the Lubben Social Network Scale, and the De Jong Gierveld Loneliness Scale.

The evaluation concludes with the Purpose in Life Test (PIL), developed by Crumbaugh and Maholick (1964 and 1969; Crumbaugh, 1968), which is analysed in Block 4 of the personal evaluation (see section 1.3.4.7, p. 161).

Table 10. **Summary of the assessment tests used**

EVALUATION OF THE LONELINESS PROFILE		EVALUATION OF THE PREVENTIVE PROFILE
Life story		Life story
Basic social data		Basic social data
Programme entry channel		Programme entry channel
Social network: Lubben		Social network: Lubben
Social support: Duke		–
Losses and transitions		–
Perceived health and quality of life		–
Loneliness:	De Jong Gierveld Loneliness Scale	De Jong Gierveld Loneliness Scale
	Existential	–
	Other aspects related to loneliness	–
	Coping	–
Purpose in life		Purpose in life
Everyday life		–
Health-related quality of life		–
Perceived health		–
Cognitive decline		–
Financial situation and housing		–

Source: Compiled by the authors.

As will be seen in the following chapter, periodic evaluations of the individual are conducted on a regular basis to carefully monitor their progress and adjust the action plan accordingly.

1.5. EVALUATION OF INDIVIDUALS INCLUDED IN THE NETWORK PROFILE

The evaluation for what we refer to as the *network profile* is a purpose-designed assessment consisting of 13 items that address the following dimensions (see Appendix 8, p. 296):

» Social data and risk factors: age, gender, educational level and marital status.

» Living arrangements.

» Evaluation of the frequency of perceived loneliness:
- Feelings of lacking companionship.
- Feelings of exclusion.
- Feelings of isolation.
- Feeling significant to others.

» Purpose in life.

» Influence of participation in the programme on daily life:

– Perception of relational changes.

– Improvement in social contact.

1.6. EVALUATION OF THE SUPPORT RECEIVED

1.6.1. Evaluation by the participants of the support received

The Always Supported programme addresses – together with the evaluation of each individual based on the support profiles analysed in the first three sections of this chapter – the evaluation carried out by participants in the programme (whether individuals or entities) regarding the support received.

The evaluation of the support received, which is conducted both in person and by telephone, has two variants: one is performed while the individual is participating in the programme, and the other at the point of discharge.

The questionnaire developed for this purpose (see Appendix 9, p. 298) was adapted from two empirically validated questionnaires: the *Client Satisfaction Questionnaire*, CSQ (Attkisson and Greenfield, 2004) and the *Consumer Reports Effectiveness Scale*, CRES-4 (Feixas et al., 2012). The adaptation used while the individual is participating in the programme consists of eight items, evaluated on a four-point Likert scale (1 = poor/nothing, 2 = fair/little, 3 = good/quite a lot, 4 = excellent/a great deal), which assess the following dimensions:

Table 11. **Evaluation questionnaire for participants on their perception of the quality of support received**

	DIMENSION EVALUATED	ITEM
1.	Quality of the support received	How would you rate the quality of the support provided in the Always Supported programme?
2.	Alignment of needs and support	Did you receive the support you were seeking?
3.	Perception of improvement achieved	To what extent has our programme helped improve your personal situation?
4.	Recommendation of the programme to others	If a friend or someone close to you were in a similar situation, would you recommend our programme to them?
5.	Satisfaction with the support	How satisfied are you with the support you have received?
6.	Programme evaluation	If you needed help again, would you participate in our programme?
7.	Emotional state before joining the programme	What was your emotional state before participating in the programme?
8.	Emotional state after participating in the programme	How is your emotional state now? How do you feel?

Source: Compiled by the authors.

This questionnaire is administered once a year to all individuals who were supported in previous years and have been participating in the programme for at least three months.

In the version used when a participant leaves the programme after achieving their objectives, administered at the point of discharge, nine additional items are included, scored in the same way. These items are as follows:

Table 11. **(continuation)**

	DIMENSION EVALUATED	ITEM
9.	Perception of empowerment	Do you feel you have more tools to cope with loneliness? Do you feel more capable of addressing loneliness?
10.	Description of achievements	· Emotional understanding · Increase in social network · Improvement in self-care · Boost in confidence · Changes in perceived support · Changes in use of free time · Increase in meaningful activities · Greater connection with others · New learning experiences · Personal development · Seeking external psychological support · Involvement in volunteering · Enjoyment of solitude · New goals · New friendships · I feel more positive · Tools for managing loneliness · No perception of significant changes
11.	Evaluation of the programme professional's performance	How would you rate the kindness and dedication of the professional who has supported you?
12.	Evaluation of the location of sessions	What is your opinion of the location where the support sessions were held?
13.	Perception of emotional safety in the spaces used	Did you feel comfortable and safe in the location where the support sessions took place?
14.	Evaluation of the time dedicated by the programme to each participant	Was the time dedicated to your support sufficient to meet your needs?
15.	Highlights of the support received	What did you like the most about the support you received?
16.	Areas for improvement	Do you think there is anything that should be improved?
17.	Impact on daily life	How would you describe the overall impact of the support on your daily life?

Source: Compiled by the authors.

1.6.2. Evaluation by the entities and professionals of the support received

The evaluation of entities is also carried out annually using a purpose-designed questionnaire, scored on a 4-point Likert scale (4 = a lot, 3 = quite a lot, 2 = a little and 1 = not at all). This questionnaire assesses the following dimensions: satisfaction, perception of users' opinions about the programme, the contribution of the "la Caixa" Foundation, and an overall assessment of the Always Supported programme (see Appendix 10, p. 302).

Specifically, the following are the items and dimensions included in the questionnaire:

Table 12. **Questionnaire for managing entities: evaluation of the perception of the quality of support**

DIMENSION OF THE EVALUATION	ITEM
Satisfaction	How satisfied are you with the programme's ability to address situations of loneliness?
Perceived satisfaction of users	Do you think the programme participants are satisfied?
Assessment of the contribution of the "la Caixa" Foundation	How do you rate the scientific and technical approach of the programme?
	How do you rate the approachability of the central services staff and the manager responsible for your area?
	How do you rate the monitoring of your organisation and the Always Supported team you lead?
	How do you rate the collaborative work between your organisation and the "la Caixa" Foundation?
	How would you rate the training received by the staff in your organisation?
Support	Does your organisation feel supported by the programme's staff and managers?
Receptiveness to changes	Do you consider the "la Caixa" Foundation receptive to changes proposed by your organisation?
Overall evaluation of the programme	How do you rate the programme overall?

Source: Compiled by the authors.

Finally, to understand the professionals' evaluation of the programme, a purpose-designed survey is administered (see Appendix 11, p. 303), assessing the following aspects:

» Satisfaction with the programme
» Perception of user satisfaction
» Assessment of the scientific and technical approach
» Self-assessment of performance
» Evaluation of programme resources
» Professional development

2.
SUPPORT PROCESS FOR THE PARTICIPANT

2.1. INTRODUCTION

In order to make it easier for the professionals to monitor the progress of individuals receiving support, a flowchart has been developed describing the intervention process of the programme. This diagram details the actions to be carried out, the timeframe for their implementation and the related documents.

The flowchart is organised according to the type of profile addressed in Always Supported (see chapter 2, section 3, p. 96). Each profile has its own flowchart, enabling the standardisation of procedures and their evaluation in terms of effectiveness and efficiency. However, this standardisation is fully compatible with a person-centred approach, as it allows interventions to be tailored to individual needs within a structured and measurable framework.

The intervention process comprises several phases, from the initial contact with the individual to their eventual discharge from the programme. Thus, two main stages can be identified:

» The first stage, common to all individuals entering the programme, involves detection, the initial contact, the suitability assessment, profile assignment and incorporation into the programme.

» The second stage, tailored to each specific profile, encompasses the initiation of the intervention, follow-up and eventual discharge.

The steps followed in each of these stages are outlined below.

2.2. FIRST STAGE: DETECTION, INITIAL CONTACT AND ENROLMENT

2.2.1. Detection and request for support

Regardless of the profile, the intervention process begins when the team becomes aware that a person could benefit from the programme, that is, when a request for support is received.

The request can be made through two different channels:

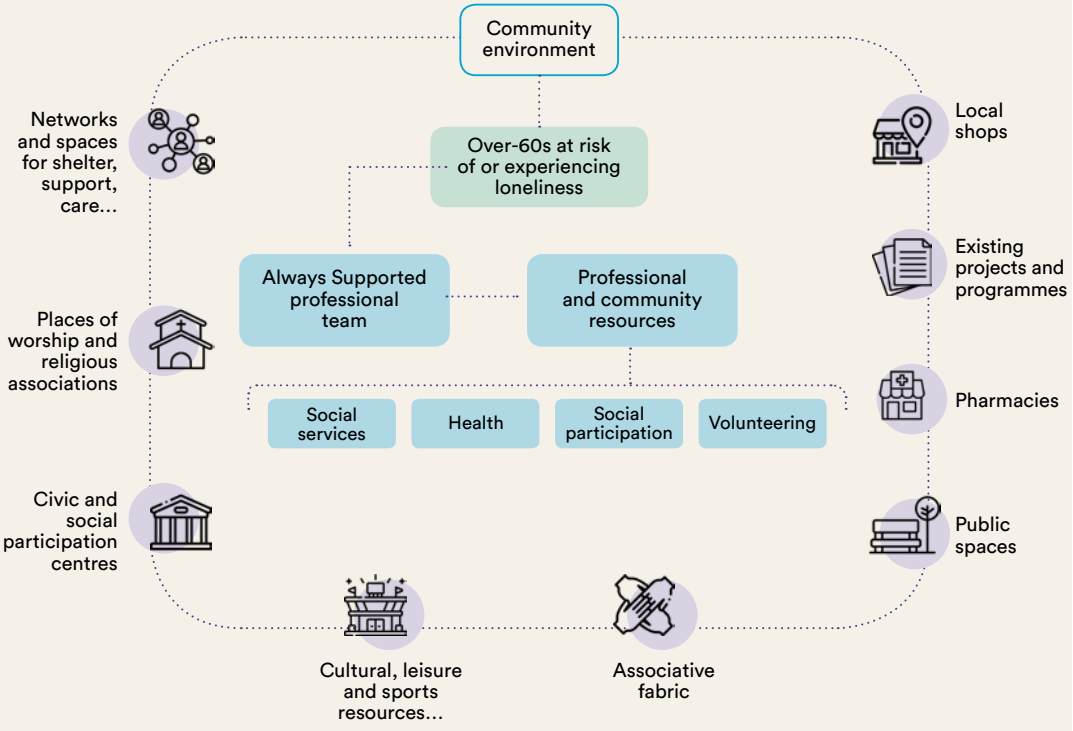
» 1. Directly from the individual interested, who contacts the team directly (direct support request).

» 2. Through an agent, channel or other means, where a request for support is submitted, prompting the team to contact the individual (request via community agents). For example: a professional from the social work unit of a health centre, staff from an active participation centre for older adults, a pharmacy or association collaborating with the programme, a volunteer from Always Supported, etc.

Figure 1. **Key agents, channels and means of detection**

AGENTS:
- Health services
- Social services
- Centre for older adults
- Managing entity
- Social entity
- Pharmacy
- Establishments
- Other SAG entities
- Participant in the Always Supported programme
- Immediate circle (family, friends)
- Volunteers

SOME CHANNELS AND MEANS:
- Meeting spaces
- Group actions or interventions
- Information points
- Awareness and outreach campaigns
- Other means



Source: Compiled by the authors.

2.2.1.1. Direct request for support

The team organises awareness-raising activities to highlight the importance of social relationships and to shed light on the issue of loneliness, particularly in later life. These initiatives also serve to share information about the Always Supported programme and reach out to people who could benefit from it.

These actions can be carried out independently or in collaboration with the Social Action Group and other agents (as explained in chapter 2, section 2, p. 61). After considering the unique characteristics of each area, its needs and other factors, the most effective channels are selected. These may include information points, awareness and outreach campaigns and group activities, among others. For example, an effective channel could involve setting up an information point at an older adults' centre, where

the team, together with a recognised and trusted figure from the centre, provides information to those interested.

As a result, through word of mouth, an announcement, an awareness-raising or outreach event or any other channel, individuals may decide to engage with the programme by making a phone call or visiting the offices in person.

2.2.1.2. Request for support via community agents

Community agents are professionals from public administration care services (primarily social and healthcare services) or organisations, as well as key members of the community. The team works directly with these agents, providing prior training to help them identify and respectfully engage with individuals who may benefit from the programme. These agents can act as advocates, sharing information with individuals and encouraging them to seek further details from the team, or they can pass on the information of the interested individual to the Always Supported team, who will then reach out to them directly.

The methods for requesting support or contacting the team vary depending on whether the agent is a professional or not. These different procedures are outlined below.

Professional agents

We define *professional agents* as the technical staff of administrations and organisations providing services in the area where the programme operates. Due to the nature of their services (older adults' centres, social services, primary healthcare, departments for older adult care, etc.), these professionals are in direct contact with people who may be experiencing loneliness or are at risk of it, and who could therefore benefit from the programme.

Following prior work by the team to establish relationships and mutual collaboration, as well as to provide training on loneliness and its detection, the most practical type of coordination for both is agreed upon with each professional. This includes the basic procedures for detecting, requesting attention and following up on specific cases for each agent (see chapter 2, section 2.5.3, p. 80).

To assist them in detecting and referring individuals who could benefit from the programme, they are provided with the "Detection and attention request protocol for professionals" (see Appendix 1, p. 254). This protocol includes:

» essential information about the programme;

» a loneliness guide to help them discuss loneliness with individuals;

» key questions based on the UCLA 3-item loneliness scale (for details on the scale, see chapter 2, section 3.2, p. 97).

It is essential for professional agents to feel confident and have a thorough understanding of the profile of individuals the programme is designed to support. This enables them to tailor the referrals they submit to the team as closely as possible, increasing the likelihood of providing appropriate assistance. In other words, it is important not to

refer people who do not meet the established profile and therefore cannot be supported by the team, as this would create expectations in these individuals that the programme would be unable to fulfil.

Non-professional agents

We define *non-professional agents* as all individuals, associations or civil society entities that collaborate or actively engage in improving society by addressing issues and situations that respond to the needs of their community.

This group includes associations for older adults, neighbourhood associations, voluntary organisations and groups, local businesses and mutual support networks, as well as key entities and individuals addressing specific needs, such as bereavement groups or associations for families of individuals with illnesses. These associations are particularly important, as carers for such individuals are often those who could benefit from the Always Supported programme.

Through their local knowledge, leadership or life circumstances, non-professional agents can significantly contribute to raising awareness, promoting the programme and identifying individuals who could benefit from it. Following training provided by the team, collaboration procedures and referral channels for directing suitable individuals to the Always Supported programme are established either via the Social Action Group or directly with each agent. These procedures may include, among others:

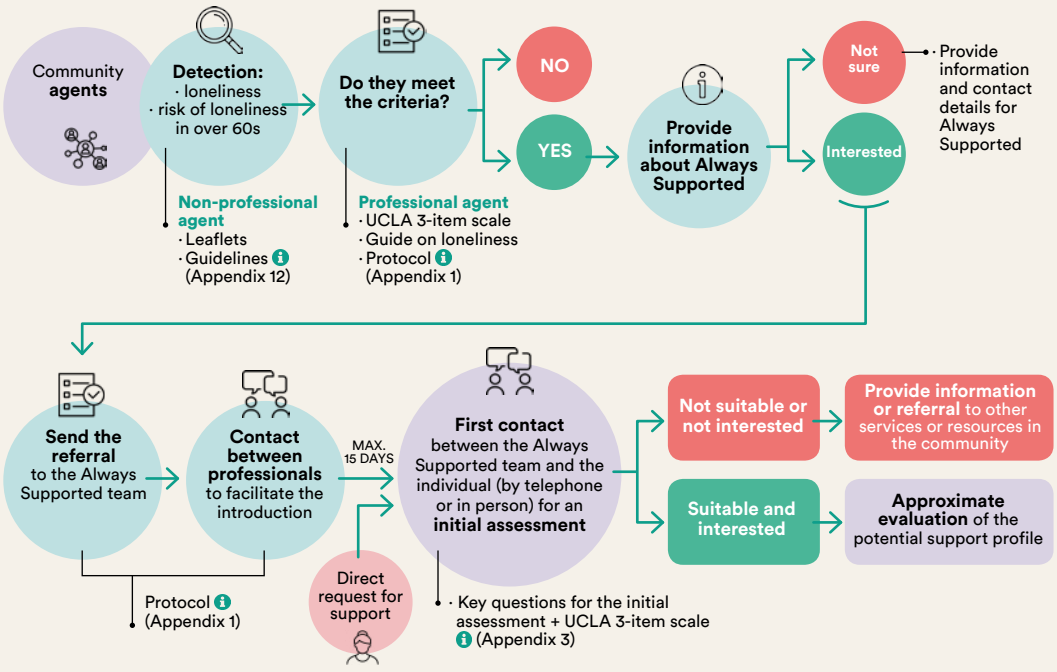
» Regular monitoring (quarterly or four-monthly) by the team and the individual, group or association to maintain collaborative relationships and review potential referrals.

» Organisation of meetings or events by the association with members or individuals who may benefit from the programme, during which the team addresses issues of loneliness and provides information about the support available.

» Distribution of programme information by the individual, group or association, among their contacts or members.

To aid detection, non-professional agents are provided with the document *Guidelines for identifying loneliness* (see Appendix 12, p. 306), which includes a guide on loneliness. This document defines what loneliness is and describes the characteristics of the people the programme can support – specifically, those who meet one of the established profiles.

Figure 2. **Detection and referral for support by community agents**



Source: Compiled by the authors.

2.2.2. Initial contact: key aspects

Duration: 1 or 2 sessions[11]

When the team receives information about a person who might benefit from the programme, initial contact is established within a maximum of 15 days. This contact may be in person or by telephone, and during the interaction the programme is explained and the person's situation is explored. The UCLA 3-item loneliness scale and the Campaign to End Loneliness Measurement Tool (CEL Tool) are used to assess and determine the suitability of their inclusion in the programme and the allocation of the appropriate profile (see Appendix 3, p. 267).

The initial contact is a sensitive phase, as it is the first time the individual meets members of the team and discusses their situation. It is important to remember that discussing feelings of loneliness can sometimes be difficult, and it may be the first time the person has shared this with anyone. For this reason, it is essential to establish a relationship based on security by demonstrating understanding and empathy towards the

11. The estimated duration of the sessions is:
· Assessment of suitability and profile: a maximum of 30 minutes (via telephone or in person).
· Follow-up sessions: first session, in person, 60 minutes; second session, by telephone, 30 minutes.
· Evaluation and life story sessions: 90 minutes.

situation presented. This is the moment to begin building the connection between the professional and the individual and to lay the foundation for a relationship of trust and support. The following are some aspects to consider during the initial contact:

» Ensuring the creation of a safe and trusting environment.

» Actively listening: paying attention to what the person says and how they say it, while gently guiding the conversation towards questions that help assess the suitability of their inclusion in the programme.

» Explaining the programme and how it works with participants. In summary, the message to be conveyed and the way to do so are as follows:
  – Programme objective: to support individuals over the age of 60 who are autonomous and may feel lonely or wish to prevent loneliness by helping them manage this feeling, reconnect with their aspirations, adjust their life plan and build meaningful relationships.
  – How it works: it is important to explain the programme clearly, adapting the concepts to the person's level of understanding and specifying what they can expect. Key points to include are:
    · The process to be followed: Initially, the person is introduced to the team and their life story is explored through interviews, alongside the completion of evaluation tests. Following this, a personalised action plan is designed together with them, outlining the changes or learnings to be supported. This plan enables the individual to gradually adjust their daily routines and develop new skills and habits to improve their situation.
    · Personalisation of the process: This is a tailored approach that respects the individuality of each person, allowing them to set the pace of their journey. For example, when working with someone we do not impose a fixed rhythm; they decide how much and how quickly to progress. If they need more time to feel comfortable before addressing certain issues, we adjust our approach and pace to meet their needs and preferences. This ensures they feel supported and grow stronger throughout the intervention.
    · Commitment requirement: It is crucial for the person to understand that their commitment to change is vital for the process. The team provides guidance, but cannot take their place in making the changes necessary for improvement.
    · Explanation of the frequency of the sessions and the approximate duration of the process.

To delve deeper into these aspects, the professionals have access to a communication manual that offers essential guidance for clear and effective communication, both with older adults and with the programme's referrers. This manual provides specific tools and strategies to ensure that agents (whether professional or non-professional) fully understand what Always Supported offers, how it works, the value it provides and how this programme supports older adults (*Manual de comunicación para los equipos del programa Siempre Acompañados*, Communication Manual for the Always Supported programme teams, 2024).

2.2.3. Enrolment in the programme and profile assignment

Once the individual has been contacted and assessed, and both their suitability and commitment have been confirmed, they are assigned a specific profile and offered enrolment in the programme, guiding them towards the intervention proposal that best suits their situation (for detailed criteria and intervention proposals by profile, see chapter 2, section 3, p. 96).

Upon acceptance of enrolment, the relevant forms are completed to register the individual in the database, ensuring all necessary information is recorded and legal procedures are followed in accordance with data protection regulations (LOPD) (see Appendix 13, p. 308).

Once the individual agrees to join the programme, it is crucial to continue building a meaningful and secure connection with them. The helping and support relationship relies on this bond of trust to ensure the individual feels safe to open up and share their experiences. Establishing a strong bond creates an atmosphere of collaboration and emotional connection, enabling work towards the set goals, as the bond fosters commitment to change and enhances empowerment. This bond is cultivated through an honest relationship, unconditional acceptance (free from value judgments) and moral symmetry, with a strong emphasis on active listening.

2.2.3.1. Does not meet the programme profile

In the event that the individual does not meet the programme's profile or it is determined that their situation cannot be addressed by the team, they will be referred to or connected with other services or community resources better suited to providing the appropriate support, such as health services, social services or volunteer organisations. Under no circumstances, unless explicitly requested by the individual, will the "case" be closed without ensuring that they are in contact with a service capable of offering them support.

For example, if an individual is alone due to a high dependency in activities of daily living that prevent them from leaving their home without assistance and they only receive one hour of home help service, the social services designated professional or relevant volunteer organisations will be contacted to inform them of the situation and activate an appropriate response. All actions will always be carried out with the explicit consent of the individual.

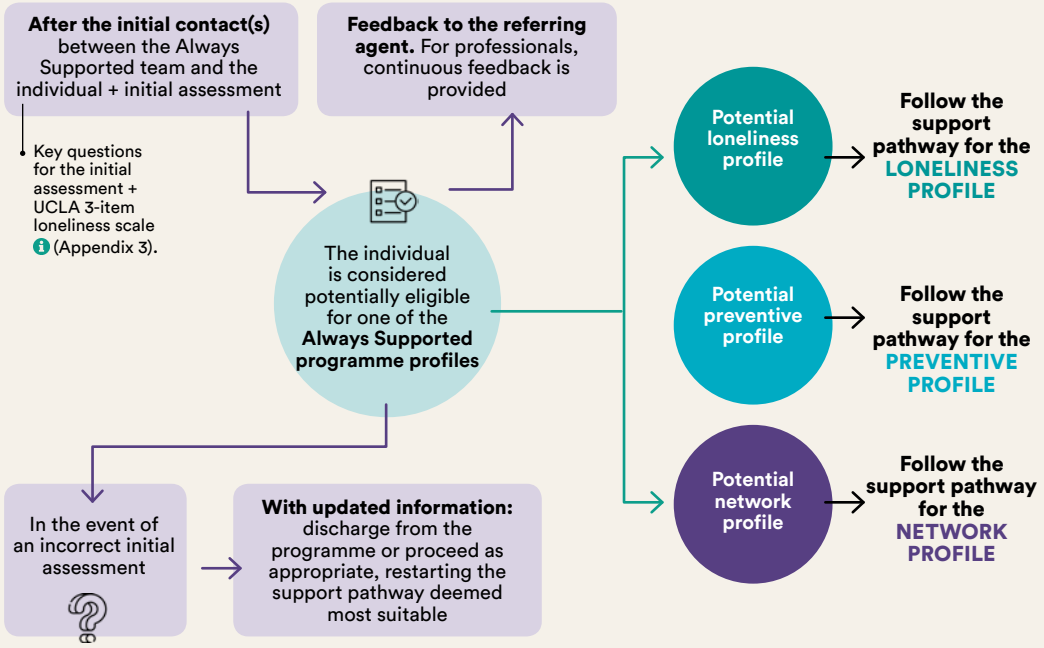
The following are the most common criteria for non-eligibility:

» Requiring support or services from other professional resources before their situation can be addressed by the programme.

» High dependency, other health factors, cognitive decline or severe mental health issues.

» The individual decides not to actively participate in the programme.

Figure 3. **Assessment of eligibility and profile allocation**



Source: Compiled by the authors.

2.3. SECOND STAGE: PROFILE-SPECIFIC PHASES

The following outlines the specific phases differentiated by profiles.

2.3.1. Loneliness profile

2.3.1.1. Phase 1. Assessment and proposal of the action plan

2.3.1.1.1. Assessment

The first step is to conduct an assessment to gain a comprehensive understanding of the person's individual needs, circumstances and strengths. This assessment is carried out using the life story and evaluation tests. Each of these elements is detailed below.

2.3.1.1.1.1. Development of the life story

Timeline: between 1 and 2 sessions

Creating the life story serves two objectives. The first is to facilitate the formation of a meaningful bond. People need to make sense of their experiences and the world around them, and this is achieved by crafting, sharing and recounting narratives that provide continuity, structure, coherence, meaning and purpose to those experiences. Through the life story or personal narrative, it becomes possible to understand the individual and ensure they feel acknowledged, respected, heard, validated and supported in their uniqueness.

The second objective is to understand their past experiences, significant relationships and key life changes. This information provides context that helps tailor the intervention to their specific needs.

To achieve these two objectives, the procedure is as follows:

» Once the person has committed to joining the programme, a face-to-face appointment is arranged to develop their life story. It is essential that this takes place in an environment where the person feels comfortable and secure, and where they can be properly heard (avoiding noisy or distracting locations such as cafés).

» The process is carried out in a maximum of two sessions, which should align with the person's pace, needs and willingness to share, aiming to gather as much detail as possible during these meetings.

» Each session has a maximum duration of 90 minutes. To ensure adherence to this timeframe, it is important to agree with the person on both the start and finish times.

» After completing the life story, the person is reminded that the next step involves conducting the evaluation interview. A face-to-face appointment is arranged for this evaluation, ensuring that the individual feels comfortable and supported throughout.

» Once the session is complete, it is transcribed immediately to avoid losing any important details. This transcription is added to the person's digital file, ensuring that all relevant information is available for future analysis (see Appendix 5, p. 270).

In short, we can only personalise interventions if we truly understand the person. The life story is a valuable tool for achieving this, as it allows us to see the individual in their full dimension, acknowledging their journey, achievements, challenges and the transitions they have experienced throughout their life (for further details, see section 1.2, p. 139).

This in-depth knowledge provides the essential elements needed to design a meaningful action plan aligned with their values and significant activities.

2.3.1.1.1.2. Evaluation of the individual

Timeline: 1 session

The next step involves conducting a comprehensive evaluation of the individual's situation in relation to loneliness and how modulating and mediating variables are influencing it (see section 1.3, p. 150). The assessment tests allow us to identify specific risk factors, levels of emotional and social well-being, coping styles and feelings of loneliness. All this information will guide our intervention proposal, ensuring it is both effective and relevant.

The evaluation is conducted periodically throughout the individual's intervention, following the timeline outlined below:

» 1st evaluation: between the 2nd and 3rd sessions, after the initial contact and life story have been completed.

» 2nd evaluation: six months after the start of the action plan.

» 3rd evaluation: twelve months after the start of the action plan.

» 4th and subsequent evaluations: annual evaluations until the completion of the support process.

If evaluations cannot be conducted within the scheduled timeframe, the reasons are documented in the section dedicated to follow-ups. This ensures the situation and reasons for not adhering to the planned timeline are properly recorded

2.3.1.1.2. Analysis and diagnosis

Timeline: between the evaluation session and the results feedback session

During this period, the professional must gather all available information about the individual to conduct a detailed analysis of their situation, aiming to establish initial diagnostic hypotheses. Based on this diagnosis, an action plan is designed that considers the participant and their circumstances, taking into account both their strengths and vulnerabilities. This plan serves to guide the objectives for change and empowerment (see chapter 2, section 1, p. 43)

This phase is essential to ensure that the intervention is personalised. The proposed intervention should be based on the analysis conducted, guiding the participant in developing personal resources that empower them while also addressing changes in their context, taking into account the modulating or mediating variables influencing their situation.

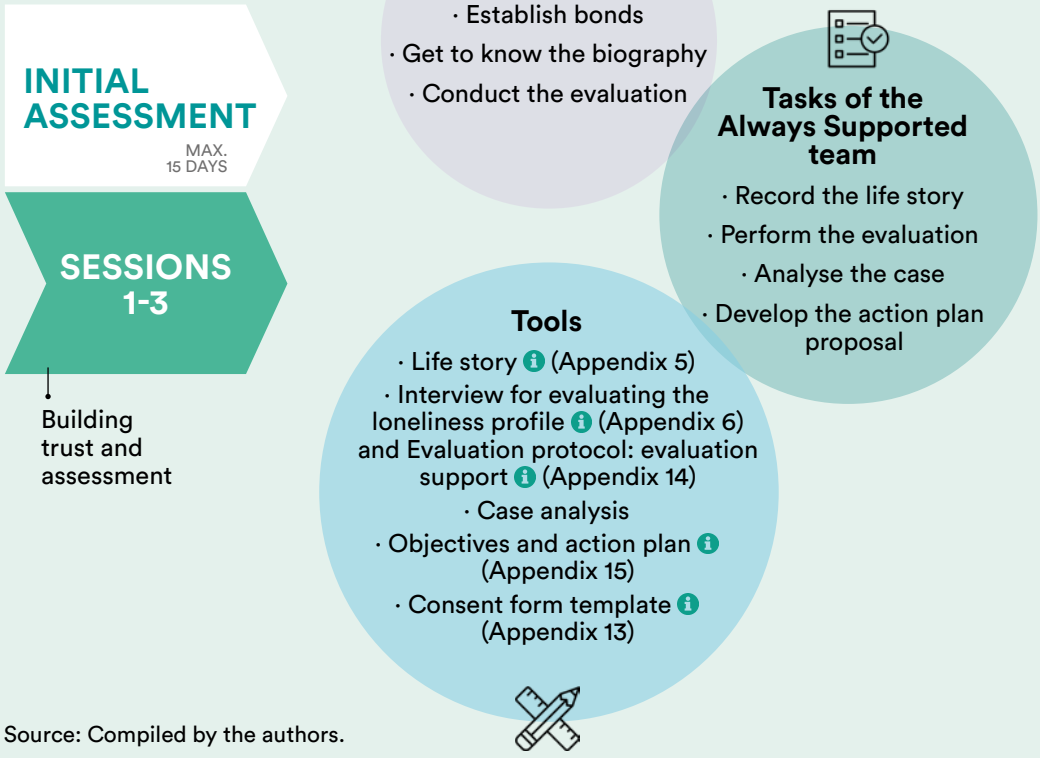
The analysis involves a comprehensive review based on the programme's conceptual model and the potential variables affecting the individual's circumstances. This includes the evaluation, life story and all other information gathered. To facilitate this process, the "case analysis" tool is used (see chapter 4, section 1, p. 203), which provides detailed guidance for the initial and ongoing analysis throughout the intervention.

