Brendoncare Clubs
Social Isolation: A Research Study

"Helping lonely people make friends...."

(Participant attending a Brendoncare Friendship Club, Dorset)

Education and Research Steering Group
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The research team would like to express their heartfelt thanks and gratitude to the members, volunteers and staff of the Brendoncare Friendship Clubs who not only gave us their time but shared their personal experiences and narratives so freely. During the reflexive and reflective processes inherent within this study, we were often moved by the sincerity and humility of what we felt privileged to read, hear and see. Thank you.

Overview of Findings

The Brendoncare Friendship Clubs successfully address those factors contributing to loneliness and isolation in the older adult. These clubs tackle loneliness by addressing social and emotional isolation, two recognised dimensions of loneliness. Brendoncare achieves this by facilitating older adults to establish or maintain satisfying interpersonal relationships. This mitigates against both loneliness and social isolation occurring in the first place, or further impacting on those individuals already affected, with the consequential negative impacts on health. The intervention offered provides sustainable social and emotional support through group activities and interaction (as well as individual support and attention) and includes the provision of a wide variety of information including signposting to relevant health/social care/leisure services.

For many club members who took part in this study, the positive impacts on health and well-being are described as being sustained long-term with the recognition also that the relationships established at the clubs extend beyond the actual club meetings themselves, thus further expanding their social networks.

The data from a plethora of research studies conducted during the last decade has confirmed that this type of service, and its style of delivery, has been identified as an effective intervention for seeking to reduce social isolation and enhance social support. Indeed, a key finding from this report confirms that of others which suggest that "belonging to a social network makes people cared for, esteemed and valued and this has a powerful effect on health" (Surf Coast Shire 2009).

The table below summarises the impacts of the Brendoncare Friendship Clubs

Table 1.

Tackles	Reaches	Enables	Enhances	Also Provides
Social isolation and loneliness in the older age group whether this experience is transient	Older people particularly at risk of social isolation, including those in	Older people to maintain or improve their overall health wellbeing as independently as	Quality of life through social participation. (Bowling 2005,	Opportunities for volunteers, regardless of age, to help

(and situational eg. due to relocation or bereavement) or chronic with persistently limited poor quality social networks.	deprived areas.	possible by assisting older people to establish or maintain social networks and friends within their local community.	Bowling and Gabriel 2007 cited Cattan et al 2011)	others in their local community.
Social exclusion in the older age group by involving them in a variety of social networks and providing transport.				Access to relevant information and advice for older people.
Self-stigma attached to the terms “socially isolated” and “lonely” by offering opportunities for social engagement and activities that address, but do not overtly relate to these labels.				Opportunities for older people to help themselves and each other thus developing enhancing self esteem and self efficacy.

1. Introduction

This report summarises the collaborative research project which sought to investigate the impacts of an intervention seeking to reduce social isolation in the older age group. The (predominantly qualitative) participatory approach adopted collected the experiences and narratives of the participants in order to explore the phenomenon of social isolation and to understand how its negative impacts can be minimised and possibly replaced with positive benefits. This three year study was a joint venture between Bournemouth University and Brendoncare, a large established charity providing care and promoting health and wellbeing for older people through its specialised homes and friendship clubs in the community.

2. Background to the Study

The United Kingdom has a total population of 60.2 million (Office of National Statistics 2006). This population is steadily aging, indeed the proportion of people aged 65 and over has already risen to 16%, with an increasing proportion of those aged over 85, to 12% in 2005.

The universal process of ageing sees the individual progressively adapting to changing life and personal circumstances e.g. retirement, bereavement, or relocation (often into needs identified accommodation). Concomitantly, emergent functional health losses within the individual may also require adaptation , e.g. impaired cognition (impacts of dementias/ stroke) or altered mobility (Hammill 2009). It is evolving changes such as these that can lead the individual to experience loneliness or social isolation as one may need to modify, or even surrender, life-long activities, that previously ensured meaningful engagement with others.

Wenger et al (1996), and Andersson (1998) highlight that the stress experienced due to social isolation/loneliness may cause poor health or, indeed, poor health in itself may cause social isolation/loneliness. Furthermore, Stanley et al (2010) suggest that the ensuing negative health impacts of social isolation and loneliness are now a global concern, especially for developed countries, as it is in those areas the number of people aged over 65 will continue to increase (Stanley et al 2010, p. 407). From their research, Findlay (2003) and Cattan et al (2005) conclude that there was little reliable evidence as to what interventions targeting social isolation/ loneliness were actually successful.

In response to the above, Brendoncare established a network of over 70 "Friendship Clubs" in the SW of England (essentially social clubs devoted to giving older people the opportunity to meet new friends, participate in club outings and enjoy a variety of speakers/entertainers) and in 2008, commissioned Bournemouth University to collaborate on a 3yr, research study working in partnership with ten friendship clubs based in Hampshire and Dorset to focus on the impact that the Brendoncare Friendship Clubs may have on the experience of social isolation,

The core research team commissioned (part time - one day a week) consisted of an experienced qualitative research fellow as the lead investigator and a lecturer/researcher to undertake the study, both experienced in participatory qualitative research enquiry methods.

Prior to the study beginning, initial informal discussions between key stakeholders and the research team took place. It was agreed at the outset that the club managers, members and volunteers were to be involved meaningfully at every stage of the project, this included informing the development, as well as the process, of the study. This was to ensure that there was shared power between the research team and stakeholders, this was key for the research team who shared the opinion of Nelson et al 1998, that the "active participation of stakeholders, those whose lives are affected by the issue being studied, [is necessary] in all phases of research for the purpose of producing useful results to make positive changes' (Nelson et al 1998 cited Fenge and Jones 2011 p. 5). The Stakeholder Strategy devised in the methodological development stages of the study reflects this, and is summarised in Table 3 Appendix A.

With this in mind, the research team felt it necessary to understand the concept of social isolation from the older person's perspective as well as gaining insight into how it may be addressed. A qualitative approach to the study was therefore agreed as a possible approach.

3. Literature Review

3:1 Search Strategy

Prior to commencing the study, the research team undertook a literature review to establish a theoretical framework for the project.

Academic texts, and books provided background information and explanations of the broad topic areas. From this, the research team identified the issues to be addressed as specifically as possible, then isolated key words and terms from the key concepts as described below Table 2 in order to undertake a search of the literature.

Table 2. Summary of Key Search Terms

Concept 1	Concept 2	Concept 3
Older Adult	Loneliness or Social Isolation	Quality of life and Well-being
Elderly People	Impacts of Social Isolation or Loneliness	Health and Well-being
Elderly person	Social participation or community participation	
Community participation		
Elderly	Community Isolation	
Older adult	Social Environment	
Elderly adult	Social involvement or community involvement	
Aged or age*	Social Separation	
Senior	Social Estrangement	
Advanced years		
Old*		
Elder*		

Peer reviewed and non peer-reviewed material was explored as were media reports, published and unpublished dissertations, conference proceedings and literature reviews. Primary rather than secondary sources were explored using predominantly peer reviewed journals. The time span for searching was from 1998 to 2008. Large electronic databases eg. Wiley Online and Sciencedirect were accessed using the Athens Access Management System providing a wide range of e-resources eg through CINAHL, Cochrane Library, BNI, ASSIA, Medline, NRR, Ageinfo, Psycarticles, Psychinfo, Internurse, New issues of the relevant peer reviewed journals were continually reviewed throughout the project using Alerting and Current Awareness Services [ACAS] eg. ZETOC, as part of the strategy to remain abreast of current research in the area.

The research team initially reviewed the literature appertaining to "Quality of Life and the Older Adult" and found that the term itself includes a broad range of life areas, with little consensus about the definition of the term itself (Victor et al 2000). However, it would seem that for the older adult, quality of life is largely influenced by their ability to maintain autonomy and independence (WHO 2002). The literature clearly demonstrated also, that social and family relationships are embedded within the definition of a 'good quality of life' for older adults.

It was noted from the literature search, that there was an apparent lack of evidence as to the older person's perspective on loneliness and/or social isolation. Indeed, Stanley et al (2010) not only highlight the paucity of research seeking to generate an understanding of the loneliness phenomena from the older person's perspective, but that the interchangeable use of the terms social isolation and loneliness exemplifies the lack of agreed definitions for both within the literature.

A concept contrary to social isolation is social support (Fioto 2002). The literature search yielded two main approaches when investigating social support; qualitative and quantitative approaches as outlined in Figure 1 below.