This analysis uncovers the variables influencing the individual's situation, helping to distinguish between aspects that cannot be changed (such as the loss of a loved one) and those that can be addressed (such as the experience and meaning of the loss) with the support of the programme's professional. This process enables the creation of an initial diagnosis of the individual's situation, identifying both their strengths and areas for improvement.

Based on this initial diagnosis, the professional develops a preliminary action plan, which is presented to the participant in a feedback session. During this session, the plan is adjusted with the person's input to obtain a co-created final version that reflects their needs and aspirations.

Throughout the intervention process, each evaluation is carried out according to the planned timeline, enabling updates to the action plan as needed. This approach, which considers both progress and setbacks, ensures that the support provided continuously adapts to the needs of the person.

Figure 4. **Loneliness profile: life story and evaluation**



Source: Compiled by the authors.

2.3.1.1.3. Feedback of results: co-creation of goals and action plan

Timeline: 1 session (4th or 5th session with the person)

During the results feedback session, the goals to be worked on and the actions needed to achieve them are agreed upon with the individual.

The session begins by sharing the initial diagnosis and preliminary goals, aiming to guide the discussion so the person takes ownership of these objectives, connecting them to their desires and needs. This approach ensures that the intervention is meaningful for the individual and aligned with their reality and aspirations.

During the session, the details of the action plan are discussed to adjust it based on the individual's input and feedback. This fosters a co-creation process that ensures the plan aligns with their wishes and reflects their motivations and expectations.

At the end of the session, the schedule for the monthly follow-up sessions is reviewed and the next meeting is set. This structured follow-up allows for continuous adaptation and consistent support, ensuring that the intervention remains relevant and effective over time.

2.3.1.1.3.1. Orientation of objectives

The action plan establishes approximately one to three objectives, tailored to the individual's situation, needs, desires and other circumstances. These objectives must answer the question: "What needs to change, improve or be achieved?" and serve as a guide toward the desired change.

An objective is a specific goal set to guide actions and efforts towards success. A well-defined objective provides direction and clarity, enabling the evaluation of progress toward its achievement. It acts as a roadmap, guiding the individual towards what they aim to accomplish. Objectives, defined by the person's intention, commitment, will and motivation, reflect their aspirations and needs.

To be effective, objectives must meet certain criteria:

» They must be measurable, meaning that what needs to happen to declare the objectives achieved must be clear. For example, "improving the person's situation" is not a well-defined objective because it cannot be measured; however, "having two or three people to go for a walk with" is a measurable objective.

» They must rely on the person setting them. For example, "meeting new people" depends on the individual and will require a series of actions on their part. However, "having their child call them more often" does not depend on them and therefore cannot be set as an objective, since they cannot force anyone to do anything.

» They must be achievable within a reasonable timeframe. It is advisable for objectives to be attainable within a period of six months to one year. For example, meeting people of interest within the next six months provides a clear time perspective.

» They must be specific and action-oriented. For instance, "being happy" or "feeling like before" are not objectives. These are intentions or desires the person may have, but they cannot be actioned as they do not encourage reflection on what needs to change. The person should be encouraged to define what "feeling better" or "being happy" means to them and what contributes to their happiness. This helps in making the objectives more concrete.

» They should be framed positively: it is more motivating and action-oriented to describe what is desired rather than what is not. For instance, "stop being angry" is a negative approach and does not offer an alternative as it does not guide the person towards a state of being. Conversely, "enjoying things" is positive: the idea is that, to stop being angry, the person will need to engage in something that motivates them and brings enjoyment.

Once the objectives have been defined, the necessary actions to achieve them must be planned.

2.3.1.1.3.2. Action plan

The action plan requires us to support the individual in taking the necessary steps to achieve the objectives they have set for themselves. This phase is one of the most challenging, as it demands the person's commitment to become active, start implementing the plan, engage in activities they were not previously undertaking and put in effort. At this stage, the established bond is crucial for motivating the individual,

fostering their self-confidence and supporting them throughout this process, in line with the core concept of accompaniment central to the Always Supported programme.

To ensure success, it is important that the steps and actions outlined are proposed by the individual. This is important for two main reasons: firstly, the process of reflection involved in developing the action plan helps the person to become aware of their potential to transform their situation; secondly, the individual is the one who knows their own motivations, desires and abilities best. The professional's role at this stage is to support the person in connecting with their own insights through reflective questioning or exploration that fosters self-awareness.

The co-creation of the action plan is essential for fostering empowerment, learning and the development of personal resources that enable the individual to improve their situation. The action plan should serve as a guide towards action by directing the person's efforts towards the desired change.

The table below outlines the categories and areas of focus for formulating objectives and the action plan (see Appendix 15, p. 317). This is followed by an example and some considerations for drafting the action plan for the loneliness profile.

Table 1. **Categories and areas of work for developing objectives**

CATEGORIES	AREAS OF WORK	
Lifestyles	Food and hygiene. Mobility. Routine. Adherence to treatment. Sleep hygiene. Personal image. Others	· Social skills · Commitment · Self-esteem · Limiting beliefs · Expanding the social network · Life plan · Enjoying solitude · Acceptance of the present moment · Valuing myself · Seeking meaningful activities · Increasing instrumental support · Increasing emotional support · Others
Social network	Family. Friendships. Neighbours. Professionals. Others	
I give, I offer **I receive, I know where to ask**	Instrumental, emotional or informational support	
Involvement in activities	Religious. Volunteering. Reading. Choir. Phone calls. Walking, cafés, chatting. Others	
Personal resources: coping styles	Productive. Non-productive. Oriented towards others. Emotion-focused	
Personal resources: meaning - life plan	Belonging. Transcendence or spirituality. Contribution to others. Personal growth. Pleasure. External recognition	
Personal resources: regulation	Self-awareness. Self-regulation. Self-motivation. Empathy. Social skills. Stress tolerance. Impulse control. Reliable assessment	

Source: Compiled by the authors.

Example of an action plan

Objective: Meet people with an interest in nature (the objective is included under improving the social network and meaningful activities as modulating variables to address).

Actions: The actions that could be suggested include the following examples:

» Identify places where such people gather, such as associations, interest groups or activities at centres related to nature, and decide which ones to contact.

» Visit between two and four of the selected locations and make inquiries.

» Enrol in one of the activities.

» Build relationships with the participants.

Considerations for developing the action plan for the loneliness profile:

» **Diversify the variables to be addressed in the objectives.** When working with people experiencing loneliness, it is crucial to recognise that various factors influence their situation. As explained in previous chapters (see chapter 2, p. 43), loneliness is linked to risk factors as well as to a range of mediating and modulating variables that affect the situation and are often interconnected. It is essential to consider these different variables in the action plan to increase the likelihood of success.

For example, if the goal is to meet new people, it may be easier to achieve this by improving self-image (self-perception), which can be fostered through physical activity (exercise).

A related second goal could be added to the previous example: taking care of personal appearance (addressing the mediating variable: healthy routines).

Actions that can be considered:

– Make an effort to groom oneself every time they go out.

– Follow a healthy diet.

– Walk for 30 minutes every day.

» **Support and anchoring elements of the action plan.** Once the plan is defined, it is recommended to use the weekly calendar (see Appendices 15 and 16, pp. 317 and 318). This calendar is intended to help the individual plan their activities for the following month, up until their next session with the designated professional. The weekly calendar serves as a support tool, not only acting as a reminder of the actions they intend to carry out but also serving as an anchor for follow-up sessions and the ongoing work.

To establish a habit, it is essential to integrate new actions into the daily routine, which can initially be challenging. The proposed actions are often different from the individual's usual activities and require additional effort. For this reason, it is crucial to create "anchors" such as the weekly calendar and the action plan. These tools help the individual stay connected to the commitment they have made with the programme. The action plan, along with the calendar, is provided to reinforce their commitment and offer a clear structure for tracking their progress.

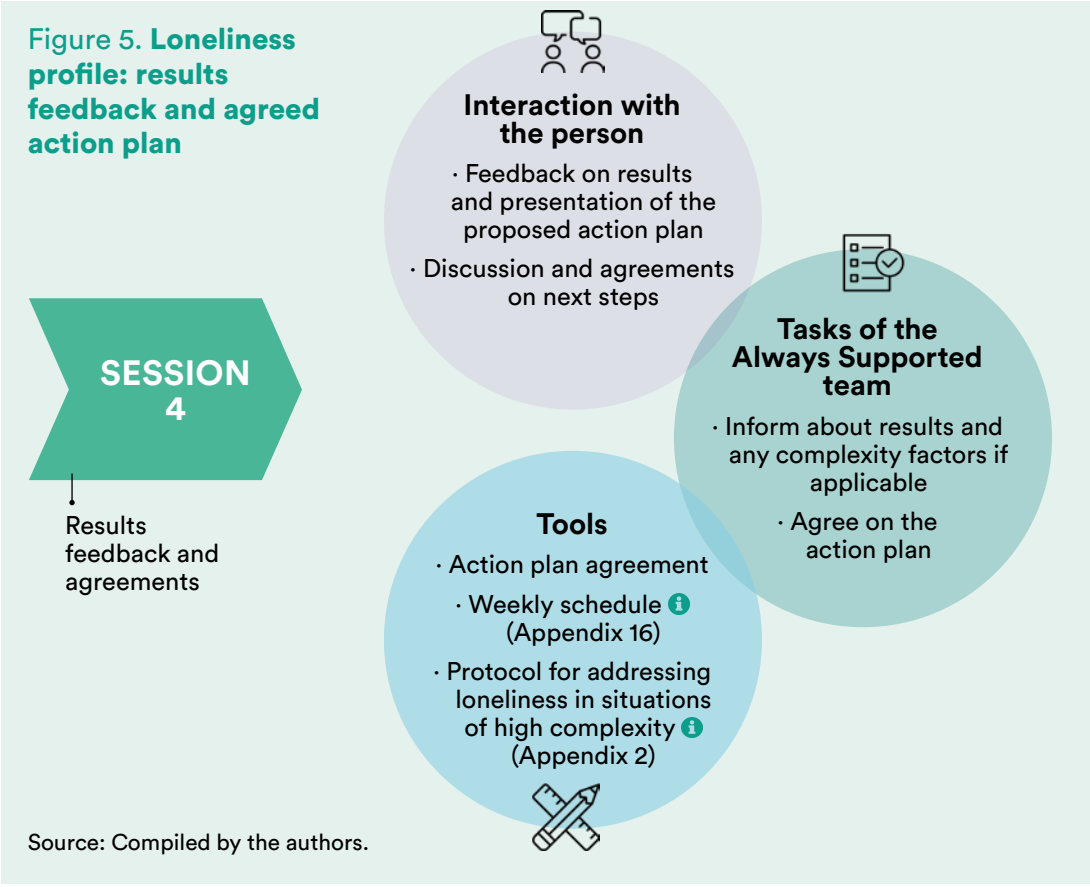


Figure 5. **Loneliness profile: results feedback and agreed action plan**

Source: Compiled by the authors.

2.3.1.2. Phase 2. Follow-up

2.3.1.2.1. Monthly follow-up

Timeline: 12 months

During the first year, monthly in-person follow-up sessions will be conducted to review the progress of the action plan.

These follow-up sessions are designed to evaluate the development of the action plan, identify challenges and achievements and analyse any changes that may arise. The sessions aim to help the individual become aware of their self-limiting aspects and difficulties, and to work towards overcoming them using the tools provided by the professional. These tools include behavioural activation, strategies for acceptance, self-compassion, building confidence, improving social skills, managing disruptive or self-limiting thoughts and problem-solving techniques, among others.

During the follow-up sessions, the participant is encouraged, valued and acknowledged, regardless of the progress they are making, as these sessions serve as a fundamental space for support. Often, the professional may be the only person who believes in the individual's ability to change and improve.

It is important to bear in mind that individuals in vulnerable situations and experiencing low mood often exhibit low behavioural activation. Due to their emotional state and

the suffering they are enduring, they tend to stop doing things, claiming they lack the motivation for anything, and wait to feel better to become active. The support provided should facilitate this activation, which is a complex task. Follow-up sessions are essential for this purpose.

When a person is in a low mood, it is crucial to support them in becoming active, as this is essential for transforming their state. Therefore, it is vital to work through the bond and trust, providing the necessary support to help the individual become active and progress in their journey of change and improvement.

It is recommended that follow-up sessions follow a structured approach to ensure all necessary aspects are addressed, helping the person to make progress.

» Opening: welcome the individual and set the tone for the session (recall a detail or anecdote from the previous session, offer recognition, acknowledge any new developments or changes, etc.).
» Specific work on the plan: discuss achievements, difficulties, how they have felt, adaptations to the plan, etc.
» Closing: recognise their effort, confirm agreements and establish commitments.

At six months into the action plan, a second evaluation of the individual is conducted. This provides the necessary information about their progress, allowing adjustments to the action plan. From this point onward, monthly follow-ups continue, alternating between in-person and telephone or online sessions.

Based on the programme's accumulated experience, it is estimated that within 12 months the individual will have made progress towards achieving their objectives, with improvements likely reflected in the results of the third evaluation. If this is the case, follow-ups will begin to be spaced out to encourage the individual to continue working more independently.

If no improvements are observed in the third evaluation and the individual is struggling to advance towards their objectives, monthly sessions will continue, adapting the process to their pace until significant progress is achieved.

2.3.1.2.2. Bi-monthly follow-up

Timeline: 12 months

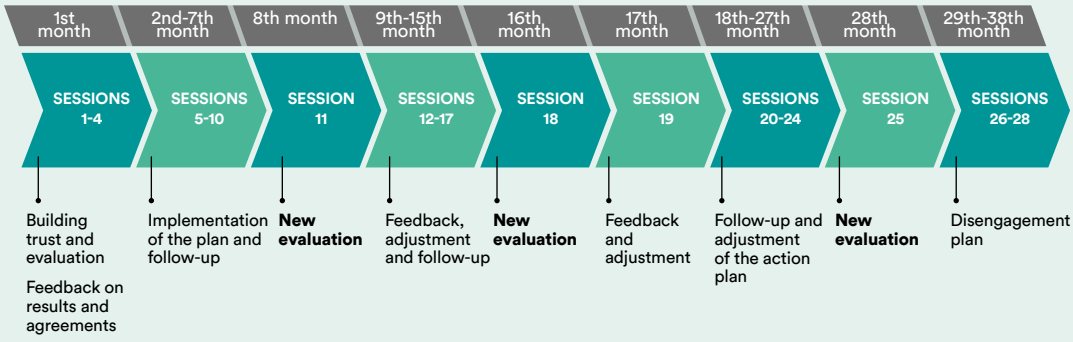
During the second year of working with the individual, follow-ups are scheduled bi-monthly, alternating between in-person sessions and telephone or video calls. At this stage, the process will have progressed, the individual will have improved and their situation will have changed. Spacing out the follow-ups is important to allow the individual time to apply and consolidate what they have learned, as well as to provide more time for reflection, which is essential for continued learning.

Reducing the frequency of sessions promotes autonomy and self-management, as it enables the individual to take greater responsibility for their progress. As they advance, they will feel more competent and confident in their ability to self-manage, which will support the sustainability of the improvements achieved.

The support process is time-limited, with the expectation that the person will acquire skills and learning to sustain their improvements over the long term. Spacing out the follow-ups helps the individual become more autonomous in decision making.

In summary, during follow-ups, the work on the action plan continues, addressing progress and challenges while exploring alternatives with the person. However, the professional should gradually shift the focus towards reducing the level of support to encourage autonomy, based on empowerment. The ultimate goal is for the individual to feel capable of maintaining their progress without the programme's assistance.

Figure 6. **Loneliness profile: assessment, proposal and follow-up**



Source: Compiled by the authors.

2.3.1.2.3. Other contacts with the person

We may have other interactions with the individual aside from the follow-up on the action plan. It is important to record these contacts in the person's file, specifying their type and purpose. Although all these interactions are part of the work with the individual, it is methodologically important to differentiate them, as they add different nuances to the established relationship. Everything we do with participants should aim to empower them and help them develop personal resources.

Types of additional interactions with the individual:

» By phone to provide relevant information, such as informing them about the start of a course they might be interested in or a scheduled outing.

» By phone or in person, initiated by the individual to address a topic of concern to them.

In summary, during the follow-ups in this second phase, the primary goal is to work with the individual on achieving their objectives through the action plan, reviewing progress and challenges to adapt the plan and offering all available resources to support change. This phase is highly individualised and personalised, tailored to each case and circumstance.

2.3.1.3. Phase 3. Discharge or adjustment of profile

Timeline: approximately 12 months (corresponding to the 3rd year)

In the fourth evaluation (at approximately 24 months), if the tests show progress and advancements in the plan, the possibility of working towards the disengagement of the individual from the intervention within the loneliness profile is considered. This may involve adjusting to another type of intervention if the situation so requires or working towards the individual's definitive discharge from the programme, thus entering phase 3 of the intervention within the loneliness profile.

As the individual progresses towards achieving their goals and demonstrates improvements in evaluations, follow-ups are conducted quarterly, and they are guided towards two potential outcomes: *a*) profile adjustment, which involves leaving the loneliness profile and entering another appropriate profile; *b*) definitive discharge from the programme.

Follow-ups during this phase focus on reinforcing the achievements made and helping the individual to recognise the progress they have made and the personal resources they have developed. The goal is for the individual to be able to use these resources whenever they face discomfort arising from feelings of loneliness.

2.3.1.3.1. Profile adjustment

When an individual leaves the loneliness profile to continue their support process within another profile that better aligns with their needs, the programme facilitates the adjustment of the participant's profile. This matching is based on the data gathered during evaluations and professional judgement to ensure that the intervention remains relevant to the individual's current circumstances. Two situations may arise:

» **Profile adjustment during the evaluation process.** Profile adjustment may occur when, during evaluations and based on professional judgement, it is identified that the individual's situation has changed, and the current intervention no longer aligns with their needs. In such cases, the profile is adjusted to provide the most appropriate intervention. This involves removing the individual from the current profile and enrolling them in the new one, either the preventive or the network profile.

  Example: A person with moderate loneliness in the loneliness profile, after two years of intervention, shows improvements in their perception of social relationships, has expanded their support network and has made progress in addressing social loneliness during the 24-month evaluation. However, a risk of relapse is also identified due to neglect of habits and routines. In this case, and always in agreement with the individual, they would be deregistered from the loneliness profile and enrolled in the preventive profile, inviting them to participate in the intervention focused on improving healthy habits and working towards the goal of enhancing their routine.

» **Profile adjustment to maintain engagement.** In many cases, individuals have made progress and improved their situation but do not wish to disengage from the programme. They may need to remain connected to relational spaces or scheduled activities, or even participate as volunteers in the programme. In such cases, they are deregistered from the loneliness profile and transferred to the network profile.

2.3.1.3.2. Definitive discharge from the programme

A definitive discharge from the programme means that the person completely disengages from it. To determine whether individuals supported under the loneliness profile are ready for this disengagement, their progress in achieving objectives, life changes and the results of various evaluation tools are assessed. This decision is made in agreement with the individual (see Appendix 17, p. 319).

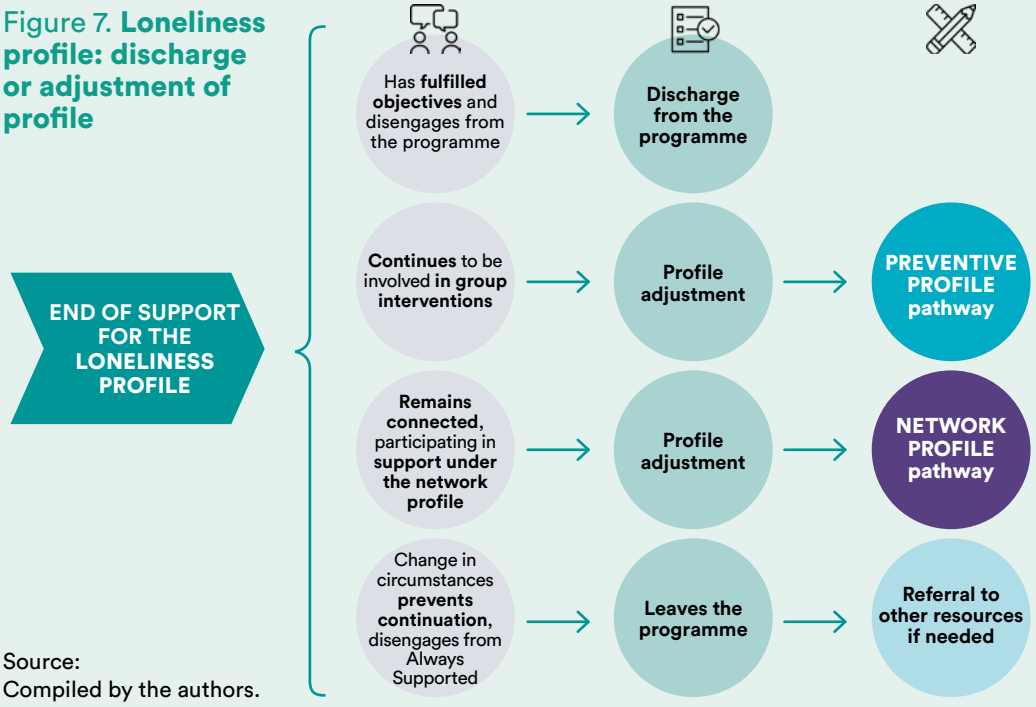
Various scenarios may arise:

» **Achievement of objectives and significant improvements.** The individual has achieved most of the objectives and priorities outlined in their action plan, has improved their situation concerning loneliness and their perception of it, and possesses the necessary tools to manage it.

» **Indirect progress in other areas.** While the evaluation of loneliness does not show direct improvements, the individual has developed personal tools to manage their loneliness, as evidenced by progress in other areas of intervention:
  – Sense of purpose in life.
  – Expansion of the social network.
  – Improvements in the quality of relationships, perception of intimacy, closeness or support in relationships.
  – Increased sense of purpose or meaning associated with relationships.
  – Other improvements identified in the evaluation.

» **Stagnation in improvement.** The person has achieved improvements from their initial situation but is not making further progress. The programme no longer provides any

Figure 7. **Loneliness profile: discharge or adjustment of profile**



Source:
Compiled by the authors.

measurable or perceived benefit (according to the technical assessment of the team), and all possible strategies have been exhausted.

» **Change in personal situation.** A change in their personal situation prevents them from continuing in the programme. Examples include moving into a residential care facility, relocating to another area, or a decline in their health.

2.3.2. Preventive profile

2.3.2.1. Phase 1. Assessment and proposal of the action plan

2.3.2.1.1. Assessment

Timeline: 1 session (or 2 if the person so requires)

The assessment session includes development of the life story and evaluating the preventive profile. The recommended time allocation is 60 minutes for completing the life story and 30 minutes for evaluating the preventive profile.

2.3.2.1.1.1. Development of the life story

As with the loneliness profile, the life story is the tool that enables us to establish the necessary connection to support the person in their process and serves as a prerequisite for offering a personalised intervention. However, in this profile, the life story is developed in a single session, with a shorter duration than in the loneliness profile.

For the preventive profile, the life story should help us understand the person, the significant moments and the transitions they have experienced throughout their life, allowing us to identify their coping strategies. It is also important to identify the current situation that could lead to loneliness if preventive intervention is not carried out (for further detail, see chapter 2, section 1.2, p. 43).

To adhere to the allocated time of 60 minutes, the following schedule is recommended:

» Introduction (5 minutes).

» Questions about the most significant life events (30 minutes).

» Exploration of specific details (15 minutes).

» Conclusion and reflection (10 minutes).

It is important to focus on the key moments in the person's life and encourage concise responses to ensure all essential aspects are covered within the allotted time.

The procedure for conducting the life story is as follows:

» **Commitment and in-person appointment.** Once the individual commits to participating in the programme, an in-person appointment is scheduled for the development of their life story (and evaluation of the person, if possible).

» **Creation of the life story.** The life story focuses on the most important and essential moments. It is crucial to create an environment where the individual feels comfortable and secure, avoiding noisy or distracting locations such as cafés or other settings that could distract them.

» **Session duration and adjustments.** The life story is completed in a single session, with adjustments made if the person wishes to share in more detail. However, the session should not exceed 90 minutes, with 60 minutes dedicated to the life story. It is important to agree on the start and end times with the individual to adhere to the schedule.

» **Next appointment and follow-up.** If both the life story and the evaluation have been completed in a single session, the individual is reminded that the next step will be the feedback session for sharing results. If only the life story has been completed, the next step will be the evaluation. In either case, a subsequent in-person appointment is arranged.

» **Transcription and recording.** After the session, the information is transcribed immediately to avoid losing important details and is attached to the individual's digital file (see Appendix 5, p. 270).

2.3.2.1.1.2. Evaluation of the individual

At this stage of the assessment, the evaluation of the individual is conducted, covering essential aspects such as loneliness assessment, the support and social network, and the purpose in life, along with socio-demographic data (see section 1.4, p. 169).

The evaluation is repeated during the course of the intervention with the individual according to the following schedule:

» First evaluation: conducted after the initial contact.

» Second evaluation: two scenarios are considered:[12]

1. If the individual participates in a group intervention, the second evaluation is conducted upon completion of that intervention.
2. If the person follows an individual preventive intervention, the second evaluation takes place six months after the delivery of the action plan, followed by a third evaluation at 12 months.

2.3.2.1.2. Analysis and diagnosis

Timeline: between the evaluation session and the results feedback session

All available information about the individual, including their life story and assessment, is gathered to analyse their situation. The aim is to establish initial diagnostic hypotheses. Based on this, an action plan is developed taking into account the participant's circumstances, strengths and weaknesses to guide the objectives for change and determine the most appropriate intervention.

12. Chapter 2, section 3 (p. 96) provides detailed information about the intervention for the preventive profile, which is preferably a group-based intervention. However, under defined criteria, an individual intervention may be chosen.

2.3.2.1.3. Feedback session: orientation of the intervention

Timeline: 1 session (this would correspond to the second working session with the participant)

The aim of this session is to guide the person towards the objectives to be worked on and the proposed intervention to achieve them. The feedback session is an opportunity for dialogue with the individual during which the objectives and priorities for the proposed intervention are agreed upon and established. Two possible scenarios may arise:

» **Guidance towards a group intervention** (see chapter 2, section 4, p. 120). After analysing the individual's situation, they are directed towards the group intervention that best addresses the identified needs. The intervention is explained in detail, including dates, times and location. If the group intervention is scheduled to begin in more than 30 days, the person is invited to participate in the programme's social meeting spaces to foster a connection with the programme through these relational settings.

» **Guidance towards an individual intervention.**[13] The proposed objectives are discussed and a personalised action plan is co-created to achieve them, ensuring that the suggested actions align with the individual's needs and aspirations.

2.3.2.2. Phase 2. Follow-up

The follow-up process varies depending on whether it involves a group or individual intervention.

» **Group intervention.** Follow-up on the individual's progress toward their objectives is conducted in two ways:

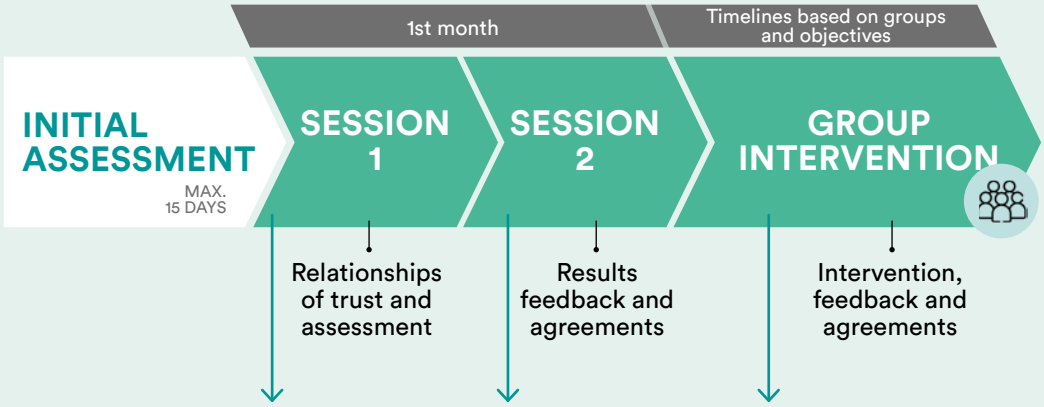
– **Observation and interaction during the group intervention.** The professional facilitating the sessions must keep a record of participants' progress and challenges throughout the intervention. This ensures that relevant information is documented for the evaluation session and that the individual is appropriately guided. At the end of the group intervention, a questionnaire on subjective perception of change and its impact on the individual's life is administered (see Appendix 4, p. 268).

– **Post-group intervention evaluation session.** Once the group intervention concludes, the individual is invited to an evaluation session to assess their progress. The professional uses the information gathered during the sessions to review the individual's achievements. The second evaluation is also conducted during this session.

» **Individual intervention.** As with the loneliness profile, follow-up consists of monthly sessions to assess progress or challenges in meeting the action plan and achieving the set objectives. These sessions allow adjustments to the action plan as needed and ensure that the individual receives the support they need.

13. If the individual is guided towards an individual intervention, the intervention pathway outlined for the loneliness profile is followed, but it is adjusted to 12 months of work with the individual instead of the three years planned for the loneliness profile.

Figure 8. **Preventive profile: assessment, feedback and group intervention**



Interaction with the person	· Establish connections · Know the person's life story · Assessment	· Provide feedback on results. Proposal of priorities and objectives · Discuss and agree on next steps. Group intervention	· Active participation in group intervention sessions · Understand the perception of change and its impact on the participant's life · Agreements for the next step
Tasks of the Always Supported team	· Record the life story · Collect demographic data · Conduct the evaluation · Analyse which group intervention to carry out and when	· Share the results · Agree on priorities, objectives and next steps · Plan the group intervention (If there is a significant delay before the group intervention, invite participation in meeting spaces)	· Monitor progress during the group intervention (observation, etc.) · Conduct the specific evaluation after the group intervention · Develop and agree on a proposal for discharge from the programme or continuation · Perform a group or individual evaluation of the preventive group intervention
Instruments	· Consent form template (Appendix 13) · Life story (Appendix 5) · Comprehensive interview for the preventive profile (Appendix 7) and Evaluation protocol: evaluation support (Appendix 14)	· Group intervention proposal	· Complete interview for the preventive profile (Appendix 7) · Group intervention evaluation (Appendix 4) · Criteria for discharge from the programme (Appendix 17)

Source: Compiled by the authors.

2.3.2.3. Phase 3. Discharge or adjustment of profile[14]

During the evaluation session, the changes made are assessed. The following possibilities may arise:

» **Continuation in the preventive profile.** During the evaluation session, the information gathered may highlight areas where the individual can continue working through group interventions offered by the programme. In such cases, the person remains connected to the programme within the preventive profile, following the established support pathway. It should be noted that there may be a gap of three to four months between group interventions, depending on the team's scheduling. During this time, the individual is encouraged to participate in relational spaces while awaiting the start of the next intervention. If the person does not participate in any group intervention over the following six months, they will be transferred to the network profile. When group interventions resume, they may rejoin the preventive profile.

» **Profile adjustment.** If the re-evaluation reveals that the individual's circumstances have changed and the preventive profile no longer aligns with their needs, the profile is adjusted to provide more suitable support. This involves withdrawing the individual from the preventive profile and enrolling them in a new profile, which could be the loneliness profile or the network profile, depending on the needs identified.

» **Definitive discharge from the programme.** When the individual demonstrates progress in periodic evaluations, has achieved the objectives set at the beginning of the programme or has developed greater capacity to manage their well-being and maintain social connections independently, definitive discharge from the programme may be considered. This decision is always made in agreement with the individual. Scenarios for definitive discharge may include:

  – **Achievement of objectives.** The individual has successfully achieved the established goals.

  – **Improvement in personal resources.** While evaluations may not show significant improvements, the individual feels more equipped to manage their situation.

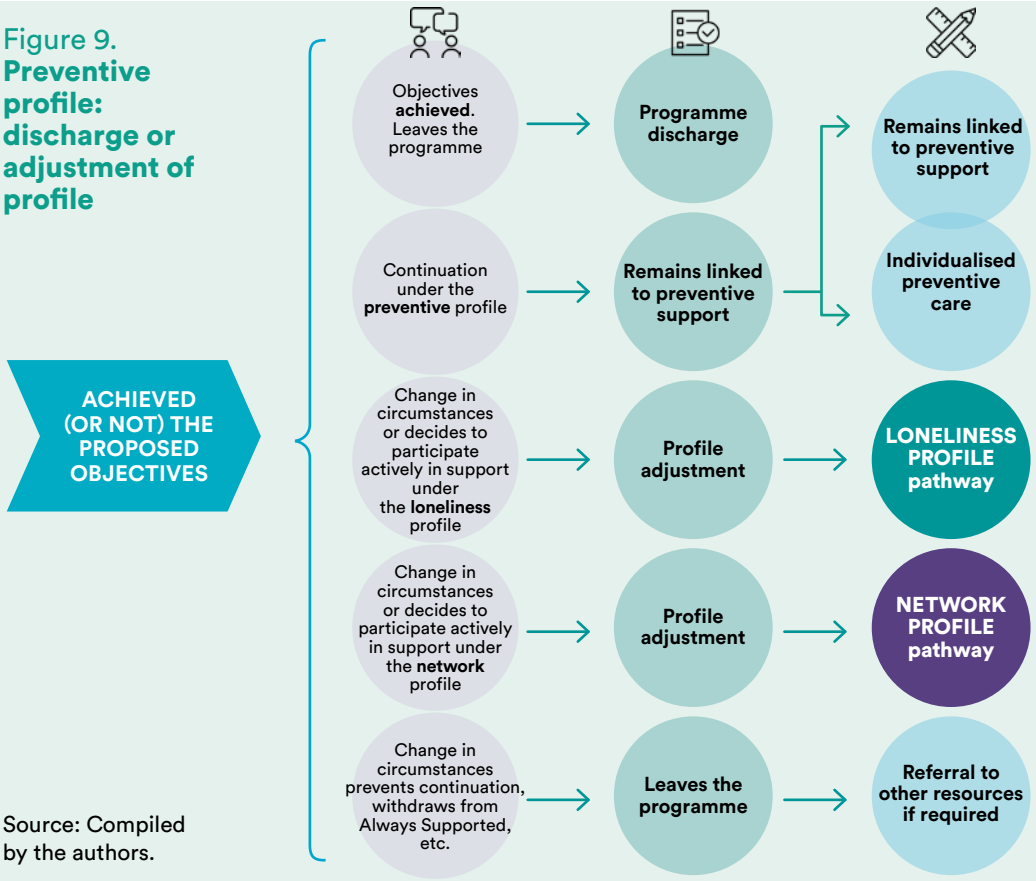
  – **Change in personal circumstances.** The individual cannot continue in the programme due to factors such as relocation, illness or a decline in health.

  – **Desire to discontinue.** The individual expresses a wish to leave the programme.

Each of these scenarios should be managed with sensitivity and in collaboration with the individual to ensure they feel supported and prepared for the transition.

14. In the individual intervention for the preventive profile, the steps outlined for the loneliness profile are followed for discharge from the programme or profile adjustment.

Figure 9. **Preventive profile: discharge or adjustment of profile**



Source: Compiled by the authors.

2.3.3. Network profile

2.3.3.1. Collection of basic data and presentation of relational spaces

In the case of the network profile, it is common during the initial contact session and programme explanation for the individual to express an interest in participating in the spaces offered by the programme without wanting to commit to other types of interventions.

At this stage, basic information about the individual is collected, such as their name, address, telephone number and email (if available). The purpose of this interaction is to introduce them to the relational spaces offered by the programme and invite them to participate.

Sometimes, the initial session takes place in the same relational space or during a scheduled activity. Based on the programme's experience, relational spaces are designed as open environments where participants themselves invite acquaintances, neighbours or family members. It is during these gatherings that introductions are made with the team's professionals.

The team should be prepared and attentive to introduce themselves to new individuals, ensure they have all the necessary information about the programme and collect their basic details to send updates about activities and events organised by the programme. Additionally, it is important to confirm that the individual understands how they can access individual or group support if needed.

2.3.3.2. Follow-up interviews

A follow-up interview is conducted every six months with the individual to assess their continued participation in the spaces, activities or initiatives designed by the team. During this interview, the possibility of alternative support options is also explored, including potential changes to the intervention profile.

It is important for people in this profile to participate in at least two gatherings per year to ensure their integration and to make the most of the programme's resources.

2.3.3.3. Intervention

Each area defines the spaces, initiatives or activities it will implement with the aim of offering opportunities for interaction and experiences of connection. These spaces, typically designed to be open, allow individuals to participate freely without requiring mandatory prior confirmation.

As previously explained (see chapter 2, section 3, p. 96), the goal of these initiatives is to foster relationships, encourage mutual support, create bonds and nurture a sense of belonging. This approach is fundamental to community work, as it strengthens social cohesion and facilitates the building of support networks (see, for example, chapter 2, section 2.5.6, p. 92).

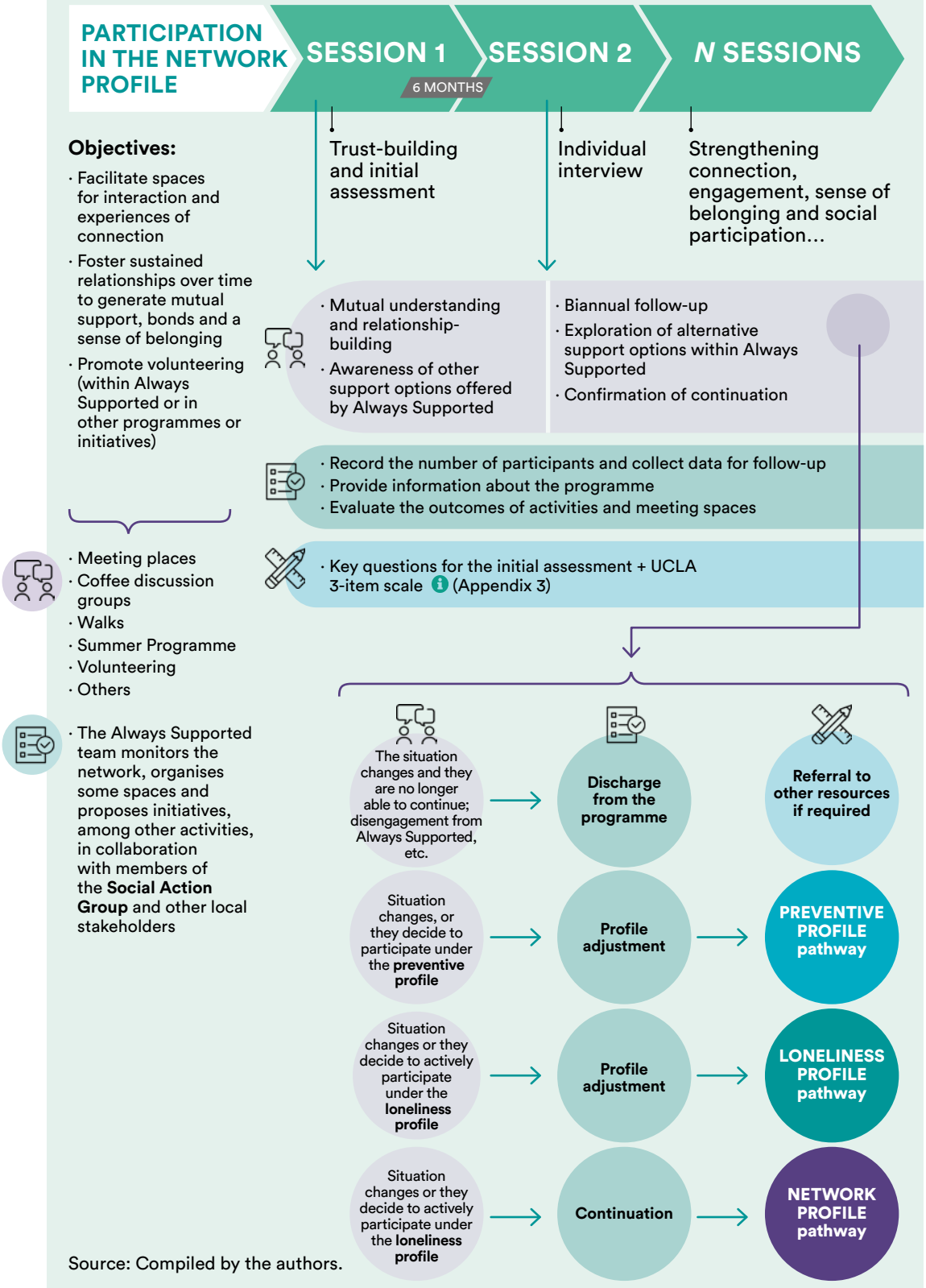
2.3.3.4. Discharge or adjustment of profile

Different scenarios may necessitate either discharge from the programme or an adjustment of the profile:

- **Change in life circumstances preventing participation.** If the individual's life circumstances change in such a way that they are no longer able to attend a minimum of two gatherings or activities per year, they are formally withdrawn from the programme. In such cases, the person is guided towards other resources that may better suit their new situation.
- **Change in life circumstances with a desire for greater commitment.** If the individual's life circumstances change and they decide they wish to participate more actively in their improvement process, suitability assessments are conducted and they are assigned the most appropriate profile for further support. From that point, the relevant process for the new profile is initiated.
- **Desire for greater commitment without a change in circumstances.** If the individual decides they want to engage more actively in their improvement process without any change in their circumstances, suitability assessments are conducted and the most appropriate profile is assigned. The support process is then initiated according to the assigned profile.

In all cases, the goal is to ensure that the individual receives the support most suited to their needs and aspirations, fostering their active participation and enabling them to make the most of the resources available for their well-being and personal development.

Figure 10. **Network profile**



Source: Compiled by the authors.

2.4. SUMMARY OF THE PATHWAYS OF THE LONELINESS, PREVENTIVE AND NETWORK PROFILES

Below is a schematic representation of the phases for each profile.

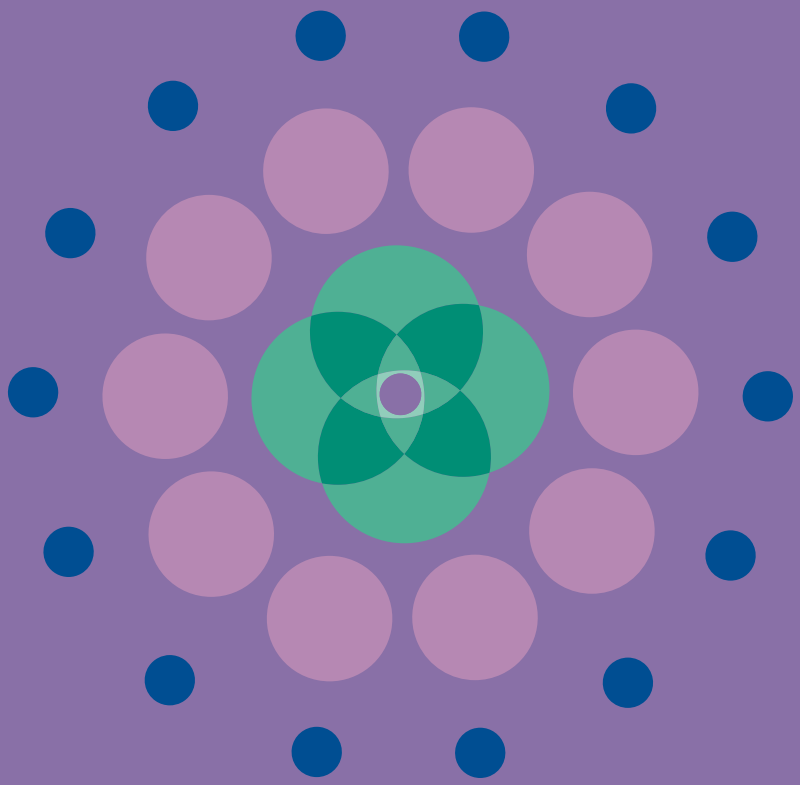
Table 2. **Summary of the profile pathways**

		ACTION	NUMBER OF SESSIONS
COMMON ACTIONS		Detection and request for support	
		Initial contact	1 or 2
		Incorporation into the programme and profile assignment	
LONELINESS PROFILE	PHASE 1	Assessment: life story	1 or 2
		Assessment: evaluation	1
		Analysis and diagnosis	Between sessions
		Feedback on results	1
	PHASE 2	Monthly follow-up	12
		Assessment: evaluation at 6 and 12 months	2
		Adjustment of the action plan	Following the evaluations
		Bi-monthly follow-up	6 (bi-monthly)
		Assessment: evaluation at 24 months	1
	PHASE 3	Quarterly follow-up	4 (quarterly)
		Discharge or profile adjustment	
PREVENTIVE PROFILE	PHASE 1	Assessment: life story and evaluation	1
		Analysis and diagnosis	Between sessions
		Feedback on results	1
	PHASE 2	Follow-up:	
		· Group intervention	1
		· Individual intervention	12
	PHASE 3	Discharge or profile adjustment	1
NETWORK PROFILE		Collection of basic data and introduction to spaces	1
		Follow-up interviews	1
		Discharge or profile adjustment	1

Source: Compiled by the authors.

Chapter 4

Methodological tools, training and volunteering



1.
CASE ANALYSIS TOOL

1.1. INTRODUCTION. METHODOLOGICAL APPROACH

Designing an action plan is a complex process; it must be personalised and, in addition to being challenging, it needs to be meaningful to ensure success. For this reason, conducting a thorough case analysis is essential.

The "case analysis" tool is a methodology designed to assist professionals in the structured analysis of a person's situation of loneliness. This tool, based on the conceptual model of loneliness proposed by the programme, considers both risk factors and the modulating and mediating variables that may contribute to the onset and persistence of loneliness.

Taking into account the participant's support process (see chapter 3, section 2, p. 174), the tool is used once the life story and the evaluation have been completed. This instrument aims to facilitate both the case analysis, as previously described, and two other essential tasks: the feedback of results and the co-creation of the action plan with each person involved in the programme.

Derived from the evaluation (see chapter 3, section 1, p. 139), the tool assists the professional in providing a comprehensive description of the person's situation, as well as identifying the variables that may be acting as positive reinforcements or as obstacles and difficulties.

The analysis carried out using this tool allows us to distinguish between variables that cannot be modified but influence the situation of loneliness, and those that are modifiable and could have a positive impact on improvement. For example, having experienced significant losses is a variable that cannot be altered and directly impacts feelings of loneliness. However, withdrawing from meaningful social interactions, that is, reducing one's social circle as a consequence of the loss, is a modifiable variable that can be addressed through intervention. Sometimes it is inevitable that a person continues to feel sadness and the absence associated with loss and the grieving process, and it may be challenging for the Always Supported programme to intervene directly in these emotional aspects. But it is possible to improve the quality of their social relationships to "alleviate" the effects of the loss, enabling the person to experience moments of well-being, understanding that it is possible to miss a loved one while simultaneously feeling accompanied by others.

This tool also facilitates the assessment of progress, as we continuously analyse changes in the different variables throughout the intervention, with the aim of identifying, alongside the evaluation, whether improvements are being made. It is, therefore, a learning instrument that tracks the evolution of each person.

It is important to note that a person's progress in relation to their feelings of loneliness is not always measured solely by a reduction in those levels of loneliness, but also through improvements in other influencing variables, such as greater awareness of personal

resources, the development of healthy routines or the discovery of meaningful activities. Continuing with the previous example of someone who has experienced the loss of a loved one, it is possible that during the intervention, the emotional loneliness linked to feelings of sadness and emptiness from the loss may persist. However, if the person has managed to regain a sense of purpose – for instance, by becoming a volunteer – this change will generate a sense of well-being, even if the associated sadness and emotional loneliness remain unchanged. Such positive changes will be reflected in the case analysis tool.

1.2. CONTRIBUTIONS AND KEY ELEMENTS

The tool aims to:

» Serve as a visual aid to synthesise the individual's strengths and challenges.

» Facilitate the identification of variables that determine the loneliness situation.

» Simplify the monitoring of each individual's progress.

» Help share information with the participant so they can understand and acknowledge the variables that either support or hinder their situation, providing them with a broad and holistic perspective.

The tool follows the intervention model of the programme and provides information on risk factors, mediating variables and modulating variables.

1.2.1. Risk factors

A *risk factor* is understood as a variable that does not directly cause a disease or condition, but is observed to be associated with it. As is well known, risk factors for cerebrovascular diseases include hypertension, hyperlipidaemia (elevated cholesterol and triglycerides in the blood), smoking, diabetes and a sedentary lifestyle. In the case of schizophrenia, risk factors include genetic predisposition, viral factors (prenatal infectious diseases), perinatal factors (anoxia, low birth weight), toxic factors (cannabis and other drug use) and demographic factors (living in large cities). Regarding loneliness, risk factors are those variables that induce or facilitate a person's experience of loneliness.

Classically, they are grouped into psychological, health, sociocultural and environmental risk factors:

Table 1. **Types of risk factors**

HEALTH	PSYCHOLOGICAL	SOCIOCULTURAL AND ENVIRONMENTAL
· Frailty · Common chronic diseases: heart conditions, strokes, cancer, etc. · Difficulties in activities of daily living (ADL) · Perceived health	· Psychiatric disorders: depression, anxiety, etc. · Cognitive impairments · Being a carer	· Social relationships (especially with family, friends and carers) · Losses of significant people · Losses due to life transitions (retirement, divorce, losing access to a car or home...) · Gender or ethnic diversity · Financial resources · Living alone

Source: Compiled by the authors.

1.2.2. Modulating and mediating variables

The conceptualisation of mediating and modulating variables has been widely used in psychology, for example, in stress models applied to caregiving (Losada et al., 2006).

Essentially, the *modulating variables* (see chapter 2, sections 1.4-1.6, pp. 56-59, where the programme's intervention model is thoroughly analysed), in our context, are those that can influence and regulate feelings of loneliness (for example, social support) by reducing them. Meanwhile, *mediating variables* are those which, although they do not directly impact loneliness, help improve situations of loneliness (for example, a healthy lifestyle), either by enabling intervention on modulating variables or by creating the conditions necessary for addressing loneliness and its associated variables.

The tool analyses the following modulating and mediating variables:

Table 2. **Analysed modulating and mediating variables**

MODULATING VARIABLES	MEDIATING VARIABLES
· Social network (who is part of the network, the quality of relationships and the level of perceived support) · Social support (whether instrumental, emotional or informal support is offered and received) · Predominant coping styles (passive or active, emotional or cognitive, problem-focused or emotion-focused, alone or with others, etc.) · Emotional regulation styles (self-awareness, self-regulation, self-motivation, empathy, social skills, impulse control, etc.) · Perception of meaning or purpose in life (sense of being significant to others, a life with purpose, life with meaningful relationships, etc.)	· Lifestyle (diet, hygiene, mobility, sleep hygiene, personal appearance, etc.) · Level of involvement, commitment and participation in the community (volunteering, interest groups, religion, etc., and, on a more informal level, walks with friends, phone contacts, etc.) · Personal values

Source: Compiled by the authors.

1.3. HOW IS THE TOOL USED?

The tool "requires" the professional to provide a detailed description (which is one of its objectives) of the person's condition in each of the variables, based on the knowledge gathered during previous sessions, where the life story and evaluation are conducted (see chapter 3, section 2, p. 174).

This description includes assigning a colour to each variable, depending on whether it is having a positive or negative impact on the person's situation, thereby offering a visual representation.

The assignment of colours is as follows:

- » **Red:** when the analysed variable has a negative impact.
- » **Green:** when the considered variable has a positive impact.
- » **Orange:** when the examined variable is being worked on (in the process of improvement).
- » **Grey:** when the variable neither positively nor negatively affects the situation.

At the end of the analysis, we will obtain a visual and descriptive summary of the variables influencing a specific situation of loneliness, as well as the strengths and weaknesses that help us design the intervention proposal to be presented to the participant, ensuring the intervention is as personalised as possible.

The tool, as previously mentioned, will be used upon the completion of each evaluation. Based on the initial analysis, subsequent re-evaluations will incorporate any changes observed in each variable, as explained in the flow diagrams (see chapter 3, section 2, p. 174).

Thus, we will assign green when there are improvements (a specific variable changes from red to green, for instance), orange when the person is actively working on it (changing from red to orange), and red when the variable continues to have a negative influence and cause distress.

For example, a specific variable is initially assessed as red because the person has a limited social network which, in addition, they find unsatisfactory. A plan is proposed which includes expanding the network. Six months later, during the second evaluation, it is confirmed that the network has grown, as the person has established a stable group of individuals with whom they share a hobby once or twice a week, and from whom they receive support. In this case, the "social network" variable would change from red to green. If, at the time of the second evaluation, the person in a similar situation has managed to meet new people but the contact remains sporadic and they do not yet perceive social support, the "social network" variable would change from red to orange, as it is still in progress.

Based on the case analysis, an action plan[15] will be designed and co-created with each individual concerned. This action plan is developed by first selecting two or three

15. For further information on how to develop an action plan, see chapter 3, section 2, p. 174.

variables to focus on (those currently marked in red) and setting improvement goals and actions in collaboration with the person. The selection of variables to be addressed will be based on the following criteria:

» The concerns expressed by the individual.

» Ensuring that the intended change depends on the individual, not on third parties.

» The professional's assessment of potential success, either because there is evident commitment or a clear desire on the part of the individual to work on the plan, or because the professional considers the plan viable.

1.4. EXAMPLE OF CASE ANALYSIS AND PROPOSED OBJECTIVES

1.4.1. The case of María

A 76-year-old woman referred to the programme by the health centre. Her siblings, with whom she had always maintained a close relationship, passed away a few years ago. She has no other family. María never married or had children.

María has a history of significant health issues, both physical and sensory, which she has adapted to over time, but these have resulted in limited functional mobility.

She was a nurse, and her work played a significant role in her life. She retired eleven years ago with some sadness, but she adapted and took on the responsibility of caring for her siblings.

She has had a social life with a few meaningful relationships, but lately she finds it difficult to connect with others.

She has gradually let herself go, and her current physical appearance is unkempt.

During a visit to the health centre, the nurse tells her about the programme and provides her with information. María agrees and contacts the Always Supported programme, expressing that she feels very lonely and no longer knows what to do to feel better.

1.4.2. Conducting the analysis

Once the information about María has been gathered through the evaluation and her life story, the case analysis tool will be completed by detailing each category based on the collected data.

The tool is structured as a table: the first column lists the different areas to be analysed; the second column represents the category for each area; the third column provides a detailed description – if known – of María's specific situation; and the fourth column consists of blank cells where the data or description for each category, in this case for María, can be recorded.

The category column is the one that will be colour-coded, as previously explained, in red, orange, green or grey, according to the assessment of each category.

1.4.2.1. Risk factors

We will first analyse the risk factors. Below is a table presenting the factors grouped by area and, within each area, the category to be explored. A brief description of the situation is given for each of these factors.

Table 3. **Case analysis tool: risk factors**

RISK FACTORS Area	Category	Subcategory (if known, it must be recorded)	Brief description of the situation presented for each category (if the person does not present any difficulty, write "No difficulty")
PHYSICAL HEALTH	Fragility: functional capacity, disability	Loss of mobility	Long-standing back problem. Concerns
	Common chronic illnesses: heart conditions, strokes, cancer, etc.		Chronic back pain which significantly hinders her mobility
	Sensory losses	Cataracts in the eyes	She recently underwent cataract surgery
	Difficulties in ADLs		Struggles with housework and mobility
	Perceived health		She is doing fewer things because it is becoming difficult for her. She is not completely incapacitated but says she feels tired. She is in a fragile state
	Others		
PSYCHOLOGICAL FACTORS	Psychiatric disorders: depression, anxiety, other pathologies	Depression in earlier stages	Vital tone is low
	Cognitive impairment		
	Carer		
	Others		
SOCIAL, CULTURAL, ENVIRONMENTAL FACTORS	Social and support relationships (objective data and impact on life)	Family	No family
		Friends	2 or 3 (makes an effort to maintain occasional contact)
		Social environment	Greets people in the neighbourhood
		Neighbourhood environment	Some relationship with a neighbour
		Others	
	Loss or bereavement (people)	Losses	Her entire family, parents and siblings, have passed away
	Losses or transitions	Retirement	It marked a period of losing daily relationships and a sense of purpose. She dedicated herself to her family, which gave her meaning
		Housing, car, etc.	
		Others	
	Others	Gender diversity	
		Cultural diversity	
		Housing	
		Financial resources	
		She lives alone	
		Age	
		Others	

Source: Compiled by the authors.

From the analysis of Maria's risk factors we can highlight the following:

» Physical health:
  – She is in a delicate health condition that limits her mobility, and she suffers from chronic back pain.
  – Recently underwent cataract surgery. It took her a long time to decide to go ahead with the operation, which affected her ability to read, a meaningful activity for her, and made her feel insecure when going out, leading to a reduction in outings. When she joined the programme, it had been a week since the surgery. Her vision has improved, but she does not feel confident enough to go out alone. She does go out, but with difficulty.
  – She perceives her health as fragile. Objectively, she is not physically incapable of doing anything, but she reports feeling tired and believes that her health is not helping her.

» Psychological factors:
  – She has a history of depression throughout her life.
  – The tone during the interview was one of "low vital energy".

» Social, cultural and environmental factors:
  – Loss of significant people has increased her emotional loneliness, as she has lost her brothers, who were her primary support.
  – She maintains social relationships: she mentions three people with whom she keeps sporadic contact, though with effort.
  – Neighbourhood relationships are positive; she greets people and has brief conversations when running errands or shopping. She has never considered her neighbours as friends or potential sources of support.
  – The transition she refers to is her retirement. It was a difficult time because her job made her feel good and useful, and she felt lost for a while until she had to care for her brothers. She says she hasn't felt well since retiring.
  – The remaining factors are not currently affecting her; she does not mention any of them as significant.

In summary, we must consider physical health and psychological factors as the most relevant areas, since these are where she experiences the greatest difficulties.

1.4.2.2. Mediating variables: lifestyle

We will now proceed to analyse María's status regarding the mediating variables and review her lifestyle.

Table 4. **Case analysis tool: mediating variables**

MEDIATING VARIABLES

	Category	Description	Objective (if it will not be addressed, note "Assess in the next plan")
LIFESTYLES **Objective:** Improve the lifestyle that is at risk	Diet and hygiene		
	Mobility (exercise)	Great difficulty	Include it in the plan. Improve her self-perception
	Routine and daily life		
	Adherence to treatments	Intermittent	Include it in the plan. Medication
	Sleep hygiene		
	Personal grooming	She is starting to neglect herself	Include it in the plan
	Others		

Source: Compiled by the authors.

Specifically, for María, we outline the following details:

» Diet and hygiene, daily routine and sleep hygiene are maintained. She has a daily routine that helps her stay organised. She mentions that maintaining a balanced diet and getting enough sleep helps her to avoid "completely losing herself". She says that she makes an effort not to neglect her daily life, which keeps her connected. However, she admits that every day is an effort.

» Her main difficulty relates to mobility. Her limitations are not disabling. She can go out, and when something interests her she makes the effort to do it. Nevertheless, her narrative focuses on "uselessness" and "I can't do anything anymore".

» She is beginning to neglect her personal appearance. She mentions struggling to go to the hairdresser, adding that it has been months since she last did anything with her hair. She arrives at the appointment with her hair tied back in a way that looks untidy.

In the case of lifestyle, it should be noted that several variables are preserved, indicating that she takes care of them – she maintains a healthy diet, a routine and good hygiene – making this a variable that can act as a lever. The factor to focus on for potential transformation is mobility, which she has gradually abandoned.

1.4.2.3. Modulating variables

Next we will analyse the modulating variables, that is, those variables that influence the situation of loneliness in which Maria finds herself.

1.4.2.3.1. Social network

First, we will explore the state of her social network,[16] the people she can rely on and the type of social network she maintains or lacks.

Table 5. **Case analysis tool: modulating variables**

MODULATING VARIABLES

	Formal activities	Size and frequency	Objective (if it will not be addressed, note "Assess in the next plan")
SOCIAL NETWORK **Objective:** Improve the size and quality of the network	Family	She has no family	
	Friends	Two friends and a carer	Expand the network with people in the programme
	Neighbours	Greets people, but does not give them importance	Establish a neighbourly relationship
	Professional		
	People in the neighbourhood		
	Others		

Source: Compiled by the authors.

Below are the key details regarding María's social network:

» She has no family relationships as her relatives have passed away, and she has no descendants.

» Her three friends are:

– A former colleague she meets every month or month and a half. They have coffee and chat for a while. She enjoys these meetings but worries that if she asks to do more activities, her friend might grow tired of her.

– Someone she met after retiring, who signed up for a sewing course. Although she did not enjoy the course, she says that at least she "gained" this friendship. They see each other around the neighbourhood and occasionally go for walks, although María tends to cancel when she is not feeling well.

– A lifelong acquaintance who was a friend of her brother. They occasionally call each other.