Figure 1. Investigative Approaches to Social Support

(Adapted from Bondevik 1998)

3:2 Literature Review: Concepts

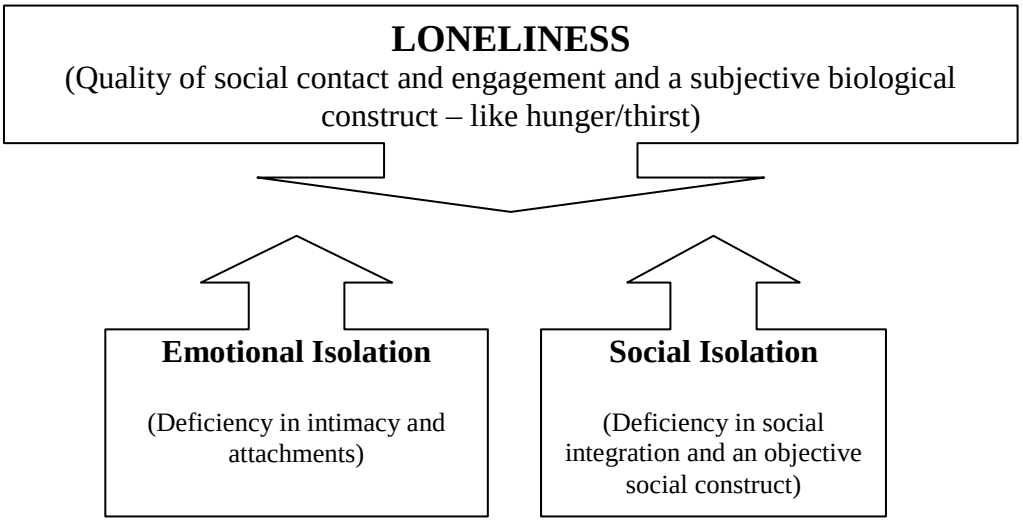
3:2: 1. Loneliness and Social Isolation

The terms 'loneliness', 'social isolation' and 'living alone' are used interchangeably within the literature, although they are three distinct (but linked) concepts. 'Living alone' is the most straightforward to define and measure in objective terms. 'Loneliness' refers to how individuals evaluate their level and quality of social contact and

engagement. De Jong-Gierveld (1987) suggests that loneliness can be described as negatively perceived social isolation.

Emotional isolation and social isolation can be viewed as two distinct dimensions of loneliness in older people (van-Baarsen et al 2001). Vincenzi and Grabosky (1987) define social isolation as a deficiency in social integration and emotional isolation as a deficiency in intimacy and attachments. Figure 1 below draws together these concepts.

Figure 1 Dimensions of Loneliness and Social Isolation



(Adapted from the work of van-Baarsen et al (2001), Vincenzi and Grabosky (1987)

3:2:2 Social Isolation

Although often discussed in the same context as loneliness, *social isolation* differs in that it concerns an objective description of a situation where there is an absence of relationships with other people. Social isolation is usually regarded as an objective state where an individual has minimal contact with others and/or a generally low level of involvement in community life. A person with a small number of meaningful relationships is said to be socially isolated but loneliness is not directly connected to social isolation. Socially isolated people may not be lonely and vice versa.

Social isolation is usually *measured* by the number, type and duration of contacts between individuals and the wider social environment ie. measuring an individual's social network. Other network-related indicators such as living arrangements (eg, living alone), availability of a confidant, and community involvement are sometimes included (Boldy 2008). Conceptualising in this way and from the figure above, it can be seen that loneliness and isolation are not the same but clearly linked, therefore, to be

successful in tackling loneliness, social isolation needs to be addressed. (Age UK 2010, p. 3)

3:3:3 Concept Summary and Methodological Considerations

In reviewing the theoretical concepts raised by the literature, the research team noted the strong qualitative theme of enquiry linking the concepts of loneliness, social isolation and social support. They concluded that a predominantly qualitative approach for the proposed study would facilitate further exploration of emotional isolation (intimacy and attachments), plus social isolation in terms of integration as well as exploring the "quality" dimension of social contacts and engagement. Furthermore, Victor (2011) suggests that "Qualitative studies, or those that link survey data with qualitative data, are likely to be of greater benefit in shaping the agenda for loneliness research in the years ahead. Such studies are also especially helpful in terms of their potential to influence on policy and practice" (Victor 2011, p.34)

It was also decided that a brief quantitative (numerical/structural) exploration of the level and number of social contacts and networks would also allow for consideration of the social support concept and the address the more general view of social isolation.

By drawing together the concepts in this way to identify the research method, the research team felt that the subsequent findings of the study may then ascertain factors not only contributing to social isolation and how to mitigate against them, but also recognise those positive influences to enhance social support.

3: 4. Health Impacts of Social Isolation/Social Involvement

As has been well documented elsewhere (Cornwell and Waite 2009), research indicates that social isolation and loneliness negatively affect both physical and mental health, particularly among older adults (House 2001; Tomaka, Thompson, and Palacios 2006). These negative health effects include all-cause mortality, morbidity, and cardiovascular disease (House 2001). Indeed the effects of social isolation and loneliness have been compared in magnitude to the damaging health effects of smoking cigarettes and other major health risks (House 2001).

Furthermore, a study by Wilson et al (2007) report that the risk for developing Alzheimer's disease was substantially increased in those older individuals who were lonely/socially isolated compared with those who were not.

Research has also indicated the positive correlation between social isolation and loneliness with particular health issues such as alcoholism, chronic physical health conditions, anxiety, depression, suicide and suicidal ideation. (Rokach 1998; Killeen 1998; Ellaway et al 1999; Hagerty and Williams 1999; Cohen 2000; Tiikkainen and Heikkinen 2005; Barg et al 2006; Murphy 2006; cited Stanley et al 2010). The social environment is now considered to be as important as genetic or biological factors on the positive or negative experience of aging (Cacciopo 2002). Brownie and Horstmanhof (2011) confirm, a lack or loss of companionship and an inability to integrate into the social environment are critical correlates of loneliness and social isolation (Brownie and Horstmanhof 2011, p. 1) with Brunner (1997) suggesting that socially isolated people are likely to die at two to three times the rate of people with a network of social relationships and sources of emotional support.

Conversely, the physiological effects of social involvement and the maintenance of social ties can increase immune function (Cohen et al. 1997; Pressman and Cohen 2005) and reduce cardiovascular and neuroendocrine damage related to exposure to stress (Seeman et al. 1994). Furthermore, being embedded within a social network is thought to promote health-enhancing behaviours (Kinney et al. 2005) and to increase sense of control and self-esteem (Cornman et al. 2003). According to Glass et al (1999) social and productive activities are as effective as fitness activities in lowering the risk of death, and enhanced social activities may help to increase the quality and length of life (Glass et al 1999, p.482). In 2007, WHO published a report citing that participation in leisure, social, cultural and spiritual activities in the community, not only facilitates older people to maintain self esteem and thus improve their health and well-being, but also creates or enhances supportive and caring relationships by fostering social integration (WHO 2007).

Machielse (2006) reports that social relationships are important throughout the lifespan, as people who are embedded in a network of personal relationships experience a higher level of well-being than those who are socially isolated, plus they also tend to be healthier . The identified factors that appear to be important in relation to this are:

1. Identity and self respect: a personal network offers people a social identity.
2. Social integration: personal involvement and feelings of security.
3. Social support: practical and emotional support, indeed, for the older age groups, their personal and social functioning depends largely on the social support they can get.

Fioto (2002) summarises thus; " Social isolation is a concept that greatly affects a person's sense of well being and increases the risk of negative alterations in emotional and physical health" (Fioto 2002, p.53) Studies have shown that it is not only more common in the elderly, but that this age group typically have increased difficulty coping with its numerous effects. (Fioto 2002)

4. Social Isolation - The UK/South West Perspective

4:1 SW Population Overview

In the South West of the UK, there is the oldest population structure of all the English regions (Hennessey and Giarchi 2006, p.1) and projections suggest that this trend will continue, one third of the region's population will be aged 60 and over in 2028 compared to under a quarter currently. This increase in the ageing population, similar to the UK generally, reflects long life expectancy, falling conception rates, the 'baby boom' generation reaching retirement age and net inward migration. It is anticipated that by 2028, older people will account for the majority (87%) of the additional residents living in the SW (Hennessey and Giarchi 2006, p.1).

Although older adults living in the South West are healthier compared to others living in England, this growing older population still presents many challenges for the South West eg. the population aged over 85 years reporting a limiting long-term illness is projected to increase to over 160,000, and those suffering from dementia to increase to 70,000 by 2030 (SWO 2011).