16. Although in the presentation of the intervention model (see chapter 2, section 1.7, p. 60) the variables related to relationships were analysed separately from the mediating and modulating variables, in this case, for the sake of simplicity, the variables associated with relationships are included within the modulating variables.

» There is a person who helps her to clean the house and to do the more complicated errands. She mentions having a good relationship with this person, but when she talks about her she does not consider her to be important.

» Neighbours and the local community are not a relevant aspect of her life; she only says hello and has brief conversations.

In summary, María has a limited social network. If any of these individuals were unavailable due to death or other difficulties, she would be at high risk of being left without anyone. The remaining categories are not significant for María.

1.4.2.3.2. Social support

Secondly, we will describe the quality of her relationships, that is, whether she feels she has people around her who care about her and provide support, and whether she, in turn, cares about others.

Table 6. **Case analysis tool: modulating variables**

MODULATING VARIABLES	Type	Description and extent What is the perception of this support? Gierveld test	Objective (if it will not be addressed, note "Assess in the next plan")
SOCIAL SUPPORT **Objective:** Increase the support given and received. Does the person have people who care about her? Does she receive invitations?	**I GIVE, I OFFER**		
	Instrumental support	She does not offer support to anyone	Include it in the plan
	Emotional support	She does not feel capable	
	Informational support	She says she has nothing to offer	Include it in the plan
	I RECEIVE, I KNOW WHERE TO ASK		
	Informational support		
	Instrumental support	Home help service	
	Emotional support / they care about me	She has a friend who cares about her	

Source: Compiled by the authors.

Each variable considered in the social support category is detailed below:

» Social relationships are primarily one-directional. María does not offer herself to her social circle or "care" about it. She has a self-perception of not being important or useful enough to offer anything.

» She mentions that one of her friends, the one who was a friend of her brother, does "think" about her and cares about her. She notes that she knows this friend is there for her, "but it's a pity they don't see each other more often".

» She expresses a lack of significant connections.

It can be highlighted that María's social support is highly deficient. She does not perceive her relationships as connections she can rely on for support.

1.4.2.3.3. Involvement and commitment

Thirdly, an analysis is conducted to determine whether she dedicates time to activities or actions that generate a sense of well-being, in which she feels involved and committed.

Table 7. **Case analysis tool: modulating variables**

MODULATING VARIABLES			
	Formal activities	**Size and frequency**	**Objective** (if it will not be addressed, note "Assess in the next plan")
INVOLVEMENT AND COMMITMENT **Objective:** Maximize engagement and participation	Religious		
	Volunteering		
	Others		
	Non-formal activities		
	Reading	Daily	
	Telephone contact		
	Walking, having a coffee, chatting, etc.	Has reduced	Seek and improve. Expand meaningful activities
	Others	Tablet	

Source: Compiled by the authors.

The activities worth highlighting for María are as follows:

» She does not participate in activities related to religion, volunteering or similar engagements.

» She has resumed reading now that her vision has improved, and uses her tablet to search for information of interest, news, etc.

» She has significantly reduced her walks, which she used to do more often and found enjoyable.

In summary, María does not engage in meaningful activities that require commitment to others or involve leaving her home. The one activity she has maintained since regaining her vision is reading. Overall, this is a weak area with significant potential for improvement.

1.4.2.3.4. Personal resources

The fourth modulating variable we will analyse consists of María's coping styles, meaning the "personal resources" that can be adaptive and help her improve her loneliness, as well as those that are maladaptive.

Table 8. **Case analysis tool: modulating variables**

MODULATING VARIABLES

	Type	Description	Objective (if it will not be addressed, note "Assess in the next plan")
PERSONAL RESOURCES: COPING STYLES **Objective:** Become aware of resources and develop those that are healthier for the person	Passive or active	**Passive:** She is neglecting herself as her mood declines	Transform **passive** into **active:** greater personal involvement to counter resignation
	Emotional or cognitive	**Cognitive:** She rationalises her situation and resigns herself to feeling unwell, communicating from that state	Transform **resignation** into **acceptance**
	Problem or feeling	**Problem:** She tends not to seek solutions and becomes stuck	
	Alone or with others	**Alone:** She usually feels comfortable being alone, although weekends feel very long to her	

Source: Compiled by the authors.

María's predominant coping styles, which are negatively affecting her, are as follows:

» Passive coping: she tends towards withdrawal and resignation, rationalising her situation as "this is what life has given me".

» Cognitive coping: she makes a negative assessment of her situation and resigns herself to it, as though it cannot be changed.

» Problem-focused coping: she fixates on the problem and does not seek support or advice from others.

Nevertheless, María benefits from the fact that she knows how to enjoy being alone and feels good engaging in solitary activities, although she has recently felt less inclined to do so and has been reducing these activities.

In summary, most of the personal resources she employs are not beneficial, as they prevent her from addressing her situation in a healthy way to enable change.

1.4.2.3.5. Meaning and life plan

The fifth variable relates to those resources María has to feel that she can continue developing, meaning that her daily life still holds significance and that she feels part of something.

Table 9. **Case analysis tool: modulating variables**

MODULATING VARIABLES

	Type	Description	Objective (if it will not be addressed, note "Assess in the next plan")
PERSONAL RESOURCES: MEANING AND PURPOSE AND LIFE PLAN Existential loneliness? / Purpose in life?	Sense of belonging	She feels she does not form part of anything	Include it in the plan by reinforcing it through participation in the programme's meetings
	Sense of transcendence or spirituality		
	Sense of contributing to others	She is a generous and attentive woman who feels the need to care for others	
	Sense of personal growth	This is a strength	
	External recognition		
	Pleasure		

Source: Compiled by the authors.

In María, we can highlight the following:

» Sense of belonging: she does not feel part of anything and struggles to position herself in relation to what gives her meaning or where she feels a sense of belonging.

» Sense of contributing to others: she knows she is important and valuable, but she does not believe in herself. She lives in this paradox.

» Sense of transcendence or spirituality: there is no significant aspect regarding her contribution to others or society. She does not feel useful. She is experiencing internal incoherence, as her current situation does not align with her values of caring for and supporting her family, which have been so important to her.

» Sense of personal growth: this is a strength she has demonstrated throughout her life. She continues to make an effort to improve, but she feels very lonely, making it difficult for her.

» External recognition: throughout her life she has appreciated external recognition, which she has needed to feel good about herself.

In summary, María feels she does not belong anywhere or to anything, and this sense of detachment makes it difficult for her to value the aspects that could benefit her, such as her commitment to helping others.

1.4.2.3.6. Emotional regulation

The sixth variable relates to María's ability to manage her emotions.

Table 10. **Case analysis tool: modulating variables**

MODULATING VARIABLES

PERSONAL RESOURCES: EMOTIONAL REGULATION

Objective: Become aware of the role of emotions and manage them for the benefit of well-being

Type	Description	Objective (if it will not be addressed, note "Assess in the next plan")
Self-awareness: being aware of what one feels and how it affects them	She feels resigned to feeling unwell and is not aware of the "pit" she puts herself in	
Self-regulation: having the ability to manage one's own emotions		
Self-motivation: focusing on goals rather than obstacles	She is focused on her physical and emotional difficulties	
Empathy: being aware of what others feel	She is empathic, she connects with other people's emotions	
Social skills: having the ability to communicate and establish friendly relationships	She has social skills, but at the moment she feels that she "doesn't know how any more"	Put them into practice again
Stress tolerance: adequately facing stressful situations	She gets nervous in situations she does not control, so she avoids being in groups	Include it in the plan by reinforcing it through participation in the programme's meetings
Impulse control: mastering impulsive behaviours		
Reliable assessment: validating one's own thoughts and feelings	She does not associate her personal circumstances with her emotional state of apathy; she attributes everything to "it's just how things are"	

Source: Compiled by the authors.

As can be seen in the table above, Maria has both **strengths and difficulties**.

» Factors that constitute **difficulties** and negatively influence her sense of loneliness:

- Self-awareness: by resigning herself, María is not aware of her situation or how it makes her feel unwell.
- Self-motivation: she focuses on difficulties, which leads to demotivation when faced with any proposal.
- Reliable evaluation: she is aware that she is not doing well and recognises that she sabotages herself.
- Stress tolerance: she knows she gets nervous in group situations and feels uncomfortable.

» Factors that are **helping** her:
  – Self-regulation: although she puts herself "in the pit", as she describes it, she makes an effort to regulate her emotions and prevent herself from being overwhelmed.
  – Empathy: she connects with other people's emotions.
  – Social skills: she has social skills, but due to low self-esteem she has stopped believing in herself and her potential.
  – Impulse control: she does not lose control.

In summary, in terms of emotional regulation, María struggles with self-regulation by remaining immersed in her negative emotions, as though it were impossible to escape them. Her social skills and empathy could help her transform this aspect once she recognises and acknowledges that she possesses these personal resources.

1.4.3. Proposal of objectives and action plan

After completing the analysis and gathering information from the life story, the following proposal is designed to be shared and worked on with the participant.

OBJECTIVE 1. Develop greater awareness and self-perception of her potential despite limitations

Regarding the variables in the area of lifestyle, we have concluded that her difficulty with mobility is negatively affecting her and has led her to self-impose limitations. She is doing less than she could, as her actions are guided by her perceived limitations.

This objective is proposed as the first to work on, since she frequently mentions this issue and it represents a significant area of concern.

Starting hypothesis: taking control of her situation by changing limiting beliefs will help her feel more capable.

To guide the objective, it is essential to consider the **variables influencing her situation**. We will propose actions based on these variables, which in this case are: perception of her mobility, passive and problem-focused coping style and sense of personal growth.

Proposed actions: during the session, the concepts of cognitive limitation, personal strength, etc., will be addressed, and the proposed actions will be clarified.

» Address cognitive and emotional limitations.

» Recognise her own potential contributions. She will be asked to keep a diary to acknowledge her personal strengths. Using a notebook provided by the team, she will write down skills or actions that bring her or others a sense of well-being, or things she does that make her feel proud. The frequency will be scheduled in the calendar (for example, twice a week).

» Plan future care:
  – Create a list of personal needs as part of a future care plan.
  – Get in touch with social and healthcare services.

OBJECTIVE 2. Strengthen the social network

Regarding the variables associated with relationships (social network and social support), we have identified that her network is limited and could be improved by her being more proactive in maintaining and nurturing it. The same applies to the neighbourhood network, which she does not fully value as a potential source of relationships: she could become more aware of the importance of daily interactions. This approach is proposed to María to address these aspects.

Starting hypothesis: becoming aware of the relationships she has as something valuable in her life will improve her self-perception and the feeling of "having someone who cares about me".

Variables that are influencing and to be worked on to achieve this objective: developing the social network, enhancing social skills, improving social support and increasing the sense of belonging.

Proposed actions:

» Maintain contact with her friends two or three times a week via WhatsApp.

» Engage with others by offering support or sharing positive moments, not solely from a place of victimhood or complaint.

» Work on improving social skills.

OBJECTIVE 3. Expand the social network

Regarding the social network and social support variables, it has been identified that her social network is limited. She expresses a desire to meet more people.

Starting hypothesis: expanding her social network will provide more opportunities to feel part of a community and valued by others.

Variables that are influencing this objective and intended to be addressed: expanding the social network, improving social skills, increasing social support and enhancing the sense of belonging.

Proposed actions:

» Attend the group intervention "Living as I want" (Díaz-Vega et al., 2015).

» Initiate contact with people she meets in these groups.

» Work on developing her social skills.

1.4.4. Work with the person

1.4.4.1. Co-creation of the action plan

Once the "preliminary" design has been completed, the results feedback session is conducted (see chapter 3, section 2, p. 174), during which the action plan is co-created with the individual and the final version is presented.

This is the stage for co-designing and finalising the action plan by outlining the steps required to achieve the proposed objectives.

1.4.4.2. Engagement with the action plan

This plan will be reviewed and adjusted during the proposed monthly follow-up sessions.

The analysis tool includes a template for the action plan and timeline, which will be shared with the individual.

For example, regarding objective 1, a discussion and reflection will be held with the individual to confirm whether she believes she can work on that objective. It will then be written using accessible language and in the first person, transcribed onto the proposed template, and a copy will be provided to the person (see Appendices 15 and 16, p. 317 and p. 318).

Table 11. **Action plan: objectives**

OBJECTIVE 1. Become more aware of my possibilities despite my limitations

MR/MS: MARÍA
DATE: 15 JULY
SIGNED

WHAT AM I GOING TO DO?	1. I will be aware of unhelpful thoughts and stop and change them: from "I'm useless because I can't walk" to "I have difficulties, but with help, I can manage".	2. I will make a list of my strengths and the qualities others appreciate in me.	3. I will plan my future care.
WHEN?	1. Every day before going to bed I will review how the day has gone.	2. Before going out I will review my strengths.	3. I will go and talk to social services.
WHY?	1. Destructive thoughts don't help me.	2. I have to remember that I have something to offer people and that I can make friends.	3. Taking care of myself is important for my peace of mind.
HAVE I ACHIEVED MY OBJECTIVES?			
HOW DID I FEEL?			

Source: Compiled by the authors.

The agreed steps will be entered into the weekly plan, a copy of which will also be provided to the person to help them see how these steps will be translated into actions in order to work towards change.

This procedure will be repeated for each objective.

Table 12. **Action plan: weekly planning**

	Morning	Afternoon	Night
MONDAY			Review thoughts
TUESDAY			Review thoughts
WEDNESDAY		Theatre: review strengths before going out	Review thoughts
THURSDAY	Care planning: social work, neighbourhood associations, etc.		Review thoughts
FRIDAY		Walking around the neighbourhood: review strengths before going out	Review thoughts
SATURDAY			Review thoughts
SUNDAY			Review thoughts

Source: Compiled by the authors.

1.4.5. Follow-up sessions

During the follow-up sessions, progress, difficulties and obstacles will be assessed and actions will be proposed to help achieve the outlined objectives.

1.5. TO SUMMARISE

Personalising the intervention means that it is (co-)designed based on the individual's needs and circumstances. Therefore, it is crucial to analyse all the information gathered about the person before presenting an intervention plan.

The case analysis tool is a methodological proposal aimed at guiding a structured analysis of the situation faced by the individual in the loneliness profile, ensuring that the proposed intervention is tailored and personalised, addressing the variables influencing their feelings of loneliness.

The proposed objectives are justified in the description of the variables, meaning that each objective should be based on the conducted analysis to ensure it addresses a clearly identified need of the individual.

2.
TRAINING OF THE ALWAYS SUPPORTED TEAMS

2.1. INTRODUCTION

As previously explained (see chapter 2, section 2.5.2 (p. 79), team training is essential to ensure the quality and effectiveness of the Always Supported interventions. To achieve this, the professionals are provided with resources, including both specific programme materials and specialised bibliographic references, which are crucial for understanding the conceptual and methodological elements underpinning the intervention, as well as for the effective use of intervention and systematisation tools.

This training is supplemented, when necessary – especially in cases where new members join already established teams – with additional in-person or online sessions that allow for the resolution of specific questions and provide more personalised support, ensuring a smooth and effective integration of all professionals into the programme.

However, this initial training is only part of a continuous learning itinerary and is integrated into a training plan designed by the Scientific Management team to systematically and strategically address:

» continuous improvement of the intervention;

» innovation, that is, the inclusion of new scientific developments in the programme.

This training plan, which is reviewed and adjusted annually, includes regular knowledge updates, the development of new skills and adaptation to both methodological and conceptual innovations, particularly those related to the intervention and support of individuals experiencing loneliness, which is the core objective of the programme. This ensures that all professionals acquire the personal and professional tools needed to excel in their daily practice.

Below is a detailed description of the profile required for Always Supported professionals, and the implementation of the training plan is developed through an approach that combines continuous training, support, monitoring, resources and tools, as well as methods and techniques to ensure comprehensive and high-quality learning.

2.2. PROFESSIONAL PROFILE OF THE ALWAYS SUPPORTED TEAMS

The professional profiles selected for the programme are closely linked to disciplines such as psychology, social work and other related fields in the social sciences. These areas provide a solid theoretical and practical foundation for understanding and addressing the complex subjective and social dynamics faced by individuals experiencing loneliness.

Professionals trained in these disciplines provide key skills, such as the ability to assess and diagnose, or design support and accompaniment strategies. In addition, their academic background and practical experience enable them to work in an interdisciplinary way, collaborating with other professionals to develop a personalised intervention tailored to the specific needs of the participants.

On the other hand, professionals are required to possess certain personal competencies and skills from the outset, although the training plan is designed to support their continuous improvement. It provides opportunities for personal development and professional refinement, ensuring that each team member can meet the programme's demands and effectively adapt to new situations.

Table 1. **Competencies and skills of professionals in an Always Supported team**

Competencies	Personal skills
· Individual intervention: ability to analyse needs, intervention plans, provide personalised support and engage participants in the programme. · Evaluation skills. · Group facilitation. · Interpersonal communication. · Identification of personal, group and community needs and demands. · Communication and relational skills. · Active listening (communicating in the way the other person needs). · Experience and knowledge in the field of older adults. · Non-ageist perspective of older adults. · Knowledge of the field of volunteering.	· Communication skills. · Results and goal orientation. · Unconditional acceptance (non-judgemental attitude). · Empathy. · Listening. · Resilience and perseverance. · Assertiveness. · Ability to set limits. · Proactivity. · Adaptability. · Ability to motivate. · Teamwork skills. · Ability to build relationships and coordinate with multiple stakeholders and to drive joint initiatives.

Source: Compiled by the authors.

2.3. TRAINING PLAN FOR ALWAYS SUPPORTED TEAMS

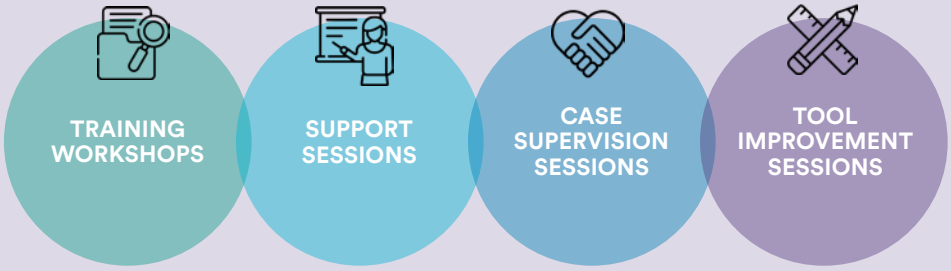
Each year, the Scientific Management team designs and implements a continuous training plan tailored to the needs of various interventions, ensuring that every professional acquires and enhances the necessary skills and competencies to deliver high-quality support.

As teams gain professional experience – building their expertise and improving their responsiveness – and as the programme's needs evolve, the training plan must be continually updated and adapted. To achieve this, new approaches and diverse content are introduced, delivered by members of the Scientific Management team, professionals from the programme itself and external specialists in the relevant fields.

The training plan includes both in-person and online sessions tailored to the specific content being covered. These sessions may be delivered to all professionals or segmented into specific groups depending on the topics addressed, ensuring a more specialised and personalised approach.

The following outline details the components of the training plan designed for the professionals of the Always Supported programme, with its objectives, content and techniques developed in the subsequent sections.

Figure 1. **Outline of the components of the training plan for Always Supported teams**



Source: Compiled by the authors.

2.3.1. Training workshops

These are essential in-person training and networking workshops aimed at fostering continuous personal and professional development, strengthening teamwork and aligning with the programme's objectives.

They are held quarterly, last approximately a day and a half and involve all team members.

The Scientific Management team designs the content and methodologies, leads and coordinates the sessions and incorporates other professionals with expertise in the specific topics selected for each workshop.

In general, these training workshops focus primarily on the following objectives:

» Understanding the **conceptual and methodological elements** underpinning the programme's intervention model, addressing technical innovations in loneliness and other related fields, introducing new tools or improvements to existing ones and sharing experiences from different areas to jointly analyse opportunities and challenges encountered.

» Providing teams with a **broader and more strategic perspective** of Always Supported and fostering engagement with the programme by sharing annual objectives, evaluations and reviews, as well as specific aspects related to communication and outreach campaigns.

» Incorporating **experiential dynamics so that professionals can practise skills and competencies** by personally experiencing the methodological approaches and gaining practical knowledge.

» Developing **spaces for reflection, exploration and case analysis** that allow professionals to share their concerns and receive constructive feedback to improve their emotional management skills and the quality of their interventions.

» Promoting **group cohesion** through recreational activities and informal networking opportunities.

During the sessions held in the first quarter of the year, **designated key persons from partner organisations participate** (see chapter 2, section 2.4.1, p. 73), with a specific session dedicated to sharing objectives and improvement proposals, as well as understanding the needs and requirements of their respective teams. This approach is essential to ensure that the partner organisations align with the annual objectives and actively contribute to achieving them, thereby guaranteeing cohesion and commitment at all levels of the organisation.

2.3.1.1. Core and cross-cutting content

Thanks to the close support and monitoring provided by Scientific Management, as well as the incorporation of suggestions and feedback from the teams, the content of the training workshops is updated annually with new knowledge, skills and tools. This approach ensures that the training addresses the actual needs of the professionals and incorporates the necessary improvements and innovations for the programme, always with a focus on enhancing the intervention.

Below is an example of the core content covered in the general in-person training workshops held to date:

» **Person-centred support.** This is one of the first topics included in the training plan as it forms a central pillar of the intervention. It covers the definition of this approach, highlighting the importance of a personalised support and life plan that addresses individual needs, abilities and desires. Emphasis is placed on creating a meaningful daily life and a relational approach that values human connections and emotional support. Additionally, the concept of a *designated professional* is introduced, responsible for coordinating and ensuring consistent and personalised care to strengthen the relationship between the professional and the person being supported.

» **Always Supported intervention model.** Although these contents are broad and adapted to the programme's stages and the teams' progress, various aspects are gradually addressed at different stages, such as the analysis of risk factors, modulating and mediating variables and the importance of social connections and personal resources. Additionally, reflection is encouraged on how the intervention should be conducted, new intervention and support techniques and the elements that should be highlighted in case analysis and intervention planning. This is achieved through a combination of expository methodologies, discussions, group work and various techniques.

» **Ethics, later life and ageing.** Several key aspects are addressed when applying the Always Supported intervention model, ranging from ethical principles to issues concerning the importance of a meaningful life and the desire for a fulfilled life, with a focus on respectful treatment in later life. The importance of social relationships is also emphasised, particularly the value of quality social interactions and, crucially, social and community support. For the Always Supported programme, ethics – principles such as dignity, justice, autonomy and prudence – are essential. Therefore, tools and reflections are provided to enable professionals to tackle the ethical dilemmas they encounter in their daily practice.

» **Ageism.** The content on ageism, which is covered in dedicated sessions and integrated across the entire intervention with individuals, as well as in community work and awareness-raising efforts, addresses the negative construction of later life through stereotypes, prejudice and discrimination. It examines how stereotypes influence perceptions of older people and how prejudice can affect feelings, emotions and attitudes towards them. The aim is to analyse and highlight, using concrete examples and real-life situations, how the combination of erroneous thoughts and feelings leads to discrimination, resulting in unjust and exclusionary actions. Furthermore, the negative societal portrayal of later life is explored, showing how it harms the image of older adults, perpetuates marginalisation and limits their opportunities and abilities to achieve a full and dignified life.

» **Awareness-raising.** Since raising awareness and promoting understanding about the importance of social connections and interdependence is one of the three key areas of the Always Supported programme, this topic is covered extensively during in-person training workshops. General and local communication and outreach campaigns are planned, effective techniques and strategies for detection and presenting the programme to various local stakeholders are analysed, and the use of social media and other communication channels to broaden the programme's reach is explored. These sessions also include practical workshops on how to craft messages, engage the community and measure the effectiveness of information and awareness-raising campaigns to ensure coherent and effective dissemination of the programme.

» **Community orientation.** In line with the objectives of the intervention and awareness-raising areas, this aspect is explored through concrete experiences shared by the professionals of Always Supported, enabling debate, shared learning and improved practices. For instance, following a preliminary presentation on the programme's

baseline and subsequent group work, the strengths and challenges of the Social Action Group (SAG) and its management are explored in depth, along with an analysis of relationships with professional stakeholders or other agents involved in social support and community networks, as these are essential for detection and cross-sector collaboration. Additionally, specific sessions are dedicated to the planning and evaluation of Summer Programmes before the holiday season, offering tools and strategies to ensure their success. As with other core contents of the training plan, those related to community orientation are adapted according to the programme's stages and strategies, and the teams' identified needs.

» **Programme evaluation.** The sessions dedicated to evaluating the programme cover both general and operational aspects. The content and indicators of the questionnaires developed by the Scientific Management team are shared, including the target groups (participants, professionals, entities, local stakeholders, etc.), the results obtained and their interpretation. Operational aspects are also addressed, such as the evaluation timeline and engaging with participants to complete the questionnaires. These activities require the active collaboration of professionals, as jointly sharing and analysing the results, identifying key learnings and developing improvement proposals ensure a comprehensive evaluation and promote the professionals' involvement in enhancing the programme.

» **Programme tools.** Part of the general training workshops is dedicated to understanding and optimising the use of the programme's intervention and systematisation tools, which are essential both for the introduction of new tools and the updating of existing ones, as well as for ensuring that teams recognise their importance and use them effectively. These include, for example, the application of the General Data Protection Regulation (GDPR), the case analysis tool, entering data into the dashboard, uploading documents generated during individual interventions onto the online platform, the systematisation and validation of group interventions, the analysis of the tool that records information about individuals identified as having a profile of loneliness and the agent who identified them, the programme's discharge criteria, etc. Achieving the objectives of these sessions also requires the active participation of professionals in jointly analysing the needs and the improvements implemented in order to achieve mutual learning and foster greater involvement in continuous improvement of the programme to enhance its effectiveness and impact.

2.3.1.2. Specific content

To incorporate methodological and conceptual innovations in the field of loneliness among older adults, as well as the suggestions provided by the teams, each training workshop includes a topic presented by a specialist professional, thereby broadening the programme's approaches and perspectives, as well as those of the Always Supported professionals.

These topics and specific contents, which are continually expanded as new aspects or demands arise, include those covered over the past three years:

» **The life story.** The objective is to provide an overview of the theories that guide the life story or narrative as an essential tool for building connection and establishing a secure relationship, offering person-centred support. Through the life story, the individual is known, recognised, supported and empowered. Creating the life story allows the person's perspective to expand beyond their current situation while enabling them to gain self-awareness and redefine their identity.

» **Support and management of loss.** The aim is for professionals to understand the fundamental concepts of grief, including its processes, manifestations and stages. This knowledge helps them provide better support in raising awareness and managing the loss experienced by grieving individuals.

» **The role of loss, transitions and meaningful life projects.** This content aims to offer a broad understanding of the role of losses and transitions throughout the life cycle, and how adapting or failing to adapt to these losses can have consequences on individuals' mental and physical health, including loneliness.

» **Acceptance and commitment therapy (ACT).** To enhance loneliness intervention through the principles of this approach, the focus is on coping with changes and transitions in old age to enable effective understanding and modification of these processes. Conceptual aspects such as psychological health and the importance of personal values in well-being are explored, covering both hedonic subjective well-being and eudaimonic psychological well-being. Additionally, tools and strategies are provided to promote value-based behavioural activation, supporting the development of the action plan and the ongoing follow-up conducted by the teams from this perspective.

» **Protective factors in the comprehensive approach to loneliness.** To identify and strengthen the elements that help prevent and alleviate loneliness in older adults, this section addresses protective factors such as enhancing personal resources, fostering positive social relationships and encouraging participation in meaningful activities. Practical strategies and tools are provided to enable professionals to promote these protective factors in their daily work, ensuring a holistic approach to addressing loneliness.

» **Loneliness and connection: ethical keys to meaningful support.** This topic highlights the importance of establishing respectful relationships with older adults and the need for fundamental ethical principles such as dignity, empathy and respect, to guide support. It explores strategies for building strong, trusting bonds that not only

alleviate loneliness but also promote emotional well-being and social connection, while valuing and enhancing the individuality and specific needs of each older adult.

» **The meaning of life: from the brain to symbolic constructions.** The objective is to explain how the meaning of life is constructed, from cerebral processes to the symbolic constructions that give it significance. It explores how neurological and cognitive functions contribute to the perception and understanding of the meaning of life and how these perceptions are transformed into symbols, narratives and cultural values. Additionally, it addresses the various ways in which older adults can find and sustain a sense of purpose and meaning in their lives through social connections, meaningful activities and reflection on their own experiences and values.

» **Ageing from a gender perspective.** The aim is to analyse how gender influences the experience of ageing by highlighting the differences between older men and women in terms of needs, challenges and resources. It examines gender roles and social expectations, as well as their impact on health, well-being and quality of life in later life.

» **Loneliness and suicide.** This topic aims to provide information on suicidal behaviour and basic practical resources to help professionals detect it by paying attention to warning signs in speech and behaviour, as well as physical and emotional indicators. It seeks to foster an understanding of the complexity of suicide, which is linked to risk factors and multiple interrelated biopsychosocial causes encompassing individual, interpersonal, community and social domains. Additionally, clear guidelines are provided on what to do and what not to do when these signs or behaviours are detected or suspected, to ensure appropriate and timely intervention.

» **Intimacy, sexuality and ageing.** To address the importance of intimacy and sexuality in the lives of older adults, and to overcome negative myths and stereotypes, this section explores the needs and desires related to sexuality in later life, as well as factors that may influence intimate and sexual satisfaction, such as physical and mental health, relationships and the social environment. Additionally, strategies are provided to help professionals offer appropriate and respectful support in these areas.

» **Empowerment and leadership.** Aimed at strengthening professionals' capacities to take on leadership roles, this section focuses on developing skills such as communication, motivation and the ability to collectively manage projects and initiatives.

» **Current policies in the field of loneliness.** This section provides a critical framework for analysing existing policies on loneliness, helping professionals understand the various strategies, objectives and methods in place. It emphasises key aspects that characterise the Always Supported intervention, such as community orientation, person-centred support and the perspective on new ageing and later life.

2.3.1.3. Dynamics and techniques used

The training workshops incorporate various techniques that facilitate both knowledge acquisition and practical, experiential learning, enabling teams to develop the skills and competencies necessary to enhance their professional roles.

These techniques include role-playing, which simulates real-life situations to improve support strategies; case analysis, allowing professionals to observe and reflect on effective practices; reflection and exploration spaces through Balint groups (Tizón, 2005); and workshops that enhance the ability to facilitate group sessions while encouraging active participation and the exchange of experiences. In addition, group dynamics are used to strengthen teamwork and constructive feedback sessions are provided to foster personal and professional development. Below is a detailed explanation of some of these methodologies and techniques.