4:2 Societal Factors Contributing to Social Isolation

Over half of all people aged 75 and over in the UK live alone (ONS 2010) and it has been suggested that the number of people aged over 65 who are often, or always, lonely totals over 1 million (Age Concern and Help the Aged, 2009). More than 180,000 people in the UK over 65 say they have gone for an entire week without speaking to

friends, neighbours or family and a million older people spent Christmas Day alone in 2006 (ICM 2007). 17% of older people make contact with family, friends and neighbours less than once a week, with 11% in contact less than once a month (Victor et al, 2000). Further research also suggests that 12 per cent of older people feel confined to their own home (GfK/NOP 2006). It is also claimed that many older people are dying alone, without family or friends willing or able to pay for their burial (The Sunday Times 2009).

In response to the global economic downturn, the sharp decline in local services has impacted socially on the older population with large numbers of local post offices, libraries, shops and public houses closing in recent years alongside reduced availability or access to public transport, all a trend set to continue. In such communities where resources are reduced and/or limited there is an increased risk of social exclusion for the older adult. ARGEH (2005) suggests that this could be seen as discrimination of the older population as their needs are not taken into account when developing or evaluating services (eg. transport) thus failing to address their needs. ARGEH (2005) suggest "older people experience prejudice, discrimination and disadvantage because of their age" (ARGEH 2005, p.3), furthermore, those who have already been disadvantaged or discriminated against in earlier life experience greater exclusion eg. black and ethnic minorities, gay and lesbian older people.

It is well recognised that social exclusion is one of the (social) determinants for most diseases, deaths, and health inequalities between and within countries (WHO 2004). The Social Exclusion Unit (2006) highlights that nearly half the older population experience social exclusion to some degree. Factors further contributing to exclusion include those aged 80 or over , being female and living alone with no living children, suffering poor physical/mental health (especially depression), lacking access to a private car and never using public transport, living in rented accommodation and with benefits as a main source of income as well as lacking access to a telephone.

Further societal transitions contribute to social isolation eg. Families dispersing as children and siblings move away from their parents, this mobility seeing local area demographics transforming over short periods of time as people move in and out of the area, often into and out of the country. Neighbourhoods can thus change rapidly impeding the development of a sense of community cohesion and belonging, recognised as important in addressing social isolation. Scharf et al (2002) suggest that as cities are being developed for the younger population and concurrently anti-social

behaviour/crime is seeming to increase, this serves to alienate the older population further. Consider also the oldest old, older people living on low income, experiencing poor physical or mental health, living in isolated rural areas or deprived urban communities and one can see how material, societal, and environmental factors can also contribute to the experience of social isolation. As with other socially excluded groups, stigma and discrimination play a part, for the older adult this directly takes the form of ageism – as in, for example, society is perceived as no longer actively seeking their views or involving them meaningfully in the workforce, paid or otherwise (Age UK 2011, p. 17)

The digital revolution, which could be seen as a means by which older people can remain in contact with each other, has left many of them behind. Research suggests that the majority (60 per cent) of those aged 65 and over have never *used* the internet with adults aged 65 and over made up almost two-thirds (64 per cent) of those individuals who have never *accessed* the Internet. (ONS 2010)

5. Research Design

5:1 Identifying the Research Objectives

As stated previously, the research team were keen to involve the older age group within this study from the outset. Therefore, following the literature review, the researcher began an initial introductory phase of the study, whereby the 10 friendship clubs identified for inclusion in the study were visited to build meaningful and effective relationships with the club members and staff as well as informing them about the study.

This also allowed the researcher to learn about the clubs and their underlying philosophy from the perspective of the older person, either as an attendee (member), staff member, or volunteer. The researcher was also able to discuss the findings from the literature review with the older people to gain their views on the theoretical perspectives and the research team's interpretation of them.

Input was also secured at this point from the clubs as to involvement in the development of the participant information sheet and consent form.

Following this introductory phase of the study and reflection on the findings from the literature review, the research team clarified the aims of the study with the identified project lead from the Brendoncare charity as:

1. To explore and describe the phenomenon of "social isolation" as experienced by those affected.
2. To explore and describe the reasons as to why attendees come to the clubs/volunteer, their experience of barriers and expectations as well as the practical pathways involved
3. To explore perceptions of the impact of attending the clubs Eg. impacts on well being/mental-physical health *as described by those who take part* in the study
4. To identify measures that may help reduce the occurrence of social isolation from a older person's perspective.
5. To meaningfully involve attendees, volunteers, and carers in the research study itself.

5:2 Propositions for Study Methodology

Following clarifying the research objectives, the research team reflected on the the literature review findings and on the data collected through the informal discussions and general participation in the club activities during the introductory phase of the study., These discussions informed the methodological development of the study by identifying the following key points.

1. Considerations to inform the study design to include the existing literature on this area, the nature of the responses (data) collected during the introductory phase and the importance of the emerging reflexive, `iterative`, process of being involved as researchers in this study.
2. A participatory approach to the research would enable club attendees, volunteers and staff to be meaningfully involved with the study as it progresses.
3. The use of existing quantitative data from the Brendoncare Charity would provide `context` to the study eg. details about the Brendoncare charity itself, the number/location of clubs, and the number of attendees and how they are `referred` or learn about the clubs and whether they attend other clubs/socialise otherwise.
4. The need to ensure collection captures not only the `amount` or `degree` of impact on social isolation which the clubs may have for those who attend, but also the narratives or stories` which offer the details of their experiences for analysis and learning from.

5.3 Developing the methodological approach

The research team felt intuitively that qualitative inquiry would embrace both research objectives and key points identified above.

Denzin and Lincoln (2005) broadly describe qualitative research as a "situated activity that locates the observer in the world" (Denzin and Lincoln 2005, p. 3). The researcher reflecting on the project discussions from the outset and from her experiences during the introductory phase of the study felt embraced into the older persons' lifeworld experience as many personal narratives were shared thus allowing the development of an understanding of social isolation far deeper than that gained from the numerical data analysis/quantitative approaches of previous research found to be dominant in the literature review. Furthermore, Denzin and Lincoln (2005) also state "[qualitative research] consists of a set of interpretive, material practices that make the world visible.....they turn the world into a series of representations, including field notes,

interviews, conversations, photographs, recordings and memos to self." (Denzin and Lincoln 2005, p. 3). They go on to summarise thus "qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them." (Denzin and Lincoln 2005, p. 3). It was felt this would enable the research team to achieve the aims of the study, particularly in exploring the phenomenon of social isolation from the older person's perspective.

Denzin and Lincoln (2005) suggest that qualitative research embraces the collection of a variety of empirical materials including eg. Case study, personal experience, introspection, life story, interview, interactional and observational texts "...that describe routine and problematic moments and meanings in individuals' lives....Accordingly qualitative researchers deploy a wide range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand." (Denzin and Lincoln 2005, pp3-4).

The research team therefore concluded that this interpretative paradigm would indeed be an appropriate philosophical approach for this study.

5:4 Methods and Methodology

The literature review had suggested that research on older people is rarely participative and participants may present to the survey interviewer only their 'public account'; that is the account that participants assume the interviewer wants to hear or which is constructed with the public accounts of others in mind. This may reflect a variety of factors including: the insensitivity of the measurement tools, the social 'undesirability' of admitting loneliness/social isolation, or differing interpretations of loneliness/social isolation. Indeed, De Jong-Gierveld (cited Victor 2011) suggests loneliness has a negative connotation and hence people tend to deny being lonely (Victor 2011, p. 45.)

It was decided therefore that to achieve the aims of the study and address the overarching themes a qualitative descriptive exploratory approach through active participation would be appropriate, particularly to ensure the voices of the older people were heard. This would also allow the researcher to be a participant as well as a researcher which may mitigate against the bias described above.

As Qureshi (2004 cited Fenge and Jones 2011) suggests, qualitative approaches do not necessarily ensure giving a voice to unheard groups. The research team felt therefore that in order to address this, working with data collected mainly through interviews,

focus groups and researcher observation and participation would be appropriate. This within- method triangulation strategy is outlined in the methods table, Table 4 in the appendix.

Kitzinger (1995) describes focus groups as a form of group interviews that benefit from the intergroup interaction and communication. This predominant method was selected as it was viewed useful for exploring the older persons' knowledge and experiences of social isolation extrapolating not only what their thoughts are, but how they think and why they think that way (Kitzinger 1995). The general benefits of using the focus group method for this study included the ability to include participants with difficulties in reading and writing (therefore would have difficulties with questionnaire completion), and those participants who may be reluctant to participate in a perceived more formal 1:1 situation but happy to take part with friends and peers. The research team were aware that a suggested added benefit to this method may lie in the researcher being able to capture (through thematic analysis including the observed use of humour, consensus and dissent) further dimensions of knowledge eg. cultural values, norms and attitudes not available through direct questioning and answering when using a more closed, formal interview methodology. (Kitzinger 1995).

As acknowledged elsewhere, research team recognised that much was to be gained by the researcher immersing herself in the clubs and club activities as far as possible given the remit of the study eg. participant observation, context, field notes and reflections. It is of note that the clubs and the members themselves were very willing to facilitate this and involve the researcher as an "honorary member". This enabled the participatory approach to include the researcher and allow immersion to take place as far as was practicable.

5:5 Research Tools

Following the introductory phase of the study and the underpinning methodology, the research team next considered the focus group framework to be used within the focus groups embedding the new knowledge gained from the initial discussion with the older people themselves.

The literature review had revealed that many of the tools employed within previous studies addressing social isolation were originally used as *measures* of "loneliness", and as such, were often predominantly quantitative in nature. Eg. OARS Scale, Gerda

Fillenbaum's Scale, Anderson's Family and Friendship Contact Scale. Chappell et al (1989) however suggest that qualitative measures which specifically examine for example companions and confidants, and not quantitative measures, are more useful when exploring issues related to social isolation and well being. Furthermore, the literature suggested that the use of direct questions including the word 'loneliness' is likely to result in underreporting and for that reason the use of a tool without references to loneliness is recommended (Pinquart and Sörensen, 2001).

The focus group framework (guiding *open* questions) developed therefore sought rich description of the older persons' perception of "social isolation", and in particular to identify what the impact on this the attendance at the clubs may have either generally or specifically in terms of well-being and also whether attendance at the clubs had widened their social network generally.

Open questions were chosen also to allow the participants to answer in their own words and allow for "richer and fuller information" (Polit et al 2001, p.267). It was also felt to be key for this study to ensure that the moderator (researcher) use open ended questions to explore the issue of social isolation, with the participants identifying the important dimensions *in their own words* and using the comments and feedback to and from each other, to consider and articulate further. The introductory phase of the study confirmed that the participants were articulate and willing to answer questions at length. Less specific open questions sought to explore the reasons as to why attendees come to the clubs/volunteer, their experience of barriers and expectations, as well as the practical pathways involved.

The final open question asked participants to identify measures that may help reduce the occurrence of social isolation from a older person's perspective.

The data collected was to be recorded, transcribed and analysed by the research team. The limit of 10 participants for a 1 hr focus group was felt appropriate to allow participants to discuss the questions. It was decided however as the use of narrative was important for the study, that if, within this hour, participants chose to expand in depth on some of the issues raised at the expense of not discussing the other questions this was acceptable.

It was also decided that quantitative and demographic data was to be sought at the beginning of the focus group ie. The participants offer age group, gender, whether they

lived alone or not, and whether the friendship club was their only source of social activity – and if not, what the other sources were.

In summary, the choice of methods and developed tools sought to enable effective and efficient data analysis to provide answers/insights into the original premise of the research study. Table 5 in the appendix summarises the questions.

5:6 Sampling

The sampling frame to be used for the project was drawn from those members aged approximately 65+ who attended the Brendoncare Friendship Clubs in Dorset and Hampshire. A list of the 10 clubs for inclusion in the study was negotiated (including discussions as to issues of rigour, confidentiality, and inclusiveness) between the Brendoncare Clubs Manager and the research team to ensure that the 10 clubs selected were typical cases ie. Representative of all the clubs and their members, and none were in any way "atypical". This case study samples selected ensured generalisability of the findings across the organisation as a whole eg. that there was a representative broad demographic mixture addressing age, gender, socioeconomic groups and urban/rural post codes as well as overall membership size of the club.

The research team were aware that each of the selected clubs were information-rich sites which would provide, through purposive sampling, information-rich participants described as "..those from which one can learn a great deal about issues of central importance to the purpose of the enquiry" (Patton 2002, p.230).

The recruitment of the individual participants was to be facilitated by the club leaders issuing a prompt to those attending the club the week before, reminding them about the study and to consider taking part, and also to ensure that those felt to be vulnerable for the purposes of this research study would not be encouraged to participate eg. those for whom their mental or physical health meant that informed consent would be difficult to ascertain.

6. Data collection

Ethical approval was sought and granted by the university prior to research activity beginning. A pilot of the study was carried out 1 month before the focus groups began.

The researcher negotiated a date to attend and participate in each of the clubs at a time suitable within their existing activities programme. Although case studies of 10 different friendship clubs were initially for inclusion in the study as sites for the data collection, at project completion however, a total of 15 clubs overall were included to accommodate organisational changes and the pilot study. This did not impact on the rigour of the study however, as the other clubs included were similar to those who could not, ultimately be included.

One focus group (and/or interviews) was conducted at each of the clubs, each group with approximately 10 participants. (The researcher noted that there were no differences between those who decided to take part on the day and those who did not, it was participant choice and consent on the day) The researcher reminded participants of the purpose of the group and the research, as well as issues around confidentiality and the anonymity of the contributors. Consent was obtained on record prior to commencement of the recording. The quantitative and demographic data was sought at the beginning of the focus group ie. The participants were asked age group, gender, whether they lived alone or not, and whether the friendship club was their only source of social activity – and if not, what the other sources were. The focus groups and interviews then followed the guided framework of exploratory open questions as outlined in table 5 in the appendix.

All focus group/ interviews were recorded and transcribed. The interviews and groups lasted on average 45mins to 1hr.

As well as the above, other relevant conversations with club managers, volunteers and other participants were noted and consent sought to include their thoughts within the project.

The researcher also kept ongoing field notes and a reflective/reflexive journal (Liamputtong and Ezzy 2005) to record observations and reflections, which would also provide an interpretive trail (Steubert et al 2003) throughout the life of the project.

7. Data Analysis

100 individuals contributed to the data collection. A total of 82 club members contributed to the data collection and 18 club leaders or volunteers. Of the 82 members, 50 took part in either recorded focus groups or interviews, and 32 (different) members talked with the researcher sharing views and opinions that they consented to have included in the research study. There were 15 focus groups in total, with 5 interviews. The mix of club leaders (7) and volunteers (11) also talked with the researcher sharing views and opinions that they consented to have included in the research study

Data were analysed thematically by the researcher. The manifest level (basic level of analysis with a descriptive account of the data: eg. what was actually said, documented or observed with no assumptions made) of analysis began with the researcher transcribing and taking notes. This was followed by interpretative analysis (higher level of analysis and is concerned with what "may be meant by the response" inferences and implications) whereby the data was read and re-read for an initial intuitive grasp of the themes seen as emerging. The raw data was therefore organised into themes, concepts and patterns.

Modified inductive content analysis was also used where themes and constructs were derived with no former framework or counting- latent level analysis. This process identifies and forms emerging categories. This approach was used as the researcher wished to explore the rich data to search for any new themes that may have emerged (True inductive content analysis would use absolutely no previous framework, however, the ongoing literature search, focus group framework, combined with the knowledge gained from meeting the older people during the introductory phase impacted on the researcher's "knowing and knowledge" therefore the process could not be seen as inductive in its purest form).

Throughout the data analysis, the researcher became aware of the emerging themes resonating with the other findings from the literature as well as the unique findings. A degree of immersion in the data was necessary for this process. A modified constant comparative strategy was therefore subsequently used. This analysis method focused on a process whereby categories emerged from the data via predominantly inductive reasoning rather than through coding from predetermined categories (Maykut et al 1984) with the overall interpretation "confirmed" using either data findings from the

other methods used or from the literature and prior research. Although not a pure (true) constant comparative strategy as is described within the theory and process for grounded theory, the researcher used it as a means of addressing the quality issues. The researcher used the data collected from the other sources the older people (as described in the introductory phase of the study) as well as the literature for comparisons. The Brendoncare Research and Education Steering Group, which met with the research team quarterly, provided a forum for development and a feedback panel of "experts" as regards the findings. The research team also echoed findings back to participant groups, stakeholders and academic experts – thus addressing trustworthiness and rigour.
Table 6 below summarises the data analysis process.

Table 6 Working with the Data - Overview

Phase	Activity
1. Preparation	Selecting a unit of analysis which may be a word or a theme (eg. What social isolation "means", contact and living with family can also mean feeling isolated)
2. Organisation	Open coding, creating categories and abstraction. Notes and headings written in the text whilst reading it. Written material re-read, adding further headings to ensure capture of all content.
3.Identifying Emerging Themes	Revisiting the data, codes and themes to elucidate emerging themes and ensure consistency

7:1 Quantitative Analysis / Brief overview of Findings

Quantitative Data Summary

Summary data was collated by the research team during one month from 13 Friendship Clubs in the Bournemouth and Poole areas (not only those participating in the main study) which regularly collected basic demographic data from its members. The data was sent by the clubs' administrator (without member names to protect confidentiality) in spreadsheet form to the research team who then used "Excel" software to perform basic descriptive analyses. The data collected was confirmed by the charity's managers as "typical" of all the friendship clubs.