» **Role-playing.** This technique, facilitated by a specialist in role-playing and the field of loneliness, is used to develop skills in specific areas such as coping with loss or ethical principles for meaningful support. Team members assume their professional roles in simulated scenarios, with an emphasis on building connections during interventions addressing loneliness. Examples include a first meeting with an older person seeking more information about the programme or a follow-up session where the individual expresses a lack of will to live or a sense that life has lost meaning. This methodology allows professionals to rehearse and practise responses and behaviours in a controlled environment. During role-playing sessions, professionals explore different approaches and receive immediate feedback from the facilitator and their peers, fostering deeper learning and greater confidence in applying these skills in real-life situations.

» **Structured observation using videos of real experiences.** This technique involves the use of real video scenarios to support visual learning and offer concrete examples for improving professional skills. It is applied, for instance, to help team professionals observe the administration of the MoCA test (Montreal Cognitive Assessment), which is part of the programme's evaluation process. Following a theoretical introduction on cognitive impairment, the rationale for the test and its timing, professionals are provided with a test model to follow and score while watching a video of a professional administering the MoCA test to an older adult. This enables participants to observe in a detailed and systematic manner how cognitive assessment is carried out and scored. After the observation, a group discussion takes place to address any questions and share different approaches. The MoCA test (MoCA Test, n.d.) is particularly valuable for the early detection of mild cognitive impairments and is designed to evaluate multiple cognitive domains, including memory, attention, visuospatial abilities, executive functions, language, abstract reasoning, numeracy and orientation. This tool is made available to the teams so that they can use it when they suspect that an individual might be experiencing cognitive decline. Once the test has been administered, professionals should inform the person of the results and, if necessary, advise them to seek specialised healthcare.

» **Sharing lessons learned.** During in-person training workshops, the exchange of experiences and mutual learning among professionals is actively encouraged. Teams

share their successful experiences, facilitating the transfer of practical knowledge through a structured presentation covering key aspects: identified need, strategies, results and challenges encountered. The methodology typically involves an initial presentation, followed by general or group discussions in which participants debate and reflect on the experience and its potential application in their own work contexts. Some of the shared content focuses on, for example, successful strategies for collaboration with healthcare professionals for detection or intervention, the design and evaluation of a Summer Programme, information or outreach campaigns in partnership with key local stakeholders, community events involving service users, volunteers and local network entities, or the strategy for reorganising a Social Action Group. This systematic documentation of strategies, methods and successful experiences becomes a valuable resource that other teams can draw on and adapt to their specific needs and contexts when required.

» **Reflection and exploration through Balint groups (Tizón, 2005).** Balint groups are a training and support methodology for health and care professionals, created by the physician and psychoanalyst Michael Balint. They consist of regular meetings where a small group of professionals discusses cases of individuals (in our case, people experiencing loneliness) from an emotional and relational perspective. In each session, one participant presents a case from their practice, describing not only the aspects of intervention but also their own emotional reactions and the relational dynamics involved. The group, guided by a trained facilitator, then explores these elements and provides observations and reflections that help the person presenting the case gain a deeper understanding of the situation. This methodology, applied to the professionals of Always Supported, creates safe and structured spaces for reflection where they can, for example, identify and consider any personal issues or conflicts that may interfere with their support work, share and analyse their emotional experiences, or deepen their understanding of the relational dynamics present in their daily work. This reflective practice enhances communication skills and facilitates the handling of complex situations by allowing for constructive feedback from colleagues, with the guidance of a specialist in these groups, in an environment of mutual support and continuous learning.

» **Workshops.** The programme for the Elderly of the "la Caixa" Foundation offers a series of workshops aimed at helping older adults develop a life plan that enhances their personal well-being. These workshops cover knowledge, strategies, techniques and psycho-emotional skills that contribute to building a fulfilling life according to each person's values, desires and needs through the following areas:

– **"Live well, feel better".** The goal of this programme is to provide tools for individuals to become active subjects in their own story, maximising their abilities and potential. The itineraries are as follows:

· *"Living as I wish"*. The thematic areas and sessions that make up this itinerary aim to address a set of contents that help participants live the life they desire. The following objectives are intended to be achieved through these sessions:

· Promote group cohesion and identify motivating activities that contribute to personal growth.

- Highlight the importance of exercising control over one's own life and delegating the development of activities or tasks to others when necessary.
- Provide strategies for managing and enjoying time.
- Engage in discussions around decision-making for future life.
- Propose resources for approaching life with a positive mindset.
- Analyse the importance of relationships with others, harmonising personal development with that of close individuals.
- Encourage the setting of new personal development goals by "giving permission" to pursue them.

- *"Living positively"*. The thematic areas and sessions that make up this itinerary aim to address a set of personal resources that help individuals manage various life situations and adapt to changes. The goal is to promote the identification and recognition of learnings derived from life experiences, as well as reflection on resources and strengths associated with personal development and emotional well-being. The following objectives are pursued:
  - Foster group cohesion and identify the adaptive capacities developed throughout life.
  - Propose strategies that promote emotional well-being in daily life, as well as those that contribute to managing emotional distress.
  - Provide strategies for managing conflicts in interpersonal relationships, as well as for dealing with loneliness as an opportunity for personal development.
  - Discuss personal strengths that promote connection with the world and personal growth.
  - Propose strengths to cope with situations associated with loss and, particularly, provide individuals with the tools and instruments to develop in depth the life they wish to live.
  - Analyse the importance of a sense of humour as a strength linked to a broader vital perspective and a positive emotional life.
- *"Living is self-discovery"*. The thematic areas and sessions that make up this itinerary aim to identify and promote personal resources that help people explore their own limits, grow and develop personally. Thus, throughout the itinerary, opportunities are provided to reflect and identify the possibilities provided by everyday life to lead a fulfilling life, paying special attention to the challenges associated with self-imposed limits, social changes that shape new situations and new relational environments. Of great importance in this itinerary are the concepts of vulnerability (in a positive sense), loneliness, self-care and commitment to lead the life you want. The following objectives are pursued:
  - Foster group cohesion and identify the adaptation skills developed throughout life.
  - Redefine vulnerability as an opportunity for personal growth.
  - Proporcionar estrategias para la búsqueda de complicidad y apoyo en el desarrollo personal.
  - Provide strategies for seeking complicity and support in personal development.

- Learn to care for ourselves and others, recognising that caring always involves attitudes that connect us with others.
- Reflect on the changes associated with interpersonal relationships as a consequence of the passage of time, and compare strategies that help adjust to these changes.
- Explore gender differences and readjust to them.
- Discuss the opportunities and risks associated with living alone.
- Analyse the implications that social and family relationships have as a result of the social changes of the last few decades.
- Seek commitment towards a better life.

- *"Living with purpose"*. This activity invites participants to embark on a personal journey in search of a better life. To achieve this, they reflect on important aspects of life and, along the way, seek out personal resources, abilities and skills in order to live life to the full, despite the difficulties and losses that may occur.

– **"Good treatment, a matter of dignity and rights".** The objective of this workshop is to raise awareness and inform about the rights of older adults, empowering them to live this stage of life to the full.

Over several days, the professionals of Always Supported participate in these workshops to experience the methodological proposals in person and gain practical knowledge on how to conduct them. This enables them to effectively carry out this type of group work with the individuals they support, thus improving their ability to facilitate sessions that promote the improvement and well-being of the participants.

2.3.2. Support sessions

These sessions focus on the specific day-to-day needs of professionals, including managing difficult situations, improving the use of tools and analysing practical cases.

These in-person sessions, which are more personalised and operational, are organised into groups of three or four teams, based on territorial proximity or similar needs. As they involve small groups, the sessions create a greater sense of trust and allow the topics discussed in the general workshops to be explored in more detail and applied to the specific contexts of each team. They are held in different geographical areas to make it easier for professionals to attend, with an annual frequency and a duration of one or one and a half days.

The Scientific Management team coordinates and facilitates these sessions using various methodologies that enhance the improvement of competencies and skills through contributions and interaction between professionals. In this way, the methodology is structured into different types of activities:

» **Reflective.** Each professional presents their main personal and professional strengths and challenges. The Scientific Management team facilitates the session by linking these experiences to the conceptual and methodological foundations of the programme, while also synthesising the key and common aspects. Some of the difficulties raised are addressed immediately, while others are recorded to be discussed in the training workshops, as they are of interest to all the teams.

» **Dialectical.** Throughout the session, the professionals actively interact with each other and with the Scientific Management team to create a space for constructive dialogue. During these interactions, the exchange of experiences and knowledge is encouraged, allowing teams to offer their own responses and strategies to address difficulties and enhance the strengths identified. This dialectical process not only enriches collective understanding, but also fosters the co-creation of practical and realistic solutions that can be applied in specific professional contexts.

» **Practical implementation.** Based on the reflections and conclusions reached, the group jointly decides which specific topics or aspects (such as the use of tools, case analysis, detection strategies, person evaluation, etc.) should be addressed more deeply. This phase involves the practical application of the selected topics through simulations, analysis of real cases or the joint development of responses to the difficulties raised.

2.3.3. Case supervision sessions

These are learning and reflection spaces aimed at unifying criteria and improving the quality of the intervention through case supervision to promote learning from experience and enhance the communication skills of professionals.

They are online sessions coordinated and facilitated by the Scientific Management, with the participation of all teams. These meetings are held monthly and last for two hours.

As the programme has evolved and professionals have gained more experience and development in their roles, the dynamics of these sessions have also changed. By way of example, below is an outline of the methodology and work dynamics of a case supervision session, which includes the presentation of a successful case.

2.3.3.1. Structure

First part (approximately 1 h 15 min)

Presentation, analysis and discussion of a challenging case arising from direct intervention with the individual. This is the core supervision session.

Second part (approximately 45 min)

Presentation and discussion of a successful case based on direct intervention with the individual. This section is introduced when the group of professionals has gained more experience and achieved positive results through newly acquired strategies and learning. It fosters greater confidence within the group and in the programme's methodological proposals. The case presented may be one that the professional previously shared during a case supervision session or other situations that did not require such supervision.

2.3.3.2. Characteristics

In the participatory and collaborative space, learning through experience is encouraged.

The acquisition of knowledge, skills and technical resources is an individual experience where the commitment and active involvement of participants are essential.

Cases and their presentations are brought forward by each professional, not by the teams, in line with the role of the designated professional responsible for personalised intervention (person-centred support).

In the supervision area, professionals are encouraged to present cases that pose a challenge or ethical dilemma related to, among other issues, the following:

» The person does not fulfil the agreed commitments.

» Chronic cases.

» Difficulty in discharging the person.

» The professional feels they have "exhausted" their resources.

» Complex situations: abuse, high dependency, bereavement, lack of recognition of the difficulty, etc.

The supervision space is organised around different roles:

» **Presenter.** The professional who presents the case, following the structure proposed by the Scientific Management.

» **Reflective group.** A small group of seven or eight people who discuss the presented case. The group acts as a consulting team, simulating a working session to improve the intervention or the narrative of the case.

» **General group.** All participants contribute by complementing the discussion so far.

The purpose of the successful case presentation space is to share effective practices and strategies that other team members can adapt to their own circumstances.

In the presentation of successful cases, the reflective group is not used.

2.3.3.3. Development

Start of the session

» The member of the Scientific Management team leading the session welcomes the participants.

» Next, they introduce the professionals who will present the cases (for supervision and success).

» They facilitate the formation of the reflective group, ensuring that different participants take part across various sessions.

» They ask the rest of the participants to turn off the camera, maintain active listening and note down any questions or impressions.

First part

» The presenter outlines the supervision case using the following structure:

– Life story, key aspects.

– Analysis focused on risk factors and modulating variables.

– Objectives intended to be achieved.

– Associated action plan.

– Questions or difficulties.

» The reflective group, through rounds of questions led by the session facilitator, first addresses any unclear aspects of the presentation, noting what stood out or what was missing.

» Next, they provide suggestions to strengthen or broaden the intervention approach or offer solutions to the questions raised by the professional during the presentation.

» The remaining participants turn on the camera, and the debate is opened to everyone to complement or enrich the contributions made so far, focusing on key learnings and linking them to the theories, methodologies and tools provided by the programme.

» The Scientific Management team summarises the conclusions, selects the person who will present the case for supervision in the next session and closes the first part.

Second part

The presenter outlines the success case using the following structure:

» Life story, key aspects.

» Notable elements of the risk factors and modulating variables.

» Objectives intended to be achieved.

» Associated action plan, tools used and the person's progress.

» Achievements and results.

The session facilitator opens the debate to gather contributions and ideas that could be applied to other ongoing cases, key learnings and connections with the theories, methodologies and tools provided by the programme, etc.

The Scientific Management team summarises the conclusions and selects the person who will present the case in the next session.

Session closure

The facilitator proceeds with expressions of gratitude, session closure and farewell, while also reminding participants of the date of the next session.

2.3.4. Tool improvement sessions

These sessions are designed to address doubts, difficulties and concerns – ranging from specific issues to broader approaches – that professionals encounter when working with programme participants. The aim is to propose possible explanations (functional analysis) and strategies and techniques for handling specific situations. This is done using the principles of the cognitive-behavioural approach and acceptance and commitment therapy, including motivational interviewing strategies.

The sessions are conducted online, coordinated by the Scientific Management team and facilitated by a specialist in loneliness and the outlined approaches. They are organised into groups of three or four teams, held quarterly and last two hours per session.

Below is an example of how the tool improvement sessions are organised over the course of a year.

2.3.4.1. Topics

After working with the teams and analysing their requests and needs, the Scientific Management team selects the following topics (by way of example) for the tool improvement sessions included in the annual training plan:

» Difficulties related to adapting to changes, transitions and losses associated with behavioural deactivation processes.

» Difficulties in handling conflicts or family and interpersonal issues in various scenarios, particularly challenges in maintaining commitment to personal values when these come into conflict with those of family members.

2.3.4.2. Structure

Each topic is covered over two sessions:

Session 1

» Part 1. Focused on adapting to changes and losses.

» Part 2. Follow-up on the session focused on adapting to changes and losses.

Session 2

» Part 1. Focused on managing conflicts or interpersonal and family difficulties.

» Part 2. Follow-up on the session focused on managing conflicts or interpersonal and family difficulties.

2.3.4.3. Development

Each topic is covered in two sessions. The first session involves case presentation and introduction of working tools, while the second focuses on follow-up of the presented case and evaluation of the applied tools.

Session 1

» One week prior to the session, the team sends the facilitator the case to be addressed.

» During the session, the submitted cases are reviewed one by one as follows:

- The team provides a summary and presents the difficulties.
- The facilitator offers their perspective and suggests tools based on acceptance and commitment therapy that could support the individual.
- The rest of the group provides input on the case or the proposed tools.

» After the session, the facilitator sends a summary of the tools discussed during the session.

Session 2

» The team presents the progress of the case and the use of the tools.

» An opportunity is provided to discuss other situations where the knowledge acquired in the first session has been applied.

2.3.4.4. Tools

Some of the tools addressed during the sessions include: acceptance; behavioural activation; self-awareness and empathy; self-care; self-esteem; confidence; dysthymia, worry or low mood; understanding and regulating emotions; interview techniques and skills for support, including motivational interviewing; social skills and communication; addressing negative worldviews and anchoring in negative thought patterns; problem solving; victim mentality, and other specific topics.

3.
THE ROLE OF VOLUNTEERS AND THEIR TRAINING

3.1. NETWORK OF RELATIONSHIPS AND SOCIAL SUPPORT

As mentioned in previous chapters, a more integrated intervention connected to the life context of the individuals supported by Always Supported is promoted through the mobilisation of various community resources and services, as well as through the improvement or strengthening of the social network and social support of those being assisted.

This network and social support, encompassed within what Fantova (2021) refers to as *primary and secondary relationship networks* – that is, people's relationships with family, friends, neighbourhoods, etc., as reflected in the following table and chart – are fundamental for everyone, especially for those experiencing loneliness.

Table 1. **Network of relationships and social support**

Primary relationships

1. Strong family or similar bonds, with cohabitation in the same household
2. Strong family, friendship, or similar bonds (characterised by effective availability for reciprocal support) with notable proximity, intensity or frequency

Secondary relationships

3. Relationships mediated by formalised public, private or solidarity organisations, with considerable proximity, intensity or frequency and a certain degree of primary relationship (trust, affection, reciprocity)
4. Family, friendship or good neighbourly relationships with a moderate level of commitment, proximity, intensity, frequency and availability
5. Weak ties of recognition, acquaintances or people one greets

Social network

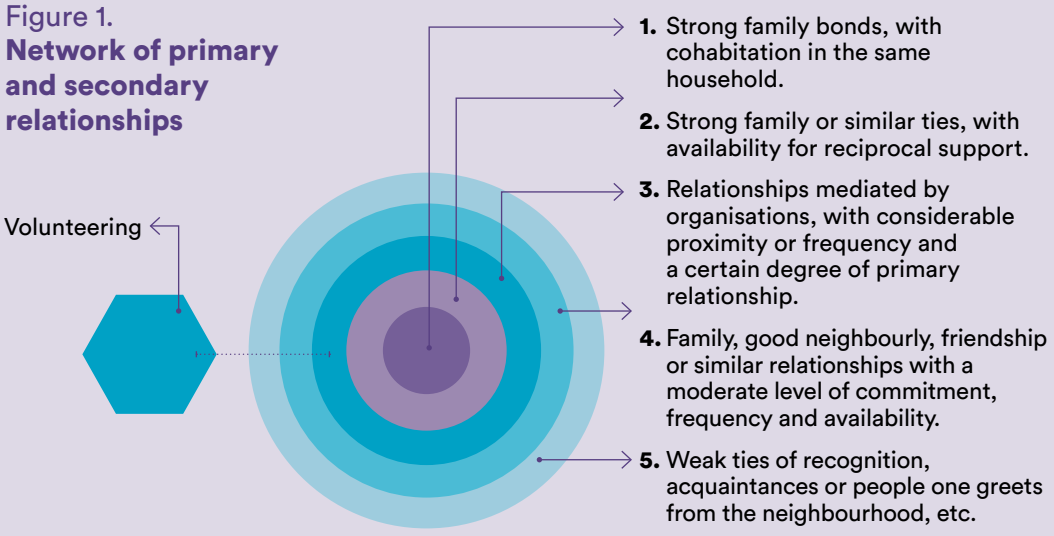
- A strong family or similar network, whose size, frequency of contact, emotional closeness and trust for seeking support when needed should be considered in the intervention by Always Supported

Social support

- A network of friends, volunteers, neighbours, etc., encompassing relationships with varying degrees of proximity, frequency and intensity, which Always Supported seeks to coordinate through various mechanisms to provide emotional, instrumental, informational or engagement support when the person needs it

Source: Compiled by the authors based on Fantova (2021) and chapter 2, section 1.4, p. 56.

Figure 1.
Network of primary and secondary relationships



Source: Compiled by the authors based on Fantova (2021) and chapter 2, section 1.4, p. 56.

This network of primary and secondary relationships, applied to the intervention on loneliness carried out by the programme, is closely linked to fundamental types of relationships essential both for a person's well-being and for addressing loneliness (social network, social support and engagement), as referenced in the chapter on the intervention model (see chapter 2, section 1.4, p. 56).

More specifically, we can illustrate this application through the following scenarios:

» **Social network → primary relationships (1-2).** If the person needs it, wants it and the circumstances allow, the Always Supported team intervenes in a more personalised manner within the network to which the person feels a greater emotional connection and trust – these are very valuable aspects for encouraging their commitment to their process of empowerment and autonomy. For example, with family members such as children, nieces or nephews, siblings, a partner or very close friends with whom the person maintains relatively stable and trusting relationships, the Always Supported team tries to work in an individualised way to seek support or to guide or strengthen these relationships. This work, centred on the person who feels alone, can vary greatly depending on individual and social risk factors and their dimensions, as well as the modulating and mediating variables being addressed at each stage of the personal process. Thus, the support may involve recognising and revaluing the steps and decisions the person is making; accompanying them – or perhaps better, not accompanying them – to an activity; providing support for a specific goal the person is finding difficult to achieve; establishing guidelines for calls or visits, and so on.

» **Social support → secondary relationships, with greater proximity or frequency and a certain degree of primary relationship (3).** The improvement or fostering of these types of relationships, aimed at ensuring the person has greater social support or at expanding their participation and increasing their commitment with members of their social network, is channelled in the programme through:
  – The creation of spaces and moments of interaction that foster meaningful relationships and a connection with others through which the person can perceive this support.
  – The connection with other people or projects through formal and informal activities to promote engagement.
  – The support provided by trained volunteers, under the supervision of the Always Supported team, in specific individual and everyday situations experienced by the person; in spaces for interaction; in initiatives launched to prevent and respond to situations of vulnerability; in awareness-raising actions; in detection.

» **Social support → secondary relationships with proximity or medium (4) or weak (5) frequency.** The promotion of these types of relationships in the programme is channelled through the involvement or collaboration of community resources, or through awareness-raising efforts; for example, by creating conditions and promoting interest in actions or projects that enable older adults to become active agents in their community; collaborating with local pharmacies and shops to identify people who may be feeling lonely; carrying out local campaigns to raise awareness of the importance of social relationships; developing initiatives to highlight the feelings of

emptiness, disconnection or frustration caused by loneliness in later life and the need to provide support and address these situations collectively, etc.

This framework, describing the different perspectives and mechanisms to strengthen the social network or seek greater social support in order to prevent or address various situations of loneliness, allows us to delve deeper and define what the role of volunteers consists of, their motivations and what they need in order to support the intervention carried out by the team during the empowerment and autonomy process of individuals in their community who suffer from loneliness.

3.2. CHARACTERISTICS AND REQUIREMENTS OF VOLUNTEERING

If we focus on the role of volunteers in providing social support to individuals who feel lonely and need it, we can characterise or define the voluntary action of Always Supported as follows:

"It is the support provided, through local organisations or associations, by members of the community surrounding those receiving assistance, driven by their interest in contributing to responses to the loneliness situations of older adults in their community. This support offers opportunities to establish reciprocal relationships of mutual companionship and fosters personal growth and development for both parties. It is also an opportunity for the broader community, as it is rooted in a social commitment that helps to enhance and strengthen the community fabric and collective action, contributing to the building of a more inclusive and supportive society."

In this regard, Aranguren et al. (2012) argue that the social commitment of volunteering focuses on a set of values that give it a unique character. Among the values mentioned by these authors, and in line with the voluntary work promoted by Always Supported, we highlight the following:

» **Personal growth.** Commitment to others and personal growth go hand in hand, as accompanying situations of loneliness involves both giving and receiving support. Moreover, engaging in the lives of others is one of the greatest sources of meaning, among other reasons because it helps us discover new personal resources and unknown abilities, all of which shape vital lessons that allow us to achieve personal maturity and improvement as human beings.

» **Centrality of the person.** This value is essential for repositioning the work of volunteering from a perspective of personalisation. The focus is not on the task the volunteer must perform, but on the individuals themselves: the person who supports and the person being supported. This forms the core around which much of the supplementary work carried out by volunteers in Always Supported revolves, as well as the management and organisation of this volunteering.

» **Participation and citizenship.** Voluntary action is also linked to participation and the exercise of citizenship, values that the programme promotes. The volunteer in Always Supported is part of a collective action aimed at addressing the loneliness

experienced by people in their community in order to improve their situation, an act that reflects involvement and a sense of belonging. Moreover, the volunteer actively participates and engages in matters that affect them as a citizen, issues they feel are their own or, at the very least, not alien to them.

In addition to these values, given that social support is a specific type of relationship that is particularly relevant, especially during moments of vulnerability when we need help, the Always Supported programme considers it essential to incorporate two key pillars in this voluntary support:

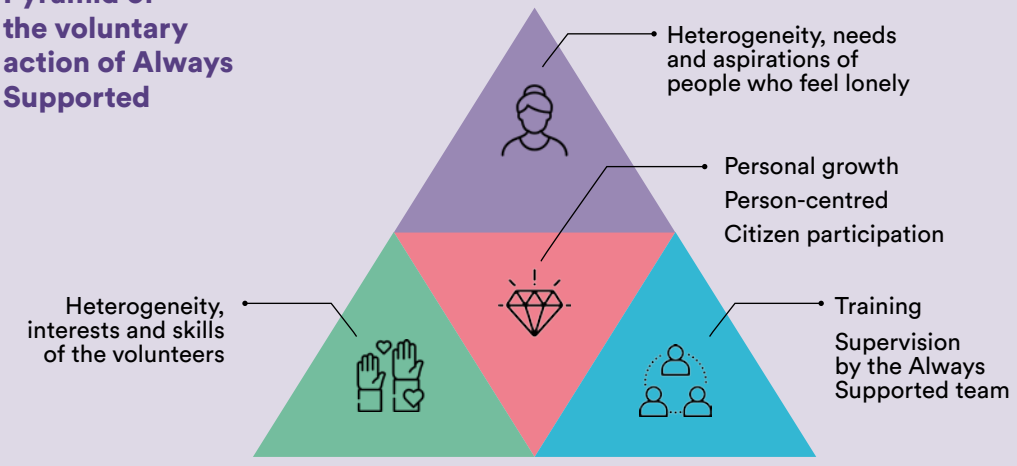
1. The training of volunteers.
2. Professional supervision.

These two pillars ensure that the desire to support is "completed" by individuals who possess the tools, skills and resources based on a deep understanding of what loneliness means.

In other words: in order to carry out a support role that requires more than mere companionship, volunteers need to understand the complexity and nuances of loneliness, both for their own personal development and for that of the person they are supporting. This also indicates that voluntary work must be managed and organised around the needs, aspirations and diversity of both the people experiencing loneliness and the volunteers (Fundación "la Caixa", 2021).

This framework of values and reciprocal relationships, the pillars of training and professional supervision, as well as the heterogeneity and diversity of interests of both those being supported and the volunteers, form the matrix and pyramid of the voluntary action of Always Supported, as shown in the following charts.

Figure 2.
Pyramid of the voluntary action of Always Supported



Source: Compiled by the authors.

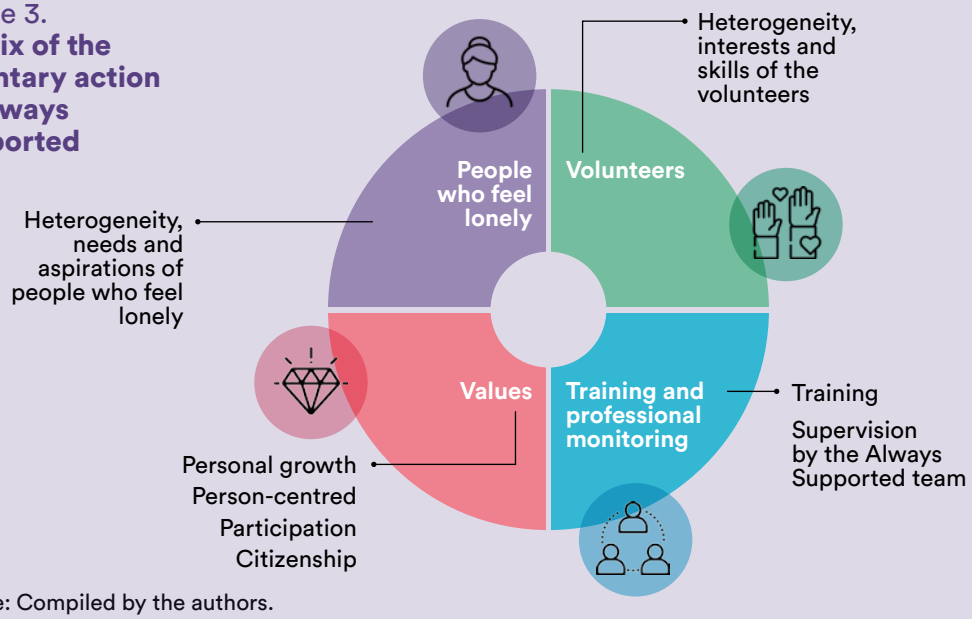
The pyramid of voluntary action of Always Supported represents the interrelationship between the different elements that make it up. At the base of the pyramid are the volunteers, training and professional follow-up provided by the Always Supported team. These components are essential for building a solid foundation of support and ongoing development.

At the centre of the pyramid, the values that guide the actions and relationships are highlighted: personal growth, a person-centred approach and active participation as citizens. These values act as the core that unites and gives meaning to the voluntary action of the programme.

At the top of the pyramid are the individuals who feel lonely, the main focus of all the actions. These people are heterogeneous, with diverse needs and aspirations, and the goal of the programme is to address these differences effectively and in a personalised manner with social support.

Thus, the pyramid reflects a model of voluntary action that aims to empower older adults to actively participate in their community while maintaining their autonomy and dignity. The interaction between trained volunteers and the individuals being supported, mediated by solid values and professional supervision, creates an environment where emotional and social well-being are fostered.

Figure 3.
Matrix of the voluntary action of Always Supported



Source: Compiled by the authors.

The matrix of voluntary action of Always Supported presents an integrative view of its essential components and how they interact to address loneliness. The axes of the matrix reflect, on one hand, the heterogeneity of needs and aspirations of those who feel lonely, and on the other, the diversity of interests and abilities of the volunteers.

In this matrix, training and professional supervision are elements that ensure volunteers are well-prepared and supported to provide effective support, acting as connectors to maintain the cohesion and effectiveness of the programme.

On the other axis of the matrix are the fundamental values of the programme's voluntary action: personal growth, a person-centred approach, participation and the consideration of citizenship (rights). These values not only guide the actions and relationships, but also reflect the commitment to empowering older adults and promoting their autonomy.

The matrix shows how each component of the voluntary action is interconnected to create a comprehensive support environment, highlighting the importance of a holistic and personalised intervention.

3.3. ORGANISATION OF THE VOLUNTARY ACTION

The articulation between the needs, aspirations and abilities of those who feel lonely and the volunteers is made possible because the programme adopts a personalised approach to seeking social support, considering the different areas of intervention (individual, community and awareness-raising) and the two essential aspects that define the model (empowering and supporting). In this way, the various possibilities provided to develop voluntary action are summarised as follows:

- **Support the person's action plan.** The volunteer work consists of facilitating the achievement of goals in situations where the person requires additional support with a defined timeframe, after specific training for the volunteer and following the professional's instructions. An example is accompanying someone to a meeting space or a group workshop over several sessions to work on the person's confidence; it has a specific purpose, agreed upon in advance and supervised by the team.
- **Fostering social and community interaction.** The role of the volunteer is to support initiatives aimed at creating safe environments that encourage interpersonal relationships and strengthen community ties, helping or complementing the team's efforts in facilitating meeting and interaction spaces, as well as in workshops, walks, etc.
- **Promoting awareness and dissemination.** In this case, the volunteer's role is to support local actions promoted by the Always Supported team or the network of local stakeholders, aimed at identifying people experiencing loneliness and raising awareness, providing information and disseminating the chosen topics, such as International Day of Older Persons, promoting the Summer Programme, etc.

To carry out this support work for volunteers, it is essential to understand and consider their motivations and availability, conduct follow-up and supervision by the team through close collaboration with the organisations they depend on, and provide specific and ongoing training. The following sections will address each of these aspects.