Of the 588 recorded members on the dataset, more than 82% were female which is a higher than expected percentage (SWO 2011) reflected throughout each of the clubs

with little variation, and with an average age of 80yrs old, although the age range embraced 60yrs. to over 100 yrs. There were no significant age differences between members at the different clubs. Membership of each club varied, as did weekly attendance at the clubs (non-attendance most frequently due to ill-health, or healthcare appointments), from 26 members to 87, with an average of 38 per club. Club managers confirmed that there was flexibility in attending the clubs which was important to members eg. they were always welcomed back if they could not attend due to illness/other appointments, or they did not just "*feel up to it*". Notably however, according to the data, most members attended very regularly.

4% wanted to, and were able to attend more than one Brendoncare club if it was sited within travelling/transport distance from their home.

Where members provided postcodes (not all members did) those clubs that were located in areas where socioeconomic deprivation is recognised (n=2) 23% (n=38) of members were from actual areas of deprivation.

Participants commonly described hearing about the clubs from neighbours or friends who already attended.

Those participants that took part in the focus groups/interviews were typical of the above.

Brendoncare Impact:

It is recognised that social isolation spans a wide age range in the older adult as well as being a transient *or* permanent experience, the clubs welcome a wide range of ages (although this take-up not apparent from the data reflected in this study) unlike some services provided by health and social care which set limits on the age range.

The literature suggests that socioeconomic factors such as living in a recognised area of deprivation can have an impact on social isolation, especially for the older age group, therefore it is of note that Brendoncare are successfully addressing this by providing their clubs in such areas.

Age UK (2010b) also recommends that any interventions or strategies employed to combat social isolation should take into account the *individual*'s circumstances and not assume that one intervention will suit everyone all of the time. The qualitative data confirms that the participants appreciated the flexibility in

attending the clubs. Just like within friendships, there was no pressure eg. no pressure from their friends or the club to attend if they do not feel well either mentally or physically, or they simply *"don't feel up to it*". Similarly there was also no pressure to take part in any of the activities or days out either, where cost for some was an influencing factor. Therefore the fact that club attendance flexibility is possible can also be seen as a factor for the clubs' success in tackling social isolation.

8. Qualitative Findings - Emerging Themes

The emerging themes very dominantly pertained to the value members attached to their attendance at the friendship clubs.

Three distinct dimensions were identified, however, it is acknowledged that they can be seen to overlap. Table 6 below summarises the dimensions extrapolated from the data.

Table 6. The Value of Social Involvement in Friendship Clubs

Dimension 1. Wellbeing	Dimension 2. Social Relationships & Friendships	Dimension 3. Health
Improved self-esteem. Improved quality of life. Sense of empowerment and control.	Enhanced social and personal identity. Role development. Sense of personal and community involvement. Practical and emotional support. Companionship. Inclusivity. Established or enhanced social ties.	Positive health impacts such as confidence, mobility and energy. Improved fitness through club activities.

The following pages provide a summary of the data obtained that informed the above table. The author has also included "Brendoncare Impacts" with links to the literature base (where appropriate) as evidence of effectiveness.

8:1 Wellbeing

Participants expressed the need to make the effort to get up and go out to attend the clubs and make the most of the opportunities there, but this was seen as a positive action as they felt empowered by the sense of routine and purpose.

They also highlighted the importance of listening, and feeling listened to by all staff and other members as they experienced when attending the clubs – viewed as key for friendship and self-esteem, and especially important if they wished to raise issues or concerns, personal or otherwise and seek advice. They also felt that staff and other members "knew and cared for them with respect" and were treated accordingly, ie. Not patronised.

For some female members, the choice of clothes for attendance was important as they viewed it as an opportunity to "get dressed up" and "feel good" about themselves. For those who would otherwise be unable to go out regularly for a social occasion or housebound (if it were not for the club), this was an opportunity to wear clothes other than very casual attire. In terms of identify and self-esteem, this was felt to be an overlooked, yet important, self-esteem dimension for the female members in particular.

Members (and several volunteers) also described the fact that following a group activity at the club, members often pursued that activity independently at home. This would seem to indicate an initiation of not only a new interest, with its possible health and wellbeing impacts, but new (and shared) learning. An example of this is the tracing of family histories and researching artefacts pertaining to WW1/WW2 within their homes, not only for their own interest but to share with family.

The speakers attending the clubs often shared knowledge and experience which was valued by the members, either for the interest and new learning experience or for the pragmatic information and guidance which could be acted upon eg. health and social care/financial advice. Members described this information as empowering as they felt encouraged and enabled to "solve their own problems", especially as these sessions also stimulated general discussion and consequent advice giving/sharing amongst friends after the speaker had finished. These findings could be viewed through the lens of social capital.

Overall, participants described attending the clubs as beneficial for their overall well-being and had improved the quality of their lives by providing purpose and most importantly, fun and friends. It could be mooted that it enhanced well-being by promoting autonomy and independence (WHO 2002).

Brendoncare Impact:

Researcher observation noted that the staff and volunteers discreetly direct members to talk to each other if they feel that it is appropriate thus strengthening bonds and also encouraging empowerment and a sense of reciprocity in the members. Olds (cited Mental Health Foundation 2011 p. 19) states "To some extent, all conversations with other people are mental health interventions." Thus in terms of mental well-being being, the Brendoncare clubs certainly enhance this by staff members and volunteers initiating and encouraging conversation.

It was also noted by the researcher, and as reported by participants, that attending the days heightened or developed a sense of well-being that extended beyond the actual day itself as well as providing stimulation for new hobbies or interests to be pursued further outside of the club.

Some participants commented that it was unusual for a research study such as this to actively seek their views and also listen!

8:2 Social Relationships and Friendships

Participants spoke of the importance of friendships in older age as often the need to relocate takes them away from established friends or family. The loss of work roles (employed work /volunteering or childcare for grandchildren) was also felt to impact negatively on feelings of isolation along with the death of close friends and family members, seen as especially difficult for those coming from large families when younger. Participants also reported that club friends provided valuable support through the grief process, by embracing a shared understanding that was felt could not be expressed with family members. Such transitions were expressed as more difficult to adapt to as one ages.

The friendship dimension articulated also reflected the fact that older people describe the *quality* of social contacts to be very important if it is to address social isolation.

" I had nothing to get up for" (participant)

"When I moved here, I knew no-body..." "You handle it a lot better when you are younger".(participant)

Surprisingly, some participants, albeit not living alone, and/or having frequent contact with their family still described feeling lonely as they did not feel they were truly engaged with their family at a level they enjoyed. Indeed sometimes they viewed attendance at the club as a welcome relief away from family.

"I just like to get away from them!" (participant)

These participants described the fact that they did not feel they could meaningfully engage with their family in their technological world with mobile phones, music, televisions etc. constantly on in the background! Participants also described conversational tensions arising with regard to parenting, whereby, the participants felt it better not to say anything rather than disagree with their children and grandchildren, in this way they felt they would rather socialise with their peers than be in a world they did not feel part of, or want to belong to.

Cattan (2003, 2005) confirms that family, may not be in fact, a source of emotional support albeit adult children may offer practical/instrumental support.

Particular dimensions as to the benefits of friendship were identified eg. Having friends in older age "*makes you stronger*" *(participant)*, articulated as reinforcing one's identity. Participants described being at the club as also reinforcing their identity as individuals, which was very important to them as it encourages "*a sense of pride in oneself*". Eg. participants appreciated the clubs' correct use of their name, viewing this as further acknowledgement of themselves as individuals.

"I used to be a man, they treat me like a man." "I am still a man."(participant)

Some participants elaborated further and suggested that regardless of "age/aging", everyone is the "same person" as they were when they were younger – nothing changes "inside" the individual as regards their identity and the clubs enabled that sense of individuality to (re)emerge especially the way that staff related to them.

"I still feel eighteen inside!" (participant)

"I wouldn't use a stick for a long time...I thought I am not that old!"(participant)
"Who is that old person in the mirror?!"[laughs] (participant)

Participants discussed the benefits of talking and sharing experiences (within the Brendoncare Club eg. Outings, as well as general life experiences) and ordinary conversation/interactions. This was further expressed as "*meaningful conversation*". Talking out loud was noted by many as important, to hear their own voice. Participating in gossip was also deemed important, even from those who had regular contact with family, as they felt it more appropriate (and enjoyable!) to gossip with friends and peers from the same age group, and in confidence.