3.3.1. Volunteer profile and monitoring

The experience over these years has shown us that the volunteers participating in Always Supported are very heterogeneous in terms of age, gender, availability and interests, and that these factors influence the fluctuation of their level of commitment. All of this leads us to structure voluntary action through different opportunities that address aspects such as the following:

» **Interests and time flexibility.** It is important to consider the availability of schedules and the types of tasks to accommodate different times and needs since, for example, a young student who is only available during the summer and whose interest is focused on raising awareness is not the same as someone who has been supported by the programme, has available time and wishes to contribute by helping others who are experiencing loneliness.

» **Commitment and stability.** The different interests and availability of volunteers cause their levels of commitment and stability to fluctuate. For this reason, it is necessary to identify the actual level of commitment and the possibilities for stability in the volunteer work before establishing a connection between these factors and the various needs (people who will require support through close ties and a high level of trust, and others who will require occasional involvement or a lower level of commitment).

» Just as an example: there will be people who wish to carry out their volunteer work to complement their training or professional experience, and others whose interest is to contribute their time and knowledge in the meeting spaces. To integrate these types of support, it will be necessary to: *a*) prepare the content together; *b*) determine what prior training is required; and *c*) coordinate all of this with the time, needs and expectations of the people supported by the programme.

» **Personal resources.** In addition to the different levels of commitment, availability or flexibility, an essential aspect is the personal resources that someone wishing to support the Always Supported programme through voluntary action brings. We are referring to the skills, attitudes, knowledge about loneliness, etc., that are needed to carry out the support work with confidence. For the most part, these aspects can be acquired through the training plan, although the content and pathways will not be the same for someone who supports a specific awareness-raising action as for someone who wishes to support everything related to the action plan.

Another element that must be considered for the voluntary work to be carried out effectively is the work that the Always Supported team must do to maintain collaborative relationships with existing volunteer organisations in the community or, if the volunteers come from the same entity that manages the programme, their close cooperation with the relevant departments.

This inter-institutional and intra-institutional collaboration must be taken into account, as training, supervision of the various tasks carried out by the volunteers, permissions

related to data protection (LOPD), ensuring civil liability coverage or the necessary resources, scheduling and organising tasks, etc., all require effective communication with these organisations and volunteers to keep them informed and engaged, as well as to meet the needs and expectations of all parties involved.

3.3.2. Volunteer training

The willingness to support people experiencing loneliness is an opportunity to establish a relationship of mutual help and reciprocal care, while also being an opportunity for personal growth and development. This desire to help and support individuals requires empowered people who possess the resources, tools and skills necessary for their work to be valuable.

From the dual perspective (the person who supports and the person being supported) and the different viewpoints or possibilities of voluntary action, the following objectives arise for the Always Supported volunteer training plan and the follow-up of their work by the professionals of the team:

» Understand the phenomenon of loneliness and recognise its consequences in the daily lives of those who experience it.

» Be able to identify the different types and situations of loneliness.

» Be capable of co-creating personalised responses, alongside the Always Supported team, based on the circumstances of individuals or groups experiencing loneliness.

» Empower both the volunteers and those experiencing loneliness so they can better support and manage their own loneliness.

» Establish mutual support relationships between the volunteers and those experiencing loneliness.

To achieve each of these objectives, a series of thematic blocks has been designed, covering fundamental aspects for understanding the complex phenomenon of loneliness, empowering individuals to manage their own loneliness and acquiring the knowledge needed to support those experiencing loneliness.

As an example, the basic content of the training plan is presented, along with other cross-cutting and complementary content, as well as a sample session, all of which are included in the *Volunteer Training Manual* (Fundación "la Caixa", 2021).

However, this group-based training plan is designed for support with a high degree of commitment and stability. Therefore, the Scientific Management of the programme, in collaboration with the Always Supported teams, is currently working on a uniform basic training, complemented by specific modules that support and ensure the different types of support that volunteers can provide in Always Supported.

3.3.2.1. Volunteer training plan

3.3.2.1.1. Basic and cross-cutting content of the training plan

The main content covered in the training plan for Always Supported volunteers revolves around the following five key areas:

A. **Awareness raising.** The relevance of social relationships is addressed, and how they influence the experience of loneliness, highlighting its components and variables. The various emotions associated with loneliness are explored, along with its causes and types, as well as the potential consequences it can have on health and well-being. Different ways of coping with loneliness are described, both individual and social, and stereotypes, prejudices and cultural factors that can affect the perception and management of loneliness are analysed. Additionally, the influence of the life cycle on social functioning is discussed, and the difference between loneliness and isolation is clarified, emphasising the importance of a deep understanding for the proper management of these experiences.

B. **Detection of signs of loneliness.** This involves identifying the signs that indicate the presence of loneliness in a person. Common signs of loneliness are analysed, along with how people often try to hide it. Key questions are also provided that can help detect loneliness in others and in oneself. Finally, the importance of personal recognition of one's own loneliness is emphasised as the first step in addressing and managing it effectively.

C. **Ability to respond.** The importance of developing effective communication skills to interact with and support people experiencing loneliness is analysed, highlighting the value of co-design between volunteers and the professionals on the team to ensure that different interventions complement each other. The ability to propose ideas and convince others of their feasibility and benefits is emphasised, and the creation of innovative activities is encouraged to respond creatively and effectively to the identified needs.

D. **Support relationship.** The nature and dynamics of the relationship between the volunteer and the person being supported are explored. Empathy is highlighted as a fundamental tool for effective support and how it facilitates the emotional protection of the person being supported. The essential functions of volunteering are described, along with the importance of establishing and respecting boundaries to maintain a healthy and effective relationship. Additionally, the "enemies" of the support relationship are identified, meaning those factors that can deteriorate or hinder the development of a supportive and trusting bond.

E. **Empowerment.** This focuses on the interrelationship between emotions and loneliness, inviting reflection on the personal feelings associated with loneliness. It encourages viewing loneliness as an opportunity for personal growth and provides tools for this. Additionally, the importance of setting clear personal goals and creating an appropriate plan to achieve them is emphasised. This content also addresses the nuances between thoughts and feelings to help understand and harmonise the discrepancies that may arise between what we think and what we feel in relation to loneliness.

Figure 4. **Main contents of the Always Supported volunteer training plan**

A Awareness raising	1. The importance of social relationships 2. Components and variables of loneliness 3. Feelings, causes and types of loneliness 4. Consequences of loneliness 5. Types of coping 6. Social stereotypes, self-prejudice and cultural factors 7. Life cycle and social functioning 8. Difference between loneliness and isolation
B Detection of signs of loneliness	1. Signs of loneliness 2. Concealment of loneliness 3. Questions to detect loneliness 4. Recognising my loneliness
C Ability to respond	1. Communication skills 2. Co-design between the volunteer and a professional from the Always Supported team 3. Propose and convince 4. Design of innovative activities
D Support relationship	1. The support relationship 2. Empathy, a tool for support 3. Emotional protection 4. Role of the supporting volunteer 5. Boundaries of the supporting volunteer 6. Enemies of the support relationship
E Empowerment	1. Emotions and loneliness 2. How I feel about my loneliness 3. Loneliness as an opportunity for personal growth: tools 4. Personal goals 5. Planning 6. Shades of grey between what I think and what I feel

Source: *Volunteer Training Manual* (2021).

In addition to these main contents, there are other cross-cutting and complementary topics:

» **Quality of life.** The different dimensions that make up quality of life and their interrelationships are addressed, highlighting how these aspects influence each other to form a person's overall well-being.

» **Basic psychosocial needs.** Emphasis is placed on the importance of communication, recreation and fun, feeling useful, staying informed and receiving comprehensive and dignified treatment for psychosocial well-being.

» **Life cycle.** The "metaphor of the candle" is used to illustrate the different stages of life and how each phase contributes to personal development and growth.

» **Life course and interdependence.** It examines how changing contexts, the interrelationship and interdependence with the environment, the information society and ageism influence us throughout life.

» **Living in three times.** The importance of balancing time dedicated to oneself, time shared with others and time dedicated to others in order to achieve overall well-being is highlighted.

Table 2. **Other cross-cutting and complementary content**

QUALITY OF LIFE
- Dimensions
- Interrelationships

BASIC PSYCHOSOCIAL NEEDS
- Communication
- Feeling useful
- Recreation and fun
- Staying informed
- Comprehensive and dignified treatment

LIFE CYCLE
- The "metaphor of the candle"

LIFE COURSE AND INTERDEPENDENCE
- Changing contexts
- Interrelationship and interdependence with the environment
- Information society
- Ageism

LIVING IN THREE TIMES
- Time for myself
- Time with others
- Time for others

Source: *Manual de formación para personas voluntarias.* Volunteer Training Manual (2021).

3.3.2.1.2. Sessions of the training plan

The training plan consists of nine staggered sessions which address basic and cross-cutting concepts through structured phases. Using thematic worksheets, group dynamics and various tools, the objectives and areas of work are clearly defined, and key ideas are summarised. Each session concludes with well wishes for the week ahead and personalised farewells for each participant. The nine sessions are as follows:

» **The importance of social relationships.** This session focuses on understanding the fundamental value of social relationships for personal health and well-being.

» **Unravelling loneliness.** In this session, a deep understanding of loneliness is explored from various theoretical and practical perspectives.

» **Recognising loneliness.** The session focuses on raising participants' awareness of the negative consequences of loneliness on health, teaching them to detect signs of loneliness both in themselves and in the people they support, and challenging prejudices and stereotypes about loneliness on the basis of scientific evidence.

» **Feeling loneliness.** This session aims to help volunteers recognise and empathise with feelings of loneliness, both in themselves and in the people they support, exploring how loneliness is experienced on an emotional level.

» **Strengthening ourselves emotionally to face unpleasant moments.** This session provides cognitive tools and strategies to help volunteers protect themselves and manage their emotions in difficult and emotionally painful situations.

» **Facing loneliness.** Different coping strategies are taught to manage loneliness, including practical cases and self-awareness activities.

» **Supporting people who feel lonely.** Volunteers learn about the support relationship, with an emphasis on empathy, trust and setting appropriate boundaries for their role.

» **Empowering ourselves for our own loneliness.** This session focuses on personal empowerment to help volunteers set and achieve their personal goals, thereby managing their own loneliness.

» **The eight keys to managing my loneliness and relationships, and improving my volunteering.** The final session summarises the training by highlighting the keys to managing loneliness and relationships, and how to apply these learnings to improve volunteering.

Below, as an example, we detail the development of the first session, "The importance of social relationships", which, unlike the others, includes a phase dedicated to creating the group.

3.3.2.1.3. Session 1. "The importance of social relationships"

Session 1 of the training plan, "The importance of social relationships", is structured to facilitate understanding of the significance of social relationships and their impact on people's lives. Through presentations, group dynamics and practical tasks, it aims to empower participants so that they can effectively support the people they accompany and also better manage their own loneliness. It is structured in five phases to ensure a deep understanding of the topic and effective interaction among the volunteers participating in the training.

Phase 1. Creation of the group

This initial phase is crucial for establishing an appropriate atmosphere of trust and rapport. It includes several activities:

» Welcome. Participants are welcomed and the importance of their presence for the success of the volunteer project is emphasised. An environment of respect and closeness is fostered, including the group's preference for either the informal (tú) or formal (usted) mode of address in Spanish-speaking countries, or Mr/Ms or given name where the programme is conducted in English.

» Introduction of the facilitator and participants, where each participant states their name, role in the programme, volunteer experience and personal experiences related to voluntary work.

» Dynamic activity "The loneliness thermometer" and a relaxation and breathing exercise to ensure participants are in the right physical and mental state for the session.

Phase 2. Theme of the session

The importance of social relationships is explored in depth using various pedagogical resources:

» Thematic worksheet. A worksheet is distributed with the specific objectives and theoretical foundations of social relationships. The main points covered include:
  – The social network as a structural element of social relationships.
  – Social support and its different types: emotional, material, instrumental and informational.
  – Social participation and its classification into formal and informal activities.
  – The role of social relationships as stress buffers.

» Explanation of basic concepts. The facilitator expands on the information in the thematic worksheet by providing practical examples and encouraging discussion for better understanding.

Phase 3. Group dynamics

Group activities are carried out to facilitate reflection and personal analysis:

» Group dynamic "My social network". Participants draw and discuss their social networks, identifying the people and relationships that form part of their support system.

Phase 4. Focus on the action plan

This phase connects learning with practical actions:

» Objectives and work areas. The objectives and areas to focus on are identified, based on the phases of the session dedicated to social relationships.

» Actions and activities. Concrete actions are discussed and planned that can be implemented in the programme's action plan, such as organising social gatherings or establishing support networks.

» Personal task. An individual task is assigned to the participants, which they must complete before the next session to facilitate the practical application of what has been learned.

Phase 5. Summary of key ideas and session closure

A reflective closure of the session is carried out:

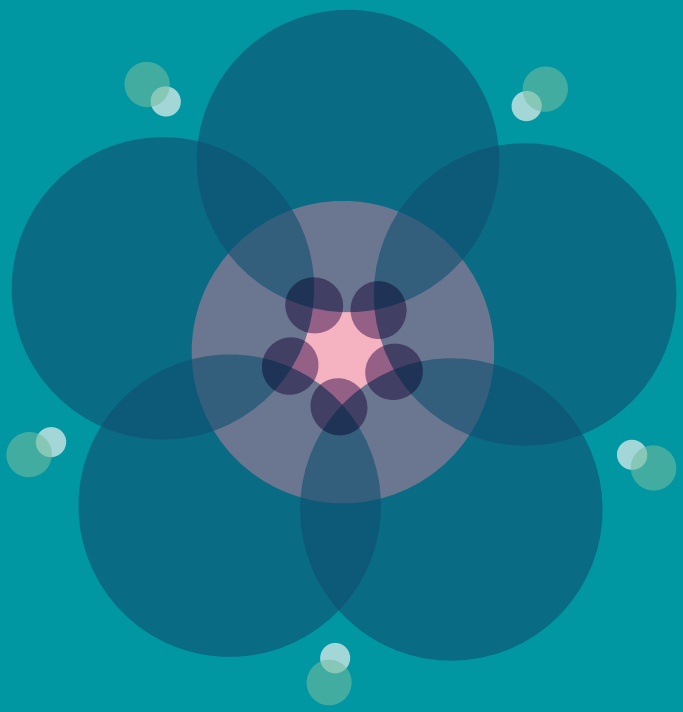
» Presentation of key words and memorable phrases. The key ideas discussed during the session are compiled and shared.

» Well wishes for the week ahead. Well-being is wished for all participants.

» Personalised farewell. Each participant receives a personalised farewell, reinforcing the atmosphere of respect and group cohesion.

This first session will introduce volunteers to understanding the fundamental value of social relationships for health and well-being, help them learn to identify and strengthen their social networks and encourage social participation. These theoretical and practical foundations will facilitate the following sessions, where the emotional and cognitive aspects of loneliness, coping strategies and empowerment tools will be explored in detail, thus creating a comprehensive and progressive approach to the training of volunteers for the social support of older adults who feel lonely.

Appendices



APPENDIX 0.

Managing entities and public and private institutions

LOCATION	MANAGING ENTITIES	PUBLIC AND PRIVATE INSTITUTIONS
Sabadell	Cruz Roja	Sabadell City Council
Terrassa		Terrassa City Council
Girona		Girona City Council
Tortosa		Tortosa City Council
Lleida		Lleida City Council
Tàrrega		Tàrrega Town Council
Santa Coloma de Gramenet		Santa Coloma de Gramenet Town Council
Murcia	Asamblea Local Cruz Roja Murcia	Murcia City Council
Granada	Fundación Albihar	Granada City Council
Málaga	Cruz Roja Española - Oficina Provincial de Málaga	Málaga City Council
Jerez de la Frontera	Cruz Roja Española - Oficina Provincial de Cádiz	Jerez de la Frontera City Council
Pamplona	Fundación Pauma	Fundación Caja Navarra
		Pamplona City Council
Palma	Grupo de Educadores de Calle y Trabajo con Menores (GREC)	Palma City Council
		Instituto Mallorquín de Asuntos Sociales (IMAS)
Lisbon	Centro Social Paroquial do Campo Grande	Lisbon City Council
		Santa Casa da Misericórdia de Lisboa
Porto	Cruz Vermelha Portuguesa	Porto City Council
	Santa Casa da Misericórdia do Porto	

APPENDIX 1.

Detection and attention request protocol for professionals

1. DESCRIPTION

This protocol regulates the procedure for detecting and proposing support for individuals at risk or in a situation of loneliness who are eligible to participate in the Always Supported programme.

Specifically, it is **intended for professionals** in social services, healthcare resources or centres and other entities that collaborate with the Always Supported programme.

2. OBJECTIVES

» To describe the detection process and proposed support in detail.

» To propose a foundational protocol that can be adapted by each area according to its situation or specific needs.

3. RESOURCES

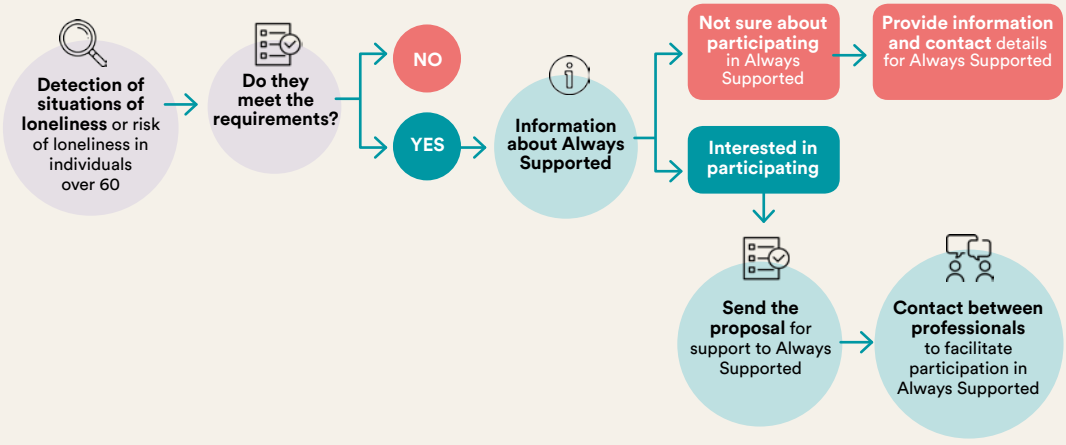
» Graphic representation of the detection process and proposed care of Always Supported.

» UCLA 3-item loneliness scale.

» Guide "How to detect loneliness?"

» Communication of the proposed support from Always Supported.

4.
GRAPHIC REPRESENTATION OF THE DETECTION PROCESS AND PROPOSED SUPPORT



Source: Compiled by the authors.

5.
DETECTION: DO THEY MEET THE REQUIREMENTS?

Before asking the person if they wish to participate in the Always Supported programme, the first thing to do is assess whether they meet the requirements.

The Always Supported programme is open to individuals aged 60 and over, who are independent, live on their own and do not require help from third parties (non-dependent), and who feel or could potentially feel lonely.

In addition to the above, **they may present one or more of the following factors:**

» They have experienced losses or transitions (retirement, divorce, children leaving home, migration, etc.), so they need to adapt to a new life.

» They are carers.

» They suffer from chronic illnesses that somewhat limit their life or they do not feel entirely well, but do not require help.

» They miss relationships, even though they do not live alone.

» They wish to turn their life around, aspiring to a better life.

» They feel vulnerable due to everything that has happened with COVID or other situations.

» They want to contribute to the common good and give back to society.

Therefore, **individuals who are not considered suitable for participation in the programme** include those who are:

» highly dependent;

» people without self-sufficiency;

» people with severe mental health issues;

» people with a moderate level of cognitive decline (GDS>4).

To determine whether a person meets the requirements or not, the instruments presented below can be used, which include questions or statements that can help identify individuals in situations of loneliness or at risk of loneliness.

The conversation generated around these questions might feel somewhat invasive, so it is important to communicate clearly – respectfully and without judgment – that experiencing loneliness is part of the "human condition", something we all feel multiple times throughout our lives. It is necessary to learn how to manage and cope with it to prevent suffering, avoid it affecting health and well-being, make decisions and adjust one's life plan, etc.

6.
HOW TO DETECT LONELINESS?

6.1. UCLA 3-ITEM LONELINESS SCALE[1]

	Hardly ever	Some of the time	Often
How often do you feel you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

From 3 to 5: not lonely; 6 or more: lonely.

1. The UCLA 3-item loneliness scale (University of California, Los Angeles; Hughes et al., 2004).

6.2. TEN PRINCIPLES OF LONELINESS

1. I don't always have someone to talk to about my daily problems.
2. I miss having a true close friend.
3. Sometimes I feel isolated from others.
4. If I have a problem, I have no-one to turn to.
5. I miss having people I can just be with.
6. Sometimes I feel like I lack people in my life.
7. I have no-one to confide in.
8. I miss having people around.
9. I feel abandoned sometimes.
10. I think my life is unattractive; I would like to have a life plan that gives meaning to my life.

7.
INFORMATION ABOUT THE ALWAYS SUPPORTED PROGRAMME

If the person meets the requirements, they are informed about the Always Supported programme. It is important to emphasise that this is a programme designed to support older adults who feel or may feel somewhat lonely, helping them become more capable of facing their situation of loneliness.

After confirming that they meet the requirements, the person could:

» Accept that a member of the Always Supported team will contact them to provide the leaflet and inform them that in a few days a professional from the programme will call to schedule an appointment. In such a case, the next step is: "Proposal or request for support".

» Have doubts or initially refuse. In that case, the leaflet containing the contact details of Always Supported is given, and they are informed that they can call whenever they wish to be contacted and receive more detailed information.

8.
PROPOSAL OR REQUEST FOR SUPPORT

If an agreed-upon form is in place for submitting requests for support under the Always Supported programme, it can continue to be used (avoiding the inclusion of any personal information about the older adult beyond their name, surname and phone number).

If such a form is not available, the procedure can be handled via email.

» To the email address of the Always Supported team

» Subject: Proposal for support from Always Supported

» Body of the email:

- Name of the professional proposing the support. Service, department or organisation.
- Name, surname and phone number of the person for whom Always Supported support is being proposed.
- A brief note on why it is considered that the Always Supported programme may be helpful for the person (without including sensitive data).

It is recommended that not too many days pass after the person agrees for a member of the Always Supported team to contact them and the support proposal form or email is sent. It is important to bear in mind that after the conversation, expectations or situations may arise that can be painful or distressing.

9.
CONTACT BETWEEN PROFESSIONALS TO FACILITATE THE SUPPORT PROCESS

When the Always Supported team receives a referral for assistance, they contact the referring professional by phone to discuss the case in greater detail. This ensures that all necessary information is gathered to facilitate the support process and to ensure that the older adult does not feel their privacy is being invaded.

The recommended information to obtain during this call includes:

» Reason for the request: situation and factors detected.

» Initial impressions and potential resistance from the older adult regarding their participation in the programme.

» Existence of immediate family members or contacts, whether they are aware of the potential participation in the programme and their level of involvement with it.

» Approach for the first meeting with the older adult. This is a key point, as it will help facilitate their entry into the programme. The aim is to determine whether it would be necessary for the referring professional or another person, such as a family member, to accompany the older adult during the first in-person or contact meeting to help establish an initial connection with the Always Supported team member.

If necessary, the professional proposing the support will inform the older adult that the Always Supported team will call them in the coming days to arrange a visit.

If it is agreed that the referring professional or another person, such as a family member, will also attend the first in-person meeting, it is important to confirm their availability. This will ensure that when the team member calls the older adult, they can inform them about who will be attending the meeting and the proposed schedule.

10.
INFORMATION FROM THE ALWAYS SUPPORTED TEAM TO THE REFERRING PROFESSIONAL

After the initial interview or assessment:

» The Always Supported team informs the referring professional whether the individual can be supported by the Always Supported programme:
  - **Cannot be supported.** The reasons are explained, such as the person declining the programme, not meeting the profile, etc. Additionally, the team informs or agrees with the professional on an alternative resource to which the person could be redirected (if applicable).
  - **Can be supported.** Brief information is provided on whether the individual fits a preventive or loneliness profile, along with a very concise summary of other observations deemed relevant for follow-up.

If the individual participates in the programme:

» The Always Supported team **keeps the referring professional informed about the individual's situation and progress throughout the support process**, so this information can be included in the relevant case file for their service. Updates should ideally be provided following evaluations or six-monthly follow-ups, as well as upon programme discharge.

This information can be shared via email or other agreed-upon channels (it is recommended to provide the information in writing to avoid confusion or misinterpretation). Documenting the support provided by Always Supported and the individual's progress in the relevant reports or case files for social or health services not only strengthens collaboration and trust between professionals but also impacts both the quality of service provided by each professional and the quality perceived by the individual receiving support.

11.
PERSONAL DATA PROTECTION

The procedure outlined in this protocol does not require informed consent or a registration form for the programme from the "la Caixa" Foundation.

However, if health centres, social services or other organisations have specific procedures in place regarding the sharing of data, these must be followed in accordance with the guidelines established by each service or organisation.

12.
LONELINESS DETECTION QUESTIONNAIRE

CODE: .....

CONTACT: .....

How old are you?.....

What is your marital status? .....

In which area of ..... **do you currently live?**

Do you live alone?

☐ NO ☐ YES With whom?.....

Have you participated or are you currently participating in any activities, a centre for older adults or another association?

☐ NO ☐ YES Which?.....

Do you have any health issues that make it difficult for you to carry out activities inside or outside your home?

☐ NO ☐ YES Specify: .....

Do you have mobility issues? Do you use any assistive devices?

☐ NO ☐ YES Specify: .....

Do you have recognised dependency?

☐ NO ☐ YES Specify the degree of dependency and type:.....

In the past few months or weeks, have you missed being able to talk or walk with someone, or participate in any type of activity or workshop?

.....

Do you feel lonely?.....

Do you feel comfortable when you are alone? .....

Do you consider yourself a lonely person?.....

Do you often think about loneliness?.....

Do you feel supported by your children, family, neighbours, etc.?.....

Do you trust someone to turn to in case of need? .....

Does your home have any obstacles
that prevent you from leaving the house? .....

Do you have a phone, tablet or computer with Internet access?
Do you know how to use it? .....

Comments: .....

.....

.....

.....

.....

APPENDIX 2.

Protocol for addressing loneliness in high-complexity situations

1. JUSTIFICATION

Support for individuals experiencing loneliness and facing complex factors focuses on managing that complexity in collaboration with other local stakeholders and the individuals themselves.

Technical coordination among professionals to address economic, health or isolation-related risks is often sufficient.

However, in highly complex cases, it is recommended to create an interdisciplinary technical workspace for addressing interventions. This approach places the individual at the centre of the process and enhances the support provided by the various institutions and technical stakeholders in the area collaborating with the programme.

To this end, the following protocol is proposed, which:

» focuses support on the individual, with an approach oriented towards their environment and community;

» views the individual as a whole, taking into account the interaction between health, psychological, economic and social factors, while identifying strengths and capabilities;

» addresses the risk factors of loneliness (health, housing, economic, relational, affective, etc.) that, due to their mutual interaction, require a complex, comprehensive and integrative approach.

2. OBJECTIVES

The aim is to address, from an interdisciplinary perspective, highly complex situations of individuals over 60 years old who experience loneliness, placing them at the centre of the work and supporting them according to their interests, desires and needs, with their agreement.

3.
PROFESSIONALS INVOLVED

Professionals from local authorities and organisations that carry out social, healthcare and community interventions can participate, provided they have expressed their willingness to collaborate with the Always Supported programme to respond in an integrated way to the needs of individuals facing various highly complex situations.

4.
ORGANISATION AND FUNCTIONS

To ensure comprehensive, continuous and high-quality support that meets the needs and interests of each person receiving support, the following is proposed:

» that the role of **case manager** should be assigned to the professional most involved in addressing the individual's needs;

» that the role of **coordinator concerning the situation of loneliness** should be assigned to the case manager from the Always Supported team;

» that the roles of **other professionals** should align with their profile or job position, as well as with the competencies of the organisations or entities to which they belong.

4.1. FUNCTIONS OF THE CASE MANAGER

» If the role is assigned to a professional outside the Always Supported team, the case manager will be responsible for proposing the approach to be taken in each specific case.

4.2. FUNCTIONS OF THE ALWAYS SUPPORTED TEAM

» Propose the admission and discharge of cases.

» Support the individual in all matters related to loneliness, within the scope and capabilities of the Always Supported programme, in close collaboration with the designated professionals and the case manager.

» If the Always Supported team takes on case management, they will be responsible for proposing the approach to be taken in each specific case.

» Participate in meetings as required, fulfilling assigned responsibilities efficiently and effectively.

» Adhere to established procedures for information management, data protection and confidentiality.

4.3. FUNCTIONS OF OTHER PROFESSIONALS

» Provide support to the individual in accordance with their expertise role, and assigned responsibilities.

5.
INFORMATION AND DOCUMENTATION MANAGEMENT SYSTEM

To enable a secure and confidential information management system, procedures for information handling, record-keeping and documentation processes must be established. These should not only ensure confidentiality but also guarantee:

» that the individual receiving support is aware of and consents to the collaboration between professionals addressing their situation;

» that the information shared is strictly professional;

» that the stages of case management are completed in a timely and proper manner;

» that the organisations to which the participating professionals belong are informed of and adhere to the procedures, ensuring continuity of work in the event of changes in personnel.

5.1. PERSONAL DATA PROTECTION

The procedure outlined in this protocol does not require informed consent from the "la Caixa" Foundation. In the case of the Always Supported team, the professional must keep the individual informed based on this protocol for the duration of their support.

If health centres, social services or other organisations have specific procedures in place regarding the sharing of data, these must be followed in accordance with the guidelines established by each service or organisation.

6.
TYPES OF HIGHLY COMPLEX CASES

The types of cases to be addressed under this protocol involve individuals over 60 years of age experiencing existential, emotional or social loneliness, alongside other highly complex circumstances arising from the following situations:

» Needs requiring mixed interventions that are social, healthcare-related and community-based, complementary and well-coordinated.

» Needs requiring strategies and tools for collaboration organised around the principle of interdisciplinarity.

» Vulnerability related to isolation, health, economic factors, housing, etc.

» Risk of neglect or abuse.

» Other situations related to mental health, caring for relatives in highly complex circumstances, the loss of children, etc.

7.
PROCESS FOR ACTIVATING THE PROTOCOL

The Always Supported team, after assessing the situation of loneliness and other highly complex factors or risks and following the process established by the Always Supported programme, has the following responsibilities:

» To inform the individual that their situation is highly complex, explaining that different professionals will work with them to provide more comprehensive and tailored support.

» To agree with the individual on how to share all the information being worked on with them.

» To record the information and initial assessment of high complexity and activate the protocol within no more than 15 days.

In cases of urgency or where the situation involves high vulnerability, neglect, abuse, etc., the Always Supported team will immediately inform the designated professional, depending on the specific need, to address the situation as quickly as possible.

It may be the case that an initial assessment does not identify highly complex factors, but as support progresses and more information is gathered, the assessment changes. In such cases, the protocol activation process will then be initiated.