"There's something about hearing your own voice...when you've been on your own for days on end you start talking to yourself because I think I must hear myself talking! [laughs]" (participant)

Friendship was also depicted as providing company/companionship, the actual presence of someone (as opposed to the television) for conversation. Companionship was especially important for those who had lost partners, they described the clubs as providing the opportunity to recapture the activities previously enjoyed with a partner eg. watching/discussing a sunset, or a trip out, or even simply talking about the newspapers or TV.

Participants also described the clubs providing the opportunity to establish emotional /romantic relationships. Marriage proposals – even if not accepted, were not uncommon and a welcome experience for some members.

As part of the "quality" of friendships mentioned previously (although valuing and enjoying the company of younger members/volunteers in the clubs) it was felt that interacting with others of a similar age, interests, experiences, personal history and historical background ensured mutual benefit for all involved eg. as this facilitated the sharing of life experiences, good and bad as well as allowing the sharing a particular worldview that was felt to come with age.

"We all have our growing up in common – or similar" (participant)

"We understand when we talk to each other, because we've got it too!" (participant)
"We have a laugh about our aches and pains".... (participant)

However, having [had] friends of an older/similar age often brought its own issues;

"I don't have any friends now, they have all died"(participant)

"I have outlived them all." "I don't know anyone now."(participant)

Albeit, younger friends could be difficult to maintain regular contact with.

"I do have friends, but they are a lot younger than me, so they've got busy lives...."(participant)

True friendship was depicted as "*being seen as an equal, an individual and treated with respect and dignity*" by others, for example, as by the staff and the other members at the Brendoncare Club. In the company of true friends one feels able to talk about anything without repercussions.

"You can talk about anything and they wouldn't disrespect you."(participant)

Participants felt that friends "*listen and have time for you*" and "*They would never let you think that you are boring*". They went on to describe feeling valued by friends, indeed by everyone at the club including the staff and volunteers who worked there.
More than one participant commented that they did not want to be in the company of those who make one feel as if "*I ought to shut up.... they are not listening*"!

Some participants expressed the importance of being able to celebrate significant events with their friends at the clubs, joyful (birthdays) or otherwise (bereavements).

Importantly, many participants recognised that new friendships made in the club were sustained beyond the actual day the club meets. This took the form of sharing a recognised interest eg. attending church events together , or dancing clubs or perhaps simply meeting for coffee or lunch.

"…..Before, I would walk into town and not know anybody….now I will walk into town and see people from the club even just to say hello to which is nice…"(participant)

"Seeing a face you recognise [from the club]……it's so nice"(participant)
"[This Brendoncare Club]is like a sociable community" (participant)

Brendoncare Impact:

The opportunity for meeting at the Brendoncare Club and forming and sustaining friendships was described as "...about seeing people you know" and the acknowledgement of one another as individuals and absolutely vital and a key reason for attending the clubs.

The clubs offer opportunities for general conversation after the initial club activity, this facilitates the important "ordinary" chatter that the participants in this study and others (Cattan 2011) value. Through the friendships at the clubs, participants also felt they received emotional and practical support from each other as part of a group and were valued as individuals *and* for the roles they had played in the past eg. work roles, or caring roles. It was of note that the attitudes and behaviour of staff at the clubs also contributed to the participants feeling valued and respected. Indeed a strong theme within the researcher's field note reflections pertained to the club staff and volunteers' ability *not* to patronise the members –this successfully addresses a feature noted in Cattan' s (2002) work whereby older people often felt patronised by [staff] at health or social care day centres..

Carstensen (1992) reports that "....older people are thought to be more judicious in their choice of companions than younger people and seek familiar, reliable relationships in which to invest (Carstensen 1992 cited Brownie and Horstmanhof 2011, p.1), As Cattan (2003, 2005) confirms, established friends offer support in times of transition eg. bereavement and also provide continuity and stability with new friends being those people with whom social activities can be enjoyed rather than providing reciprocal support. Established friendships are maintained by joint attendance at the club that would otherwise be terminated due to the lack of opportunity/facility (especially transport) to meet.. Brendoncare achieves this by

not only welcoming individuals into their clubs but accommodating partners, spouses and fostering relationships formed outwith the clubs.

This is especially important as many other organisations, due to the current economic crisis, are currently withdrawing services for the older age group.

8:3 Health

Participants felt that by attending the Club there was a reduction in possibly becoming, or reducing the effects of, becoming introverted as can happen *"...if one spends too much time alone*". Meeting people and being able to chat was felt to enhance mental well-being, by providing the "*opportunity to look out of oneself"* as well as stopping one from becoming introverted and focussing on one's own problems alone.

"You know if you've got a problem, you can go to anyone of these [members and staff] and have a chat."(participant)

When asked, they also described the clubs as definitely impacting on social isolation through the medium of friendship which in itself impacts positively on physical and mental well-being. Expressed thus; "*feeling better about yourself and your life*". *(participant)*

The chance to speak with others not only allowed for the sharing reciprocally of problems (and thus feeling useful) but also had the effect of stimulating their brains – further promoted by the active learning many of the activities offered. With regards to mental health in particular, members stated that their mental health (referred to as "wellbeing" and "how you are in yourself") definitely improved in attending the clubs, most commonly described as

"...being here certainly [positively] affects mental well-being..." (participant)

Participants described being a member of the club as giving them something to look forward to in the week and this lifted their mood, in particular, as they looked forward to meeting friends. The fun aspect was very important with respect to this. The aforementioned elevated mood was described as extending beyond the ending of the club itself and lasting at least until the evening and sometimes into the next day with

the obvious positive health and wellbeing impacts. The most common rationale for this being that they felt they "*had done something [fulfilling]"* and remarkably feeling akin to *"having had a holiday."*

"I look forward to a Tuesday now, we all do....."(participant)

Simply the process of getting up, out of the chair/bed to wash and dress in order to attend the club was for some participants, contributing to improving their mobility.

A common comment made by participants pertained to the use of touch within the clubs by staff and other members eg. hugging as a welcome or farewell plus the gentle touching of hands/shoulders during conversation. This was very much appreciated by those for whom touch from others was very limited due to their limited social contacts.

Brendoncare Impact:

Researcher observation and discussion recorded that touch is consciously employed by the staff to good effect as is the offering of a listening ear should a member have concerns or problems. There is extensive research in the health and well-being literature which confirms that touch has both emotional and physical health benefits. Furthermore, although there is a body of evidence as to the efficacy of technology in reducing social isolation as ActiveAge (2008) comment "A computer cannot, after all, reach out and hug you!" (ActiveAge 2008, p.4)

It is of note that the elevated mood that participants experienced, lasted before and after their attendance at the clubs.

One participant summarised the health impact of the clubs thus "*Mitigating against degeneration in the elderly*"

9. Sub Themes

There were a number of sub themes that also emerged from the data, as outlined below.

9:1.

Participants felt that social isolation **is** indeed a problem for the older age group with the lack of transport being a crucial issue.

9:1:1 Transport, travelling and confidence

- A key finding from this study pertaining to **all** research exploring social isolation is that the lack of available transport was cited by the majority of participants as a reason for becoming socially isolated.

"I wouldn't be able to come if I didn't have transport" (participant)
"Unless I am being picked up, or [travelling] by taxi, I just don't go out." (participant)

Participants also described differences between becoming isolated in one's younger years and as one ages, in that isolation is more difficult to overcome as you get older with discussion around a loss of confidence that does not "*come back as easily*" as it does when one is younger. Crucially, participants described difficulties in regaining confidence if lost due to an adverse event.

"When you're young, you're very resilient aren't you? You bounce back.....But the older you get, you lose confidence...and it doesn't come back."(participant)

Participants described losing confidence in travelling, even locally by public transport.

"I had a fall on a bus...as he braked very sharply" (participant)

"Also on the bus, you have to carry things...and get on and off while carrying things" (participant)

"I'm afraid of falling, I don't go anywhere alone now." (participant)

Participants described a loss in confidence in driving as roads have become busier over the years. For those participants who used an electric buggy, lack of confidence remained an issue as regards the environment pertaining to obstructions/layout of the landscape eg. Hills, as well as the speed of other traffic.

"Things swoop towards me..." (participant)

A significant impact of this loss of personal confidence extended into a reluctance to join new clubs or participate in new activities.

"I was apprehensive about joining anything..." (participant)

Some participants suggested that older people themselves may thus unwittingly contribute to their feelings of social isolation eg. either by not being willing to "make the effort" to go out, meet up with friends etc. OR alternatively, by being unwilling to invite new (at risk of social isolation) friends to join if they were socially active. This was further elaborated on by several members explaining that this can occur when bereaved, established couples appear to reluctant to continue to involve an individual when their partner passes away – "*it was both of us or nothing*".