8.
STAGES OF CASE MANAGEMENT

The Always Supported team will document the tasks or responsibilities agreed upon at each stage for follow-up. If necessary, a specific meeting will be held with the professionals involved to discuss the case.

8.1. STAGE 1. PRELIMINARY ASSESSMENT AND PROTOCOL ACTIVATION

» The Always Supported team assesses the situation of loneliness with high complexity, opens the case file and informs the designated professionals based on the identified needs.

» The designated professionals gather the necessary information to present at the agreed meeting to discuss the case.

8.2. STAGE 2. JOINT AND COMPREHENSIVE ASSESSMENT

A joint and comprehensive assessment is carried out to identify needs, risk factors, available resources, etc., taking into account the person's wishes and opinions.

At least the following circumstances may arise:

» Not all the necessary information is available to conduct a complete assessment, so priority is given to addressing the most urgent needs while gathering further information about the individual's situation.

  Based on the challenges in collecting information and the individual's needs, a date is proposed for a follow-up meeting where the case will be re-evaluated.

» The necessary information is available, and the joint assessment is completed, agreeing on the support and follow-up through this protocol:

  - A case manager is appointed to coordinate the follow-up across the different professional interventions. Actions are agreed upon.
  - Referral to the appropriate professional or service is arranged based on the identified need. The Always Supported team's intervention plan may be reconsidered while addressing the individual's urgent situation (for example, high vulnerability, abuse, mental health issues, etc.).

8.3. STAGE 3. INTERVENTION PLAN

A coordinated intervention and case management plan is implemented, outlining the distribution of responsibilities, work guidelines and the timeline assigned to each action.

8.4. STAGE 4. MONITORING THE INTERVENTION PLAN

The case manager, the Always Supported team and the professionals involved provide updates on progress based on the agreed proposals.

The intervention, the work of the team members and the assigned timeline are jointly evaluated. As a result:

» The agreed intervention plan is continued.

» The agreed intervention plan is modified or adapted.

8.5. STAGE 5. CASE CLOSURE

At the initiative of the Always Supported team, the case file closure is agreed upon.

In general, each case should be resolved as promptly and efficiently as possible.

APPENDIX 3.

Initial assessment and establishment of entry profile

STATEMENT: For each of the following statements, please mark the response that best reflects your current situation.

VARIABLE/TEST	ITEM
END LONELINESS CAMPAIGN (own translation)	**1.** I am happy with my friendships and relationships. (1) I agree (2) I do not agree **2.** I have enough people I feel comfortable asking for help at any time. (1) I agree (2) I do not agree **3.** My relationships are as satisfying as I would like them to be. (1) I agree (2) I do not agree
UCLA 3-Item loneliness scale	**4.** How often do you feel that you lack companionship? (1) Rarely (2) Sometimes (3) Often **5.** How often do you feel left out? (1) Rarely (2) Sometimes (3) Often **6.** How often do you feel isolated from others? (1) Rarely (2) Sometimes (3) Often

PROPOSED SCORING

If the person responds "I do not agree" to one or more of the first three items (*End loneliness* campaign), and in the UCLA test scores no more than 3 points, this indicates a **preventive profile**.

If at least one of the first three items is answered with "I do not agree" (there may be more with 2 points) and in the UCLA test scores 4 or more points, this indicates a **loneliness profile**.

APPENDIX 4.

Group intervention assessment[1]

SATISFACTION SURVEY

NAME: .....

ID:.....

TOWN/CITY:.....

Please circle or mark with an X the correct option for each question.

1. How would you rate the quality of the support received in the groups you attended?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did it meet your expectations?

4	3	2	1
No	A little	Yes, in general	Yes, very much

3. Have these groups helped you improve your personal situation?

4	3	2	1
Yes, very much	Yes, in general	Very little	Not at all

4. If a friend or someone close to you were in a situation similar to yours, would you encourage them to attend?

4	3	2	1
No, under no circumstances	No, I don't think so	Yes, I think so	Yes, absolutely

1. Taken from Attkisson and Greenfield, 2022, and Feixas et al., 2012.

5. How satisfied are you with the support you have received?

4	3	2	1
Not satisfied at all	Indifferent or moderately unsatisfied	Moderately satisfied	Very satisfied

6. If you needed help again, would you participate in our programme?

4	3	2	1
No, under no circumstances	No, possibly not	Yes, I think so	Yes, definitely

7. What was your emotional state before participating?

4	3	2	1
I was feeling bad. I found it hard to do things. Everything was difficult and complicated	I was feeling okay. Not very happy	I was doing quite well	I was feeling very good

8. What is your current emotional state? How do you feel?

4	3	2	1
I am feeling bad. I find it hard to do things. Everything feels difficult and complicated	I am feeling okay. Not very happy	I am doing quite well. I feel motivated	I am feeling very good. I feel capable and enthusiastic

APPENDIX 5.

Life story

NAME: .....

DATE: .....

1.
BIOGRAPHY

Overview of life.

Life periods: significant memories and personal identification with each stage.

Eras: creation of one's own family nucleus and development throughout life.

Losses and transitions: relevant and pivotal life events that have shaped their life, challenges and obstacles faced, successes and failures. How their life has changed, what gave their life meaning, life balance and the geography of their life.

2.
CURRENT LIFE AND FUTURE

Relationships or loneliness and significant people: social network, frequency of contact and quality of connections; most trusted significant individuals; designated professional and support, if applicable.

Loneliness: subjective perception of loneliness or isolation. When they feel lonely, what do they think about? What do they miss? Social support (people they can turn to for some form of support).
Participation: associations they belong to or have belonged to, and projects they would like to participate in or that capture their interest.
Fundamental preferences and habits in their life: daily activities that bring them satisfaction and those they dislike.
Everyday life: key aspects of their life that should be considered; best and worst moments; notable skills they can contribute.
Meaningful activities: activities, habits and interests, personal priorities, activities that help them relax or bring them a sense of well-being; places they would like to visit or frequent; sexuality; spirituality.

Satisfaction with current activities: hobbies, important celebrations with friends or family; support needed (if applicable) to carry out activities that bring a sense of well-being.
Emotional life: fears, worries, self-description of subjective life, description of current situation, aspirations, perceived health, self-assessment and limitations.
Health: perception of their own health and its impact on daily life.
Future: exploration of how they envision or project themselves in the future.

APPENDIX 6.

Complete interview for the loneliness profile

FIXED DATA

Code of the person benefiting from the platform: .....

Name: .....

Surname(s): .....

Type of document: ☐ Tax ID (NIF): .....
☐ Foreigner ID (NIE): .....
☐ Others (passport): .....

Gender: ☐ Male
☐ Female
☐ Other

Address: .....

Town and neighbourhood: .....

Telephone: ..... Email: .....

Date of birth: ..... Age: .....

Place of origin: .....

Nationality: .....

Connection to local government services: (mark with an X)

☐ Health ☐ Social Service ☐ Others (specify): ..... ☐ No connection

Centre/entity:

Contact person: .....

Telephone: .....

Email: .....

Notes (type of connection, resources, ongoing relationship or one-off instance...):

.....

.....

Entry channel:

- ☐ Social services
- ☐ Centre for older adults
- ☐ Health
- ☐ Managing entity
- ☐ Pharmacies
- ☐ Establishments
- ☐ Other SAG entities
- ☐ Other community stakeholders
- ☐ Meeting space (open, ongoing)
- ☐ Group action (open, structured…)
- ☐ Information point
- ☐ Other awareness and outreach activity
- ☐ Programme participant
- ☐ Direct circle (family, partner, friends…)
- ☐ Volunteering
- ☐ Others

REASON FOR LEAVING: .....

DATE OF LEAVING: .....

- ☐ Deceased
- ☐ Relocation to another municipality
- ☐ Permanent admission to a residential facility
- ☐ Temporary admission to a hospital or residential facility
- ☐ Health issues preventing continued participation in the Always Supported programme
- ☐ Voluntary discharge
- ☐ End of intervention
- ☐ Others

Specify "Others": .....

.....

ENROLMENT DATE: .....

Interviewer/support worker: .....

Interview date: .....

Interview location:

☐ Home ☐ Centre

Presence of third parties during the interview (mark with an X):

☐ No observers ☐ Children

☐ Grandchildren ☐ Friends or neighbours

☐ Partner ☐ Siblings

☐ Other relatives ☐ Other individuals (specify): .....

1.
BLOCK 1. BASIC SOCIAL DATA

EDUCATIONAL LEVEL

☐ Cannot read or write ☐ Incomplete primary education

☐ Primary education ☐ Secondary education (vocational training, baccalaureate...)

☐ University studies

MARITAL STATUS

☐ Single ☐ Married

☐ Separated ☐ Divorced

☐ Civil partnership or cohabiting ☐ Widowed. Specify: ☐ Less than 1 year ☐ More than 1 year

2.
BLOCK 2. FAMILY LIVING ARRANGEMENTS

Family genogram (optional)

LIVING ARRANGEMENTS

Do they live alone?

☐ Yes ☐ No ☐ Others (occasionally): .....

Lives with (mark with an X):

- ☐ No-one
- ☐ Partner
- ☐ Son/daughter
- ☐ Parents, in-laws
- ☐ Grandchild
- ☐ Brother/sister
- ☐ Other relatives
- ☐ Others who are not relatives
- ☐ Carer

Total number of people living in the household (including the individual): .....

Notes (Lives alone, with how many and with whom, is a carer for any relative, has dependents, etc.):

.....

.....

3.
BLOCK 3. SOCIAL NETWORK AND SUPPORT

We are now going to ask you about some personal aspects of your life. There are no right or wrong answers, so we kindly ask you to answer as openly as possible. If you have difficulty understanding any of the questions, please let us know. Thank you very much!

3.1. SOCIAL NETWORK: LUBBEN SCALE

We will now ask you about your social relationships. Please answer as honestly as you can.

Table 1*a*. **LSNS-6 scale**

ITEM	SCORE
1. How many relatives do you meet or hear from at least once a month?	0 1 2 3 4 5
2. How many relatives do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
3. How many relatives do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5
4. How many friends do you meet or hear from at least once a month?	0 1 2 3 4 5
5. How many friends do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
6. How many friends do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5

Source: Lubben et al., 2006.

According to its authors (Lubben et al., 2006), the LSNS-6 scale provides two key outcomes:

» Perceived social support: A single score (range 0—30) indicating a broader, closer and more frequent/intense social support network as the score increases.

» Risk of isolation: The LSNS-6 score indicates a risk of social isolation when the value is equal to or less than 12.

» **Items 1 and 4:** frequency of contact

» **Items 2 and 5:** emotional closeness

» **Items 3 and 6:** perception of support

Table 1*b*. **Coding and scoring of the LSNS-6 scale**

CODING OF ITEMS 1-6	CALCULATION OF THE LSNS-6	RISK OF ISOLATION:
0 = 0 **1** = 1 **2** = 2 **3** = 3 or 4 **4** = between 5 and 8 **5** = 9 or more	1 + 2 + 3 + 4 + 5 + 6	LSNS-6 ≤12

Source: Lubben et al., 2006.

3.2. SOCIAL SUPPORT: DUKE-UNC QUESTIONNAIRE

The following list shows some of the things that other people do for us or provide to us. Please choose the response that best reflects your situation for each one.

Table 2. **Duke-UNC-11 Functional Social Support Questionnaire**

1. I receive visits from my friends and family.	1 2 3 4 5
2. I receive help with matters related to my home.	1 2 3 4 5
3. I receive praise and recognition when I do things well.	1 2 3 4 5
4. I have people who care about what happens to me.	1 2 3 4 5
5. I receive love and affection.	1 2 3 4 5
6. I have someone I can talk to about my problems at work or at home.	1 2 3 4 5

7. I have someone I can talk to about my personal and family problems.	1 2 3 4 5
8. I have someone I can talk to about my financial problems.	1 2 3 4 5
9. I receive invitations to go out and do things with other people.	1 2 3 4 5
10. I receive helpful advice about important things in my life.	1 2 3 4 5
11. I receive help when I am ill in bed.	1 2 3 4 5

Each item is scored as follows: 1 = much less than I would like, 2 = less than I would like, 3 = neither much nor little, 4 = almost as much as I would like, 5 = as much as I would like.

Source: Bellón et al., 1996.

The scoring range is between 11 and 55 points, with the score obtained reflecting perceived support, not actual support.

The lower the score, the lower the support. In the Spanish validation, a cut-off point at the 15th percentile was chosen, corresponding to a score below 32. A score of 32 or higher indicates normal support, while a score below 32 indicates low perceived social support.

4.
BLOCK 4. ASSESSMENT OF LONELINESS AND OTHER SUBJECTIVE ASPECTS

For each of the following statements, please mark the response that indicates how accurately it describes your current situation and how you feel.

4.1. LOSSES AND TRANSITIONS

Table 3. **Scale for losses and transitions**

	ITEM	SCORING
LOSSES	1. In the past year I feel that I have experienced significant losses.	1 2 3 4 5 6 7
TRANSITIONS	2. I am going through a delicate/ complicated time in my life.	1 2 3 4 5 6 7

Each item is scored as follows:
from 1 = strongly disagree to 7 = strongly agree.

Source: Compiled by the authors.

4.2. PERCEIVED HEALTH AND QUALITY OF LIFE

Table 4. **Scale for perceived health and quality of life**

	ITEM	SCORING
PERCEIVED HEALTH	1. In the last month, my health has been…	1 2 3 4 5 6 7
QUALITY OF LIFE	2. I think my quality of life is…	1 2 3 4 5 6 7

Each item is scored as follows: from 1 = very poor, to 7 = very good.

Source: Compiled by the authors.

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening.

4.3. DE JONG GIERVELD LONELINESS SCALE

For each of the following statements, please mark the response that indicates how accurately it describes your current situation and how you feel.

Table 5. **De Jong Gierveld Loneliness Scale**

	NO	MORE OR LESS	YES
1. There is always someone I can talk to about my day-to-day problems.	1	2	3
2. I miss having a really close friend.	1	2	3
3. I experience a general sense of emptiness.	1	2	3
4. There are plenty of people I can lean on when I have problems.	1	2	3
5. I miss the pleasure of the company of others.	1	2	3
6. I find my circle of friends and acquaintances too limited.	1	2	3
7. There are many people I can trust completely.	1	2	3
8. There are enough people I feel close to.	1	2	3
9. I miss having people around me.	1	2	3
10. I often feel rejected.	1	2	3
11. I can call on my friends whenever I need them.	1	2	3

Each item is scored as follows: 1 = no, 2 = more or less, 3 = yes

Source: De Jong Gierveld and Van Tilburg, 2006.

Calculation of the scale

The response categories are: 1 = no; 2 = more or less; 3 = yes. According to the scoring criteria of the DJGLS outlined in its manual (De Jong Gierveld and Van Tilburg, 2011):

» **Emotional loneliness** subscale**:** to calculate this subscale, add the number of times the respondent answers "yes" or "more or less" to the items related to this dimension (2, 3, 5, 6, 9 and 10). The score for this subscale ranges from 0 to 6.

» **Social loneliness** subscale**:** this subscale score is calculated by adding the number of times the respondent answers "no" or "more or less" to the other items (1, 4, 7, 8 and 11). The score for this subscale ranges from 0 to 5.

» Total scale score: **total loneliness** is the sum of the values obtained in both subscales, ranging from 0 to 11 points.

Interpretation of results:

» 0 to 2: no loneliness.

» 3 to 8: moderate loneliness.

» 9 to 10: severe loneliness.

» 11: very severe loneliness.

4.4. EXISTENTIAL LONELINESS

For each of the following statements, please mark the response that indicates how accurately it describes your current situation and how you feel.

Each item is scored as follows:

» 1 = no

» 2 = more or less

» 3 = yes

Table 6. **Items about existential loneliness**

	ITEM	SCORING		
REGARDING RELATIONSHIPS	1. I stay in bad relationships for too long to avoid being alone.	1	2	3
	2. I matter to others.	1	2	3
REGARDING THE MEANING OF LIFE	3. My life has a purpose.	1	2	3
	4. I feel that life has little meaning.	1	2	3

Each item is scored as follows: 1 = no, 2 = more or less, 3 = yes

Source: Van Tilburg, 2021a.

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening.

4.5. OTHER ASPECTS RELATED TO LONELINESS

For each of the following statements, please mark the response that indicates how accurately it describes your current situation and how you feel.

Table 7. **Scale on types of loneliness**

VARIABLE	ITEM	SCORE
FREQUENCY OF FEELINGS OF LONELINESS	1. How often do you feel lonely?	0 (Never) ..... 10 (Always)
POSITIVE LONELINESS	2. Do you feel good when you are alone?	0 (Never) ..... 10 (Always)
RUMINATION OF LONELINESS	3. Do you often think about loneliness?	0 (Never) ..... 10 (Always)
STEREOTYPES OF LONELINESS - I	4. To what extent do you agree with the following statement? "It is 'logical/normal' for older people to be lonely."	0 (Completely disagree) ..... 10 (Completely agree)
STEREOTYPES OF LONELINESS - II	5. To what extent do you agree with the following statement? "Young people (who are not elderly) think it is normal for older people to be lonely."	0 (Completely disagree) ..... 10 (Completely agree)
FAMILY LONELINESS (ASKED ONLY IF THE INDIVIDUAL HAS FAMILY)	6. To what extent do you agree with the following statement? "I miss sharing life, joys and time with my family."	0 (Completely disagree) ..... 10 (Completely agree)
"SENTIMENTAL" LONELINESS	7. How much do you identify with the following phrase? "I miss having a romantic or meaningful relationship."	0 (Completely disagree) ..... 10 (Completely agree)
LONELINESS DUE TO LOSS (GRIEF)	8. How much do you identify with the following phrase? "Since I lost X, I feel lonely or less motivated to do things."*	0 (Completely disagree) ..... 10 (Completely agree)

Source: Compiled by the authors.

***Observations:** Specify the loss referred to in the test. Explain what you believe is the reason that makes you feel lonely or any other relevant considerations (optional).

.....

.....

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening.

4.6. STRATEGIES FOR COPING WITH LONELINESS

For each of the following statements, please mark the response that indicates the extent to which it describes how you cope with your loneliness.

Score from 1 to 7:

» 1 = Strongly disagree

» 7 = Strongly agree

Table 8. **Scale for coping with loneliness situations**

1. If I feel lonely, I accept my situation, resign myself and do nothing.	1 2 3 4 5 6 7
2. If I feel lonely, I reflect and try to change how I think.	1 2 3 4 5 6 7
3. If I feel lonely, I seek out people to spend time with.	1 2 3 4 5 6 7
4. If I feel lonely, I join activities.	1 2 3 4 5 6 7
5. If I feel lonely, I try to change how I feel and at least avoid being sad.	1 2 3 4 5 6 7
6. I avoid feeling lonely; I don't even want to think or talk about my loneliness.	1 2 3 4 5 6 7
7. If I feel lonely, I ask for help.	1 2 3 4 5 6 7
8. If I feel lonely, I distract myself with my hobbies and make an effort to keep up with my routine.	1 2 3 4 5 6 7
9. I feel comfortable with myself; I enjoy being alone.	1 2 3 4 5 6 7
10. I do many things alone (reading, walking, household tasks...) and feel good about it.	1 2 3 4 5 6 7

Each item is scored as follows:
from 1 = strongly disagree, to 7 = strongly agree.

Source: Compiled by the authors.

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening.

4.7. PURPOSE IN LIFE

Select the question below that best reflects your personal situation.

Score from 1 to 7, linking the score to the extreme situations presented.

Table 9. **PIL or Purpose in Life test**

1. Sometimes I feel...	completely bored	1	2	3	4	5	6	7	exuberant, excited.
2. Life seems to me to be...	completely routine	1	2	3	4	5	6	7	always exciting.
3. In life...	I have no goals or aspirations	1	2	3	4	5	6	7	I have many defined goals or aspirations.
4. Each day is...	exactly the same	1	2	3	4	5	6	7	always new and different.
5. My life is...	empty	1	2	3	4	5	6	7	full of exciting things.
6. When I think about my life...	I find no reasons to live	1	2	3	4	5	6	7	I find reasons to live.
7. I have discovered that...	I have no purpose in life	1	2	3	4	5	6	7	I have purpose in life.

Source: Noblejas de la Flor, 1994.

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening (based on the factorial structure of the test).

4.8. DAILY LIFE

Which time of the day do you feel the saddest, loneliest or most down?

☐ Morning ☐ Afternoon ☐ Night ☐ None ☐ Always

Which day of the week do you feel the saddest, loneliest or most down?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ All week ☐ No day

Observations

.....

.....

5.
BLOCK 5. HEALTH

5.1. ITEM PREPARED FOR THE PURPOSE OF IDENTIFYING POTENTIAL HEALTH DIFFICULTIES

Do you have any health issues that make it difficult for you to engage in leisure activities inside or outside the home?

☐ Yes, due to sensory impairment. ☐ Yes, cognitive. ☐ No.
☐ Yes, due to reduced mobility. ☐ Yes, due to mood. ☐ NA.
☐ Yes, due to accessibility. ☐ Yes, due to lack of information about community activities.
☐ Yes, other (specify): .....

Observations: Please indicate if you are overweight or underweight, have reduced mobility, the type of sensory impairment, how long it has been since you were able to engage in activities, if you use any specific support products and which ones (optional):

.....

.....

5.2. HEALTH-RELATED QUALITY OF LIFE: EQ-5D-5L

a) Under each statement, tick ONE box that best describes your health TODAY.

MOBILITY

I have no difficulties walking ☐
I have slight difficulties walking ☐
I have moderate difficulties walking ☐
I have severe difficulties walking ☐
I am unable to walk ☐

SELF-CARE

I have no difficulties washing or dressing myself ☐
I have slight difficulties washing or dressing myself ☐
I have moderate difficulties washing or dressing myself ☐
I have severe difficulties washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES (e.g.: work, study, household tasks, family or leisure activities)

I have no difficulties doing my usual activities ☐
I have slight difficulties doing my usual activities ☐
I have moderate difficulties doing my usual activities ☐
I have severe difficulties doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN OR DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY OR DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am very anxious or depressed ☐
I am extremely anxious or depressed ☐

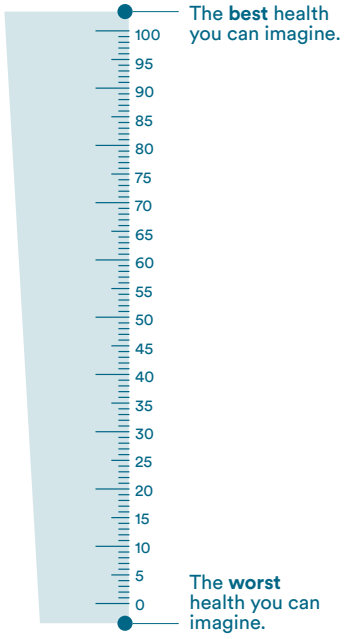
b) We would like to know how good or bad your health is TODAY.

Mark with an X on the scale to indicate your health status TODAY.

The scale is numbered from 0 to 100, where 100 represents the best health you can imagine, and 0 represents the worst health you can imagine.

Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =



c) Compared to your health status six months ago, your current health is:

☐ Better. ☐ The same. ☐ Worse.

d) How many times have you been to the family doctor in the last three months?

☐ None. ☐ From 1 to 3 times. ☐ From 4 to 6 times.
☐ From 7 to 9 times. ☐ More than 9 times.

e) How many times have you used the emergency medical services in the last 12 months?

☐ None. ☐ From 1 to 3 times. ☐ From 4 to 6 times.
☐ From 7 to 9 times. ☐ More than 9 times.

Observations: types of chronic illnesses, medication, ADLs, whether assistance is received for performing ADLs, other relevant health aspects (optional):

.....

.....

5.3. COGNITIVE IMPAIRMENT QUESTIONNAIRE: MONTREAL COGNITIVE ASSESSMENT (MOCA©)

The questionnaire should only be administered if the person has a history or fundamental indications of cognitive impairment (optional).

Test result:

Number of points (between 0 and 30):

Interpretation of the test:

· 0-25 points: indicates probable cognitive disorder.

· 26-30 points: considered normal.

The maximum possible score for the MoCA© is 30 points. For individuals with 12 or fewer years of education, the score should be adjusted by adding 1 point to the total score.

6.
BLOCK 6. FINANCIAL SITUATION, HOUSING AND OBSERVATIONS

6.1. FINANCIAL SITUATION

a) Do you have any financial difficulties in managing your day-to-day life?

☐ Yes. ☐ No.

What is the reason?

.....

.....

.....

b) Could you tell me which individual monthly income bracket you fall into?

INCOME BRACKETS:

☐ Income or pension equivalent to more than 1.5 times the minimum wage.

☐ Income or pension equivalent to the minimum wage or up to 1.5 times the minimum wage.

☐ Income equivalent to or less than the minimum pension.

☐ Income equivalent to or less than the non-contributory pension.

☐ No personal income or income below the thresholds outlined above.

Interpretation:

» Likely low-risk financial situation: Option 1 (more than 1.5 times the minimum wage).

» Likely intermediate financial situation: Option 2 (minimum wage to 1.5 times the minimum wage).

» Likely high-risk financial situation: Options 3, 4 and 5.

6.2. HOUSING

a) Do you feel comfortable in your home?

0 1 2 3 4 5 6 7 8 9 10

Not at all — Very much

b) Do you feel comfortable in your neighbourhood?

0 1 2 3 4 5 6 7 8 9 10

Not at all — Very much

c) Do you have to negotiate any steps, ramps or uneven surfaces to access your home from the street?

☐ Yes. ☐ Yes, but it can be avoided with a lift. ☐ No.

d) Are all the rooms in your home on the same level or are there different levels?

☐ They are all on the same level. ☐ There are different levels.

6.3. OBSERVATIONS BY THE PROFESSIONAL

a) General situation of the dwelling (if interview is conducted at home):

☐ Not observable.

☐ Adequate, no modifications needed.

☐ Lacking sanitary conditions.

☐ Requires minor adaptations to improve mobility and accessibility.

☐ A room or installation needs refurbishment.

☐ Major renovation required.

b) Appearance of the person:

☐ Well-groomed.

☐ Neglected. Lack of personal hygiene.

☐ Prostheses (hearing aids, dentures, etc.) and other supports (such as glasses, crutches, etc.) in poor condition.

What are your hopes or expectations for the programme? (optional):

.....

.....

Observations: risk of cognitive impairment, communication, interruptions during the interview, family members, etc. (optional)

.....

.....

APPENDIX 7.

Complete interview for the preventive profile

FIXED DATA

Code of the person benefiting from the platform: .....

Name: .....

Surname(s): .....

Type of document: ☐ Tax ID (NIF): .....
☐ Foreigner ID (NIE): .....
☐ Others (passport): .....

Gender: ☐ Male
☐ Female
☐ Other

Address: .....

Town and neighbourhood: .....

Telephone: ..... Email: .....

Date of birth: ..... Age: .....

Place of origin: .....

Nationality: .....

Connection to local government services (mark with an X):
☐ Health ☐ Social Service ☐ Others (specify): ..... ☐ No connection

Centre/entity:
Contact person: .....

Telephone: .....

Email: .....

Notes (type of connection, resources, ongoing relationship or one-off instance...):

.....

.....

Entry channel:

- ☐ Social services
- ☐ Centre for older adults
- ☐ Health
- ☐ Managing entity
- ☐ Pharmacies
- ☐ Establishments
- ☐ Other SAG entities
- ☐ Other community stakeholders
- ☐ Meeting space (open, ongoing)
- ☐ Group action (open, structured …)
- ☐ Information point
- ☐ Other awareness and outreach activity
- ☐ Programme participant
- ☐ Direct circle (family, partner, friends …)
- ☐ Volunteering
- ☐ Others

REASON FOR LEAVING: .....

DATE OF LEAVING: .....

- ☐ Deceased
- ☐ Relocation to another municipality
- ☐ Permanent admission to a residential facility
- ☐ Temporary admission to a hospital or residential facility
- ☐ Health issues preventing continued participation in the Always Supported programme
- ☐ Voluntary discharge
- ☐ End of intervention
- ☐ Others

Specify “Others”: .....

.....

ENROLMENT DATE: .....

Interviewer/support worker: .....

Interview date: .....

Interview location:

☐ Home ☐ Centre

Presence of third parties during the interview (mark with an X):

☐ No observers ☐ Children

☐ Grandchildren ☐ Friends or neighbours

☐ Partner ☐ Siblings

☐ Other relatives ☐ Other individuals (specify): .....

1.
BLOCK 1. BASIC SOCIAL DATA

EDUCATIONAL LEVEL

☐ Cannot read or write ☐ Incomplete primary education

☐ Primary education ☐ Secondary education (vocational training, baccalaureate...)

☐ University studies

MARITAL STATUS

☐ Single ☐ Married

☐ Separated ☐ Divorced

☐ Civil partnership or cohabiting ☐ Widowed. Specify: ☐ Less than 1 year ☐ More than 1 year

2.
BLOCK 2. FAMILY LIVING ARRANGEMENTS

Family genogram (optional)

LIVING ARRANGEMENTS

Do they live alone?

☐ Yes ☐ No ☐ Others (occasionally): .....

Lives with (mark with an X):

- ☐ No-one
- ☐ Son/daughter
- ☐ Grandchild
- ☐ Other relatives
- ☐ Carer
- ☐ Partner
- ☐ Parents, in-laws
- ☐ Brother/sister
- ☐ Others who are not relatives

Total number of people living in the household (including the individual): .....

Notes (Lives alone, with how many and with whom, is a carer for any relative, has dependents, etc.):

.....

.....

3.
BLOCK 3. SOCIAL NETWORK AND SUPPORT

We are now going to ask you about some personal aspects of your life. There are no right or wrong answers, so we kindly ask you to answer as openly as possible. If you have difficulty understanding any of the questions, please let us know. Thank you very much!

3.1. SOCIAL NETWORK: LUBBEN SCALE

We will now ask you about your social relationships. Please answer as honestly as you can.

Table 1*a*. **LSNS-6 scale**

ITEM	SCORE
1. How many relatives do you meet or hear from at least once a month?	0 1 2 3 4 5
2. How many relatives do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
3. How many relatives do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5
4. How many friends do you meet or hear from at least once a month?	0 1 2 3 4 5
5. How many friends do you feel comfortable enough with to talk about personal matters?	0 1 2 3 4 5
6. How many friends do you feel close enough to such that you could call on them for help?	0 1 2 3 4 5

Source: Lubben et al., 2006.

According to its authors (Lubben et al., 2006), the LSNS-6 scale provides two key outcomes:

» Perceived social support: A single score (range 0—30) indicating a broader, closer and more frequent/intense social support network as the score increases.

» Risk of isolation: The LSNS-6 score indicates a risk of social isolation when the value is equal to or less than 12.