Further themes from the data included general reasons as to why the participants felt they may be at risk of becoming/being isolated, many of which mirrored those in the literature eg. loss of spouse, moving away from family and close friends, and poorer health limiting mobility or ability to drive. It was of note that participants reported that living or being very close to family does not always mitigate against isolation eg. Poor health of the family member that normally visits, or the general "busyness" of the family.

Brendoncare Impact:

As has been repeated throughout this study, the provision of transport is key for many participants enabling them attend the clubs. This provision also enhances the likelihood of the participant continuing attend *"...and the fact the car is coming helps push you to put the effort in to go, no matter the weather or what you might feel like*" as well as removing any fear of travelling is removed. The participants also expressed enjoyment of the company of the transport drivers to and from the club!

9:1:2. Physical limitations, carer responsibilities and finances

Participants described in depth the possible physical limitations (short term or due to chronic conditions) affecting mobility which may contribute to social isolation. These physical limitations extended to discomfort in travelling distances, compounded by

reductions in bus services resulting in either no transport, or a longer walking distance which could also pose difficulties. This made visiting friends and family very difficult as do the physical limitations which adversely affect mobility or one's ability continue to drive a car. A lack of confidence again, in physical abilities, was also felt to contribute to becoming isolated. Some participants also described feeling insecure going out at all, either alone or in company, due to actual or perceived physical limitations eg. fear of falling.

"I just [feel I] can't go out alone anymore" (participant)

Participants also described being physically unable to be outside as much as before – eg. To do some gardening, and consequently being unable to chat randomly to people walking past their garden as they once would have able to do. It was felt that there was also a tendency for people to drive rather than walk to their destination, regardless of how close, which therefore further reduces opportunities for social contact and interaction. Participants also commented that one no longer "knows" one's neighbours to converse with or have a meaningful relationship with.

Concerns over finances also was suggested as being a factor, some participants outlined that despite being able to find activities that they would like to pursue with their peers, the cost was prohibitive due to their limited pension income.

For some participants, being a carer became an isolating experience eg. Caring for a partner with dementia. They suggested that this role can limit freedom in choosing where to go out, and with whom to mix, when in the company of the partner as others frequently "*do not understand*" when their partners behave in an unexpected way thus causing embarrassment for the carer. "Sitters" are not always a practical/available/financially possible option. It can also become difficult simply to chat and mix with others when the partner is present as the physical and behavioural needs of the partner could make it difficult to maintain the usual social interactions and activities.

"When I came out [of the theatre], he was gone....he couldn't keep up beside me.."(participant)

Importantly, some participants spoke of the loss of their pets as contributing to a sense of social isolation as they lose a trusted companion. They commented that pet ownership becomes more difficult as their physical health declines, so it is not uncommon for pets to be re-homed severing all contact with the older person.

"[I just said] Take her [dog] with you, I've got to stick this life, she doesn't have to."(participant)

This loss of a pet also contributed to social isolation in that they lose, not only vital animal companionship but a source of meeting and conversing with others eg. when out walking the dog.

Brendoncare Impact:

It would appear that the lack of available transport, or confidence in using public transport was highlighted as a key factor in experiencing social isolation, and for many, the fact that the Friendship Clubs provided transport was seen as vital for their attendance. Furthermore, the low cost of attending, and the fact that the transport provided was free, was appreciated by many and ensured their ability to attend. Brendoncare also welcomes individuals and their (less able mentally or physically) partners, which for many meant they could be accompanied by their partner without trepidation. It should be noted also though, that many members who were carers cited benefitting from attending the clubs independently both as a "break" for themselves and also to share the experiences and problems of being a carer as well as being able to" pick up useful tips and advice about services."

9:1: 3. Safety Issues, confidence and a changing society

Participants described sometimes feeling unsafe going out of the house which not only sapped confidence but also encouraged a reluctance to venture out, especially after dark, even if driving or going by electric buggy. There was a dominant theme of "a fear of crime" expressed, either to be subjected to or witnessed. This fear made it difficult to pursue hobbies and interests at external venues, as well as maintaining friendships outside of the home.

"It isn't a safe place today is it?" (participant)
"It's a wicked world....some weird people out there...?" (participant)
"I wouldn't let anyone carry my bags [for me] now..." (participant)

The participants then explained that once an individual stops going out because they are afraid, their confidence in themselves as "a person" diminishes. For some, simply being unable to go out for several days due to inclement weather reduced their confidence in stepping over their front door even when the weather had improved. Furthermore, once an individual had spent a period of time alone in the house, a common thought arose "*I had nothing interesting to say*" which further impeded on pursuing and maintaining (even existing) social ties which contributed further to a loss of confidence in the self.

Note: As suggested elsewhere in this report, the theme of losing confidence emerged in relation to many factors adversely affecting social isolation. Importantly, the majority of participants alluded to a spiral downwards of confidence loss ie. Once it started to decrease, it very quickly decreased further, often without explanation. This study was not able to explore this in further detail

Participants felt that younger people "*don't really relate to our age group, and when they know you are on your own and becoming an old biddy, they tend to shy away...." (participant)*

They also felt that the world seemed a very different place to them now compared to when they were younger which was seen to possibly enhance a sense of isolation. Participants went on to describe the absence of expected behaviours such as greeting people generally and acknowledging their presence, "*walking on the outside [of a pavement for] lady*", holding open and closing a door before and after others, giving up seats on a bus [adversely affecting one's safety whilst travelling]. The absence of these types of social behaviour applied to both parents and their children of all ages. These behaviours were thought to indicate a general lack of respect which would not have been tolerated when they were younger. The participants seemed to describe the experience of discrimination because of their age.

"It's a different world." (participant)
"...there's no discipline today.. ..."(participant)
"No-one else has time for our age group...." (participant)

"We just don't feel listened to...." (participant)

Participants also described feeling that people generally always hurried everywhere and had no time to interact with others.

"[they're] always in a rush....flying through the doors"(participant)

Brendoncare Impact:

As well as the availability of organised and safe transport more than one participant acknowledged the benefits of the Brendoncare Clubs running in the afternoons.

"The clubs are run the afternoon, so darkness is not an issue" (participant)

Pertinently, participants were asked whether they felt they would be at risk of becoming socially isolated if they did not attend the friendship club, common responses were as below:

"Oh, definitely..." participant)
"It's lovely, because I don't feel threatened coming here." (participant)
"They (the Clubs) are better than family..." (participant)
"If I wasn't here, I would be out in my buggy, looking at the cows in the field at the bottom, or just doing nothing...." (participant)

The participants not only felt valued by the club staff and volunteers but expressed feeling valued by the other members regardless of any disabilities they may have, be it physical or mental health difficulties, thus not discriminated against or stigmatised in any way.

10. Further findings in brief.....

Typically, the participants described what the experience of social isolation felt like within an objective and subjective framework – similar to what has been described extensively in the literature review and which can be gleaned from the many comments

reported above. Furthermore, the participants in this study confirmed that the quality of relationships (friendship relationships) was important, indeed more important than the number of contacts or relationships which is confirmed by current research "..... the quality of a relationship is a stronger predictor of loneliness than the quantity or size of an individual's social networks." (Brownie and Horstmanhof 2011, p. 1). With this in mind, it is of note that some participants described not speaking to, or interacting with, anyone from week to week – the club was their only source of company and human contact.

The researcher was aware from the quantitative findings that the majority of club attendees, and indeed study participants, were female and therefore re-visited the data with this in mind.

Akin to the findings in Ormsby's work (2010), the ladies appreciated the company of other ladies in the clubs for the companionship and opportunity to form social bonds. This often took precedence above the activities and outings offered by the clubs for participants. Similarly, they also stated that they looked forward to the clubs for this reason, as well as appreciating the informal atmosphere plus the sharing of *"ladies"* (gender specific) jokes! (Ormsby 2010, p.609). The participants also found benefit in the listening to and sharing of each others' stories and experiences, particularly from the female perspective eg. in particular about caring roles of mother/grandparent, or carer of a partner, Again, echoing the findings of Ormsby (2010) this (re) story telling had benefits that extended beyond the clubs, as participants described being made to feel "more interesting" as they had stories to share with others upon their return home.

Brendoncare Impact:

For some participants, they described attendance at the club as providing the only contact with others, indeed the weekly club for some was the only source of conversation in the entire week. Furthermore, this important social contact/conversation can begin with the transport driver who drives them to the club.

Previous studies have reported that friendships, women's especially, impact positively on their sense of well-being in terms of life satisfaction, self-esteem and self-concept (Larson 1987,Lee and Ishii-Kuntz 1987, Russell 1987 cited

Radina et al 2008, p.99) it is clear therefore that this study's described impacts are not unexpected, indeed confirmed.