» **Items 1 and 4:** frequency of contact

» **Items 2 and 5:** emotional closeness

» **Items 3 and 6:** perception of support

Table 1*b*. **Coding and scoring of the LSNS-6 scale**

CODING OF ITEMS 1-6	CALCULATION OF THE LSNS-6	RISK OF ISOLATION:
0 = 0 **1** = 1 **2** = 2 **3** = 3 or 4 **4** = between 5 and 8 **5** = 9 or more	1 + 2 + 3 + 4 + 5 + 6	LSNS-6 ≤12

Source: Lubben et al., 2006.

4.
BLOCK 4. ASSESSMENT OF LONELINESS AND OTHER SUBJECTIVE ASPECTS

4.3. DE JONG GIERVELD LONELINESS SCALE

For each of the following statements, please mark the response that indicates how accurately it describes your current situation and how you feel.

Table 5. **De Jong Gierveld Loneliness Scale**

	MORE NO	OR LESS	YES
1. There is always someone I can talk to about my day-to-day problems.	1	2	3
2. I miss having a really close friend.	1	2	3
3. I experience a general sense of emptiness.	1	2	3
4. There are plenty of people I can lean on when I have problems.	1	2	3
5. I miss the pleasure of the company of others.	1	2	3
6. I find my circle of friends and acquaintances too limited.	1	2	3
7. There are many people I can trust completely.	1	2	3
8. There are enough people I feel close to.	1	2	3
9. I miss having people around me.	1	2	3
10. I often feel rejected.	1	2	3
11. I can call on my friends whenever I need them.	1	2	3

Each item is scored as follows: 1 = no, 2 = more or less, 3 = yes

Source: De Jong Gierveld and Van Tilburg, 2006.

Calculation of the scale

The response categories are: 1 = no; 2 = more or less; 3 = yes. According to the scoring criteria of the DJGLS outlined in its manual (De Jong Gierveld and Van Tilburg, 2011):

» **Emotional loneliness subscale:** to calculate this subscale, add the number of times the respondent answers "yes" or "more or less" to the items related to this dimension (2, 3, 5, 6, 9 and 10). The score for this subscale ranges from 0 to 6.

» **Social loneliness subscale:** this subscale score is calculated by adding the number of times the respondent answers "no" or "more or less" to the other items (1, 4, 7, 8 and 11). The score for this subscale ranges from 0 to 5.

» Total scale score: **total loneliness** is the sum of the values obtained in both subscales, ranging from 0 to 11 point.

Interpretation of results:

» 0 to 2: no loneliness.

» 3 to 8: moderate loneliness.

» 9 to 10: severe loneliness.

» 11: very severe loneliness.

4.7. PURPOSE IN LIFE

Select the question below that best reflects your personal situation.

Score from 1 to 7, linking the score to the extreme situations presented.

Table 9. **PIL or Purpose in Life test**

1. Sometimes I feel...	completely bored	1 2 3 4 5 6 7	exuberant, excited.
2. Life seems to me to be...	completely routine	1 2 3 4 5 6 7	always exciting.
3. In life...	I have no goals or aspirations	1 2 3 4 5 6 7	I have many defined goals or aspirations.
4. Each day is...	exactly the same	1 2 3 4 5 6 7	always new and different.
5. My life is...	empty	1 2 3 4 5 6 7	full of exciting things.
6. When I think about my life...	I find no reasons to live	1 2 3 4 5 6 7	I find reasons to live.
7. I have discovered that...	I have no purpose in life	1 2 3 4 5 6 7	I have purpose in life.

Source: Noblejas de la Flor, 1994.

There is no calculation; evaluation 1 is compared with evaluation 2 to assess improvement or worsening (based on the factorial structure of the test).

APPENDIX 8.

Interview for the network profile

Information to be completed by the professional:

DATE: .....

TEAM: .....

ACTIVITY: .....

Next, we are going to ask you to answer a few questions to assess whether the activities you participate in contribute to your personal well-being. Please take as much time as you need and answer them with complete honesty. Thank you very much for your cooperation.

1. Age .....

2. Gender ☐ Male ☐ Female ☐ Other

3. Educational level

☐ Cannot read or write
☐ Incomplete primary education
☐ Primary education
☐ Secondary education (vocational training, baccalaureate...)
☐ University studies

4. Marital status

☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Civil partnership or cohabiting
☐ Widowed

5. Do you live alone?

☐ Yes ☐ No

For each of the following statements, please select the response that best describes your current situation:

6. How often do you feel that you lack companionship?

☐ Never ☐ Rarely ☐ Often ☐ Always

7. How often do you feel excluded?

☐ Never ☐ Rarely ☐ Often ☐ Always

8. How often do you feel isolated from others?

☐ Never ☐ Rarely ☐ Often ☐ Always

9. I matter to other people:

☐ No ☐ More or less ☐ Yes

10. My life has a purpose:

☐ No ☐ More or less ☐ Yes

For each of the following questions, please select the answer that best reflects your assessment of the activity:

11. How would you rate the quality of the activity you participate in?

☐ Poor ☐ Fair ☐ Acceptable ☐ Excellent

12. To what extent does participating in this activity have a positive impact on your life?

☐ Not at all ☐ A little ☐ Quite a lot ☐ A lot

13. Does participating in this activity help you to have more social contacts?

☐ Not at all ☐ A little ☐ Quite a lot ☐ A lot

Thank you very much for completing the questionnaire.
Your feedback is very valuable to help us continue improving.

APPENDIX 9.

Questionnaire for participants: evaluation of the support received in the programme

PERSONAL IDENTIFIER *

Name: .....

Gender: .....

Age: .....

City:.....

Neighbourhood: .....

Length of time in the programme (less than 6 months, between 6 months and a year, more than 1 year): .....

Marital status: .....

Does the person live alone? .....

** All these details will already be on the platform.*

TODAY'S DATE:

Good morning/afternoon, are you .....?
I am ....., I am calling you on behalf of the Always Supported programme, where you have participated/participate with the ....., team, is that right?

The reason for this call is that we would like to know what you think about the programme in order to continue to improve and offer quality support to the people who participate in it.

We would like to ask you a few questions. Can you tell us which option best suits your opinion? Thank you very much.

1. How would you rate the quality of the support received in the Always Supported programme? Are you satisfied with the support received?

(4) Excellent (3) Good (2) Fair (1) Poor

2. Did you receive the support you requested? Were you offered what you were looking for?

(4) Yes, very much (3) Yes, in general (2) A little (1) Not at all

3. Has our programme helped improve your personal situation? Do you think the programme has helped you feel better?

(4) Yes, very much (3) Quite a bit (2) A little (1) Not at all

4. If a friend or someone close to you were in a similar situation, would you recommend our programme? If someone you know were in your situation, would you tell them to join the Always Supported programme?

(4) Yes, absolutely (3) Yes, I think so (2) No, I think not (1) No, not at all

5. How satisfied are you with the support you have received? How happy are you with the support offered to you?

(4) Very satisfied (3) Moderately satisfied (2) Indifferent or moderately unsatisfied (1) Not satisfied at all

6. If you were in a similar situation, would you participate in our programme again?

(4) Yes, definitely (3) Yes, I think so (2) No, possibly not (1) No, definitely not

7. What was your emotional state before participating in the programme? How did you feel before joining the Always Supported programme?

(4) I was feeling, very well (3) I was doing quite well (2) I was feeling okay. Not very happy (1) I was feeling bad. I found it hard to do things. Everything was difficult and complicated

8. What is your current emotional state? How do you feel now?

(4) I am feeling very well. I feel capable and enthusiastic (3) I am doing quite well. I feel motivated (2) I am feeling okay. Not very happy (1) I am feeling bad. I find it hard to do things. Everything feels difficult and complicated

THANK YOU VERY MUCH FOR YOUR COLLABORATION

ADDITIONAL QUESTIONS WHEN A PERSON LEAVES THE PROGRAMME OR TRANSFERS TO THE NETWORK PROFILE:

9. Do you feel you have more tools to cope with loneliness?
Do you feel more capable of addressing loneliness)?
Please answer yes or no.

9.1. Since participating in the Always Supported programme…
(Please answer yes or no for each of the following statements.)

- ☐ I understand my emotions better. I have a clearer understanding of how I feel.
- ☐ I have more social connections. I have more relationships, friends…
- ☐ I take better care of myself.
- ☐ I feel more confident participating in social or community activities. I feel more confident about joining in activities.
- ☐ I seek more support. I ask for help more often.
- ☐ I spend my time more productively. I have more things to do.
- ☐ I am developing interests that fulfil me. I do things that bring me joy.
- ☐ I am connecting more with friends and family. I see or talk to friends and family more often.
- ☐ I am learning new things.
- ☐ I am working on my personal growth. I feel better about myself.
- ☐ I have sought or am seeking professional support, such as a psychologist.
- ☐ I have started volunteering or am engaging in a volunteering activity.
- ☐ I enjoy moments of solitude.
- ☐ I have new goals.
- ☐ I am making new friends.
- ☐ I feel more positive.
- ☐ I believe I have more tools to manage loneliness.
- ☐ I do not perceive a significant change.

10. Please rate the following programme activities from 1 to 4
(1 = has not helped me at all, 4 = has helped me a lot):

- ☐ *a*) Individual support: sessions with professionals.
- ☐ *b*) Participation in group activities: café chats, walks, etc.
- ☐ *c*) Personal growth workshops.

If you wish, you can specify any other activity (open field):

.....

.....

11. How would you rate the kindness and dedication of the professional who has supported you?

(4) Excellent (3) Good (2) Fair (1) Poor

12. What is your opinion of the location where the support sessions were held?

.....

.....

13. Did you feel comfortable and safe in the location where the support sessions took place?

(4) Very (3) Fairly (2) Not very (1) Not at all

14. Was the time dedicated to your support sufficient to meet your needs?
Was the time given to you adequate?

(4) Yes (3) Yes, in general (2) It was not enough time (1) No

15. What did you like the most about the support you received?

.....

.....

.....

16. Do you think there is anything that should be improved?

.....

.....

.....

17. How would you describe the overall impact of the support on your daily life?

.....

.....

.....

THANK YOU VERY MUCH FOR YOUR COLLABORATION

APPENDIX 10.

Questionnaire for managing bodies: evaluation of the perception of the quality of support

We would like to hear your opinion on aspects related to the Always Supported programme. This form is anonymous and aims to improve the quality of the programme. It will take no more than three minutes to complete and will be available for two weeks. Thank you very much for your collaboration.

* Required response

ROLE WITHIN THE ENTITY:

1. What is your professional role within the entity? *

- ☐ Team coordination
- ☐ Area management
- ☐ Other

PLEASE RATE THE FOLLOWING ASPECTS FROM 1 TO 4:

(1 = not at all and/or poor, 4 = very much and/or excellent)

2. Are you satisfied with the programme's ability to address situations of loneliness? *	1	2	3	4
3. Do you think the programme's users are satisfied? *	1	2	3	4
4. How do you rate the programme's technical-scientific approach? *	1	2	3	4
5. How do you evaluate the support the programme provides to your entity and the team you lead? * (Supervision, recommendations, guidelines, frequency of meetings, responsiveness, etc.)	1	2	3	4
6. How do you evaluate the training received by the professionals on your team? *	1	2	3	4
7. Overall, how do you rate the programme? *	1	2	3	4

8. Do you have any suggestions or comments? .....

APPENDIX 11.

Questionnaire for professionals: evaluation of the perception of the quality of support

We would like to hear your opinion on aspects related to the Always Supported programme. This form is anonymous and aims to improve the quality of the programme. It will take no more than three minutes to complete and will be available for two weeks. Thank you very much for your collaboration.

* Required response

PLEASE RATE THE FOLLOWING ASPECTS FROM 1 TO 4:

(1 = not at all and/or poor, 4 = very much and/or excellent)

1. Are you satisfied with the programme's ability to address situations of loneliness? *	1	2	3	4
2. Do you think the programme's users are satisfied? *	1	2	3	4
3. How do you rate the programme's technical-scientific approach? *	1	2	3	4
4. How do you rate the support provided to your team by the programme? * (Supervision, recommendations, guidelines, frequency of meetings, responsiveness, etc.)	1	2	3	4

5. Please rate the usefulness of these programme resources from 1 to 4: *

Supervision space	1 Not useful	2 Slightly useful	3 Useful	4 Very useful
Balint groups	1 Not useful	2 Slightly useful	3 Useful	4 Very useful
Training sessions	1 Not useful	2 Slightly useful	3 Useful	4 Very useful
Tools: life story, flowchart, profiles, etc.	1 Not useful	2 Slightly useful	3 Useful	4 Very useful
Workshop "Improving Tools" (M. Márquez)	1 Not useful	2 Slightly useful	3 Useful	4 Very useful

6. Do you feel that you have opportunities for professional development and knowledge updating within the programme? * (1) (2) (3) (4)

7. Is being part of this programme enriching for you as a professional? * (1) (2) (3) (4)

8. When do you consider that a bond is established with the individuals being supported? *

A bond is understood as a space for relationship and trust. You may select up to three options if you believe there is more than one key moment when the bond can be established.

Select up to 3 options:

- [ ] Upon completing the life story.
- [ ] Upon finishing the evaluation.
- [ ] After agreeing on the action plan.
- [ ] After completing the first two follow-up sessions.
- [ ] Upon conducting the second evaluation.
- [ ] Other.

9. Do you think the individuals being supported ultimately gain more tools to cope with loneliness? * (1) (2) (3) (4)

(For example: greater self-awareness, increased assertiveness, better recognition of emotions, expanded social network, etc.)

10. Based on your experience, which of these tools would you highlight? *

Select up to 4 options.

- [ ] Recognition of emotions
- [ ] Expansion of social network
- [ ] Greater self-confidence
- [ ] Seeking support / ability to ask for help
- [ ] Motivation
- [ ] Exploration and/or development of interests
- [ ] New learning
- [ ] Strengthening relationships and communication with close friends and family
- [ ] Personal development
- [ ] Social and/or community participation
- [ ] Emergence of new challenges or life goals
- [ ] Change in perspective on loneliness
- [ ] Improved mood
- [ ] Better management of the loneliness situation
- [ ] Self-awareness
- [ ] Personal care and self-care
- [ ] Other

11. Do you think the support provided by the programme has a significant impact on the daily lives of its participants? *

1 2 3 4

(For example: increased motivation, greater enthusiasm for activities, new challenges, etc.)

12. Do you think your team collaborates well with other stakeholders in the area to jointly address loneliness? *

1 2 3 4

(For example: healthcare, social services, etc.)

13. Overall, how do you rate the programme? *

1 2 3 4

14. Can you justify the response you gave to the previous question? *

.....

.....

.....

.....

15. Do you have any suggestions or areas for improvement you would like to share?

.....

.....

.....

.....

APPENDIX 12.

Guidelines for identifying loneliness

WHO IS IT AIMED AT?

Older adults over 60 years of age, who are self-sufficient, live **independently and do not need assistance** from third parties (dependence), and **feel lonely**.

In addition to the above, the following factors must be taken into account:

» They have experienced losses or transitions (retirement, divorce, children leaving home, etc.) and need to adapt to a new life.

» They want to turn their lives around and aspire to a better life.

» They are carers.

» They have chronic illnesses that somewhat limit their lives; they do not require assistance, but do not feel entirely well.

» They miss relationships, even if they do not feel lonely.

» They feel vulnerable due to everything that happened during the COVID epidemic.

» They want to contribute to the common good and give back to society.

» Other.

HOW MANY PEOPLE MEET THE CHARACTERISTICS DESCRIBED?

According to statistical data from the Continuous Register of the Spanish National Statistics Institute (INE), as of 1 January 2019 there were 9,057,193 people aged 65 and over in Spain, representing 19.3% of the total population (47,026,208). Of these, those aged between 65 and 80 accounted for 13.2% of the total population, while octogenarians made up 6.1%.

If loneliness affects between 30% and 40% of people aged 65 and over, this translates to **between 2,717,158 and 3,622,877 individuals**.

RISK FACTORS

Living alone	The person lives alone.
Family	They either have no family, their family lives far away, or they have limited contact with them.
Friends	They have no social network or have lost it.
Carer	They are a carer.
Sadness	They appear downcast, speak little, seem withdrawn, have a low tone of voice, cry, or complain about their situation.
Symptoms of dementia or mental confusion	They have difficulty responding, experience confusion with money, forget things, hesitate, take an excessive amount of time to respond, or give evasive answers, etc.
Loss (death) of close or significant persons	They have lost a partner, friends, children, relationships or close individuals with whom they used to share their life.
Illness (own or of close ones)	They suffer from chronic illnesses (diabetes, heart disease), mental health issues (depression or anxiety), cancer, etc., or require prolonged care.
Health	They have mobility problems, weight gain or loss, dizziness, pain, etc.
Later life	They express general complaints about later life, such as: "Life has no meaning", "Why live like this?", "Every day gets harder", "I've seen it all", "What's left for me, what a future!"

EVALUATION OF SOLITUDE (UNWANTED)

UCLA 3-item scale (*UCLA 3-item loneliness scale*, Hughes et al., 2004)

	HARDLY EVER	SOME OF THE TIME	OFTEN
How often do you feel you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

Scoring: from 2 to 5, not lonely; 6 or more, lonely.

TEN PRINCIPLES OF LONELINESS

1. I do not always have someone to talk to about my daily problems.
2. I miss having a true close friend.
3. Sometimes I feel isolated from others.
4. If I have a problem, I have no-one to turn to.
5. I miss having people I can just be with.
6. Sometimes I feel like I lack people in my life.
7. I have no-one to confide in.
8. I miss having people around.
9. I feel abandoned sometimes.
10. I think my life is unattractive; I would like to have a life plan that gives meaning to my life.

APPENDIX 13.

Consent form template

The **Always Supported programme (hereinafter, the programme)** is a personalised support initiative aimed at enhancing the well-being and empowerment of older adults participating in it, while also fostering the development of personal connections and trusted social relationships.

You are participating in the programme voluntarily. Therefore, we kindly ask you to complete the form provided below and carefully read the section on **Personal data processing**, located at the end of this information sheet and on its reverse side. If there is anything you do not understand, please ask the contact person to clarify any doubts you may have.

REGISTRATION FORM FOR THE ALWAYS SUPPORTED PROGRAMME

ID *(platform code to be completed by the professional team)*: .....

Full name *(in capital letters)*: .....

Contact telephone numbe: .....

I, ... ,
have read and understood the data processing described in this document and confirm that I am providing only accurate and up-to-date personal information.

SIGNATURE:

....., ... of ..... of 20.....

PERSONAL DATA PROCESSING

The "la Caixa" Foundation will process your personal data for the purpose of managing your participation in the Always Supported programme and providing you with a personalised action plan, as well as to comply with the entity's legal obligations. For more information about the processing of your data and how to exercise your rights, please refer to the reverse side of this document.

DETAILED INFORMATION ON THE PROCESSING OF YOUR PERSONAL DATA

Who is responsible for the programme?

The organisation responsible for the data you provide is the "la Caixa" Foundation, with registered address at Plaza de Weyler, 3, 07001 Palma (Balearic Islands).

What does participation in the Always Supported programme involve?

To better understand you and your situation, and to provide you with the most suitable resources and those that may interest you, a personal interview will be conducted with you at the start of the programme. This interview will allow you and the designated professional to develop and agree on an action plan that will help you better manage your situation and connect with others. The diagnosis obtained from the interview will be shared with you. To adapt the action plan as needed, the interview will be repeated periodically.

What type of personal data will we process?

During the interviews, we will request your identification data and ask about your family and social relationships, daily habits, leisure activities and free time. Additionally, more sensitive or special data will be processed, such as your level of well-being, degree of loneliness and your state of health.

Why do we need to use your data?

Your data will be used to provide you with an action plan and resources tailored to your needs, with the aim of assessing the increase in your well-being. Additionally, the data will be processed to evaluate the impact and progress of the programme.

The "la Caixa" Foundation is authorised to process your personal data because such processing is necessary to fulfil the agreement between you and our organisation, to meet your requests and to enable our organisation to comply with its rights and obligations in the area of social protection. These obligations arise from the programme and align with our organisation's mission to promote and develop social and welfare initiatives.

Please note that the data provided will not be used to make any automated decisions. In other words, no decisions will be made using solely technological means without human involvement.

To whom will your data be disclosed?

The "la Caixa" Foundation will not disclose your data to third parties without your prior consent, except where necessary to comply with legal obligations to Spanish and European public administrations and supervisory authorities. In this regard, your data may be shared with public or private social entities, emergency services, police bodies or non-governmental organisations participating in the programme, as such sharing is necessary for the management of the programme's benefits.

Our organisation has engaged the services of technology providers located in countries outside the European Union ("third countries") that do not have data protection regulations equivalent to those of the EU. These services are contracted in compliance with all requirements established by data protection regulations, and the necessary guarantees and safeguards are applied to preserve your privacy. Sensitive or special personal data is not subject to international transfer to third countries. For more information about the privacy safeguards in place, you may contact the Data Protection Officer, using the postal or email addresses provided.

How long will your data be stored?

The period for which your data will be stored may vary depending on specific criteria, such as your place of residence or the location where your relationship with our organisation is formalised.

In any case, your personal data will be stored as long as your relationship with the "la Caixa" Foundation continues or until you exercise certain rights you hold. If any of these circumstances occur, your personal data will be kept for the applicable legal retention periods, in accordance with relevant regulations. During this time, the data will only be processed to demonstrate compliance with our legal or contractual obligations. Once these periods have expired, the data will be deleted or anonymised, ensuring that you can no longer be identified.

For more information about the specific retention period for your personal data, you can contact our Data Protection Officer at the postal or email addresses provided.

Where can you exercise your rights and lodge a complaint?

For more information about the safeguards for your privacy, to withdraw your consent or to exercise your rights of access, rectification, erasure and portability of your data, as well as the limitation or objection to its processing, you can contact the Data Protection Officer at Avenida Diagonal, 621-629, 08028 Barcelona, or via the following email address: *dpd@fundacionlacaixa.org*.

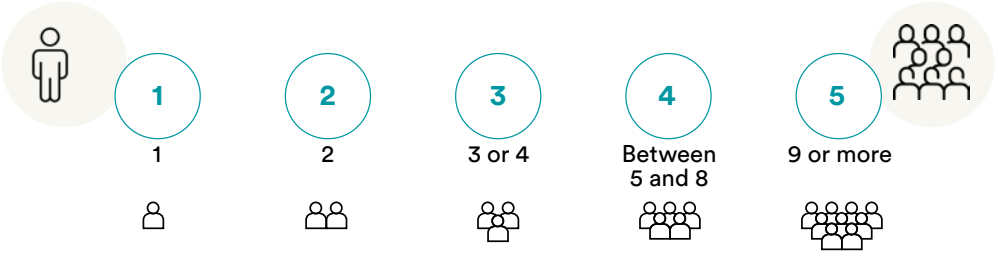
In addition, you may file a complaint related to data processing with the Spanish Data Protection Agency, through its electronic headquarters or postal address.

APPENDIX 14.

Evaluation protocol: evaluation support

1.
BLOCK 3: SOCIAL NETWORK AND SOCIAL SUPPORT

3.1. Social network: Lubben scale



3.2. Social support: Duke-UNC questionnaire

2.
BLOCK 4: ASSESSMENT OF LONELINESS AND OTHER SUBJECTIVE ASPECTS

4.1. Losses and transitions

Questions 1 and 2

4.2. Perceived health and quality of life

Questions 3 and 4

4.3. De Jong Gierveld Loneliness Scale

4.3.1. Social loneliness

Questions:
1, 4, 7, 8 and 11: De Jong Gierveld

4.3.2. Emotional loneliness

Questions:
2, 3, 5, 6, 9 and 10: De Jong Gierveld

4.4. Existential loneliness scale: four-question questionnaire

Questions:
2 and 3: existential loneliness

Questions:
1 and 4: existential loneliness

4.6. Strategies for coping with loneliness

1. If I feel lonely, I accept my situation, resign myself and do nothing.

2. If I feel lonely, I reflect and try to change how I think.

3. If I feel lonely, I seek out people to spend time with.

4. If I feel lonely, I join activities.

5. If I feel lonely, I try to change how I feel and at least avoid being sad.

6. I avoid feeling lonely; I don't even want to think or talk about my loneliness.

7. If I feel lonely, I ask for help.

8. If I feel lonely, I distract myself with my hobbies and make an effort to keep up with my routine.

9. I feel comfortable with myself; I enjoy being alone.

10. I do many things alone (reading, walking, household tasks...) and feel good about it.

4.7. Purpose in life

1. Sometimes I feel...

2. Life seems to me to be...

3. In life...

4. Each day is...

5. My life is...

6. When I think about my life...

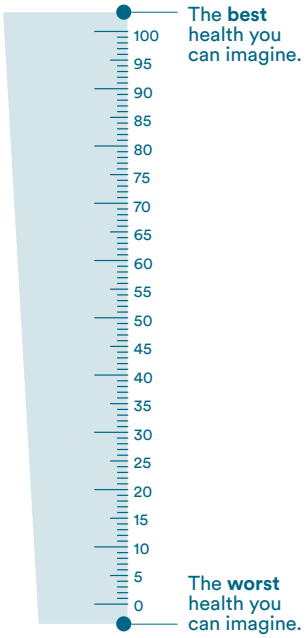
7. I have discovered that...

3.
BLOCK 5: HEALTH

5.2. Health-related quality of life: EQ-5D-5L

a) We would like to know how good or bad your health is TODAY.

Mark with an X on the scale to indicate what your health status is TODAY.



APPENDIX 15.

Objectives and action plan

MR/MS:
DATE:

SIGNATURE:

OBJECTIVE 1:				
WHAT AM I GOING TO DO?	WHEN?	WHY?	HAVE I ACHIEVED MY OBJECTIVES?	HOW DID I FEEL?

OBJECTIVE 2:				
WHAT AM I GOING TO DO?	WHEN?	WHY?	HAVE I ACHIEVED MY OBJECTIVES?	HOW DID I FEEL?

OBJECTIVE 3:				
WHAT AM I GOING TO DO?	WHEN?	WHY?	HAVE I ACHIEVED MY OBJECTIVES?	HOW DID I FEEL?

APPENDIX 16.

Weekly schedule

PLAN

MR/MS:

FROM DD/MM/YY TO DD/MM/YY

	Morning	Afternoon	Night
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

APPENDIX 17.

Criteria for discharge from the programme

To determine whether individuals supported under the loneliness and preventive profiles can be discharged, the Always Supported team will make this decision in agreement with the individual and taking into account the results of the various loneliness scales and periodic evaluations.

Different scenarios may arise:

» Most of the objectives and priorities of the action plan have been achieved and the individual has sufficient tools to manage their loneliness.

» It is considered that the individual's situation regarding their perception of loneliness is not improving; however, they have developed personal tools to manage their loneliness due to indirect improvements in other areas of intervention:
  - Greater sense of purpose.
  - Expanded social network.
  - Improvements in the quality of relationships measured by the Lubben scale (closeness or support).
  - Enhancements in the sense of purpose or meaning associated with relationships.
  - Other improvements identified during evaluations.

» The individual has personal tools for managing their loneliness for other reasons, which must be justified with evidence of the work carried out.

» The individual has achieved improvements from their initial situation but is no longer progressing. The programme is unable to provide any further measurable or perceived improvements (based on the team's technical assessment) and all possible strategies have been exhausted.

The opportunities introduced in the programme with the preventive profile and the network profile also support decision-making in these different scenarios. In many cases, the decision will not be to discharge the individual from the programme, but rather to adjust their profile. For example, the individual may move from the loneliness profile to the preventive profile or the network profile, or from the preventive profile to the loneliness profile or the network profile, and so on.

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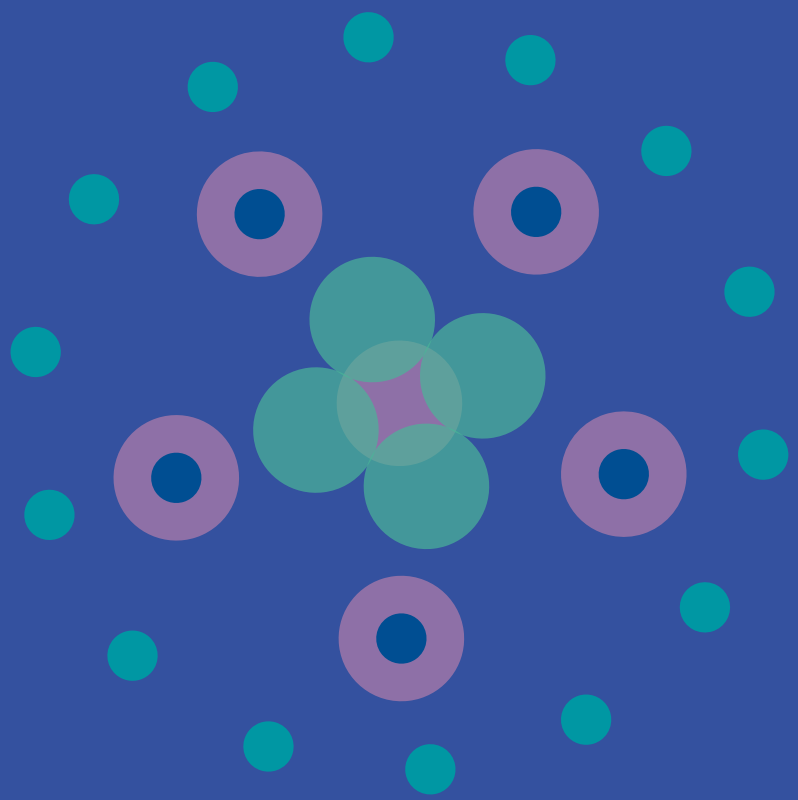

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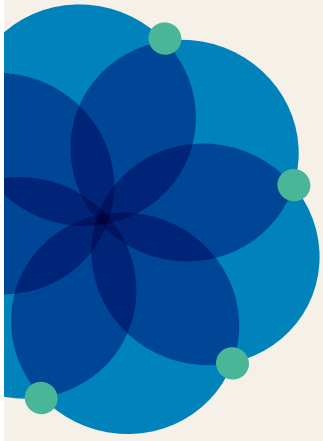

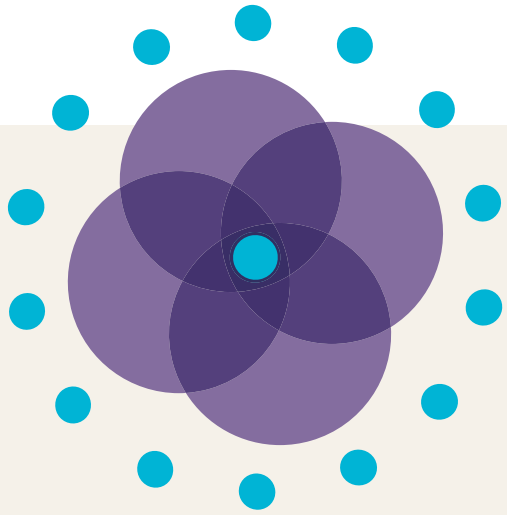

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