11. Issues arising from attending the Brendoncare Clubs

There were very few comments with regard to this. One or two participants described it as "*not always easy to get on with*" all members of the club which can be expected within any social gathering. Given the age range of members, some participants felt they were mixing with others that were too old to share their interests or that some of the activities and outings offered were not of interest to them eg. arts and crafts or "dull speakers". For a small number of those participants who drove, they felt that parking could be problem as well as having to drive at a busy time of day on their return journey home.

Despite the above comments, the participants who shared these views and opinions still confirmed they benefitted from attending the clubs and would continue to do so, indeed many had been attending the clubs since they had opened despite their comments and this was, for some, over a period of 2 years.

12. Discussion

12:1 Health Promotion

a) Given the emerging three themes from the data it can argued that the friendship clubs promote healthy active aging as it provides opportunities for the promotion of health, social participation/ integration and security as described by WHO (2002).

The Brendoncare Clubs appear to offer an important space for women similar to the "Men's Sheds" described in Ormsby's (2010) study in that "The physical space is not only a space to meet, but also a place where social bonds and relationships are understood, potentially acting as a cushion against the negative health effects arising from losses of various kinds. " (Ormsby 2010, p.611). Brendoncare would appear to have achieved what Cruikshank (2003, cited Radina et al 2008) called for in the creation of informal groups to facilitate older adults to redefine themselves in a place where they can ".....age in accordance with own sets of values, attitudes and beliefs...such groups provide opportunities for continued growth, learning and development and encourage participants to celebrate and accept themselves as participatory members of society" (Radina et al 2008, p. 104).

In addition, White (2007) highlights that older people like to "hang out too" and enjoy being part of the community in which they live thus enhancing their sense of social connectedness and being engaged with society. Cattan (2002) suggests that older people want activities available within their local neighbourhood or within a reasonable travelling distance, this study provides the evidence that the current friendship clubs are indeed strategically placed locally enough both in terms of travelling distances, but also situated to enhance the sense of local community spirit amongst its members and help establish and importantly sustain existing relationships formed outside of the club eg. church, residents' committees.

The aforementioned "hanging out" includes people watching which is an activity that spans all generations. White (2007) acknowledges that "hanging out" can be difficult as one ages if the open, public spaces eg. parks, shopping centres, libraries are perceived as being unsafe either due to fear of crime or an unsuitable environment. The respondents in this study confirmed that this was a contributing factor towards becoming socially isolated and furthermore that attendance at the clubs positively addressed both the social connectedness experience and provided an opportunity for people watching at the clubs – this more likely to be a response from those participants who described themselves as quiet or shy. This feature of the clubs is highlighted by

the work of Cattan (2002) who recommends that services need to be responsive to individual needs and accept that, for some socially isolated or lonely individuals, they lack the desire or confidence to take actively part in group activities.

b) The participants had also commented that it was important for health to keep physically and mentally active in older age. The process of attending the club provided the necessary physical activity (through getting up put the bed/chair and dressing, walking to the transport etc.) plus the clubs had regular chair fitness sessions as their weekly activity on occasion.

The participants also suggested that the club activities and outings provided mental stimulation/activity, often through new learning, this again was similar to Ormsby's (2010) findings. Furthermore Cattan (2002) states that older people wish support and encouragement to learn new skills, or share skills *with other older people*.

In addition, Willcock (2004) suggests that the use of creative expression may enhance self-esteem and may make interpersonal communication more meaningful (Willcock 2004., p.45) Brendoncare offers this through their variety of creative activities eg. recipe card making, and the researcher field notes confirmed that there was significant interpersonal communication occurring as a result of, and throughout the activity. The literature also revealed that friendships may emerge more easily from shared activities and projects than from interactions focused overtly on friendship formation (Potts 1997).

c) The many comments from the participants as to the benefits of the friendship clubs for their mental health and well-being are corroborated in detail by many other subject specific research studies eg. McCrae et al (2005) as well as the abundance of confirmative data generated by general research studies exploring social isolation as outlined in the literature review.

d) WHO (1998) states that healthy ageing is affected by other determinants eg. social and community networks, economic status with further influencing factors including transport. The fact that Brendoncare charges a low attendance cost and provides free transport demonstrates that they not only take on board these factors but their members do indeed benefit from them as well as appreciate them enormously.

12:2 Confidence

a) On field note reflection and through reading the Brendoncare literature made available, the research team were aware that the Brendoncare philosophy for the friendship clubs saw fun and friendship as part of normal healthy aging and indeed a necessary health promotion premise for the older person. Brendoncare are therefore at the forefront of health promotion for this age group in adopting this positive approach In this way, it would seem that the Brendoncare organisation has a successful salutogenic approach towards ageing whereby the clubs seek to positively strengthen those determinants and factors which "strengthen older people to adapt to and compensate the negative consequences of ageing" (Leswijn et al, 2011, p.45).

b) Reflecting on the theories of salutogenesis as was recognised pertinent to this study, two main concepts (Antonovsky 1979, 1987) are generally considered. The first concerns the Generalised Resistance Resource (GRR) , the second of relevance, is SOC (Sense of Coherence). It could be suggested that the loss of confidence that emerged as a thread factor contributing to social isolation is linked to this.

Leswijn et al (2011) described SOC as an individual "global orientation that expresses the extent to which one has a feeling of confidence" in that they can deal with life stressors in a structured, manageable way and repeat this when required. (Leswijn et al, 2011, p.45). SOC has three dimensions.

The first pertains to the individual understanding the stressful situation/stressor, the second addresses the motivation the individual has to cope with it and the third, the capacity to do so.

The participants in this study demonstrated understanding of, and motivation to address, factors contributing to social isolation - in this context considered a stressor (it is of note that but they did not appear to make any reference to capacity). The participants in this study also described being aware that one aspect in reducing social isolation lies in the effort an individual makes to overcome it – eg. by attending the clubs regularly and engaging with other members. De Jong-Gierveld (cited Victor 2001) confirms that older adults are indeed active in respect of this by seeking to widen their social networks or improving the quality of those already existing (Victor 2011, p.45).

Theoretically, the link between the GRRs and SOC surrounds the GRRs addressing the demands posed by SOC eg. the capacity to cope with stressors. Therefore, if an

individual has limited social networks (a GRR resource) then as stressors occur eg. fear of travelling, crime, falling, frailty – the capacity to deal with this is perhaps significantly reduced, therefore the individual may then lose that overarching sense of confidence with which to deal with the current stressor, and then may go on to lose confidence generally as well as perceiving non-threatening/stressful events as stressful and threatening, and in this way a downward spiral of losing confidence ensues.
The data from this study suggested that confidence *was* increased by attendance at the clubs and that the fears participants made mention of no longer appeared to impact on the same way. It would useful therefore to explore the above theoretical position in greater detail in further research to identify particular measures/strategies to further enhance this confidence building.

Willcock (2004) suggests that groups (such as those encountered at Brendoncare) not only promote interdependence and the learning of self-help skills but also improve and enhance social /communication skills this implies perhaps that confidence is increased on many levels. (Willcock 2004, p. 44)

12:3 The importance of independence and self-help

a) The findings from this study echo previous research (Joseph Rowntree Foundation 2004) whereby older people value independence and interdependence as well as being part of a community where people care about and look after one another with an emphasis on mutual help, as one willingly offers and receives support from others, be it in the form of practical advice and/or emotional support. Age UK confirms "mutual exchange and reciprocity builds trust between people and creates positive social relationships" (Age UK, 2010, p. 16). Furthermore the clubs in this study had a structure and content influenced by those who attend and/or volunteer .

b) The data collected in this study also reflected the fact that staff actively encouraged independence whilst discreetly offering physical/emotional assistance where necessary, thus avoiding the older person either feeling, or becoming "helpless" Cattan (2002). Sorrell (2007) confirms that the when older people experience "having things done for them", often without negotiation, this can lead to a loss of personal identity increasing the likelihood of both a sense of isolation and depression.

c) Is "facilitation" and "enabling" the key to the success of the Friendship Clubs?

A key finding from Cattan's seminal work exploring social isolation (2002) was that older people wanted practical, flexible, and low-level assistance that helps them to remain independent, gain the confidence to identify their own solutions and supports them in retaining their own social networks. In this study participants also concluded that the social skills and choices one makes when younger in establishing friendships are still present– no need for agencies to "find friends", just the provision of opportunity.

The findings from this study suggest that the friendship clubs facilitate and enable their members to come together socially and thus establish their own mechanisms to address this. In addition, the positive data collected from this study suggests that older people discovered a solution for combating social isolation themselves. Literally….THEMSELVES? Indeed, it would seem that Brendoncare Clubs organisation *are* expert enablers and facilitators by providing the means (transport, accessible locale, and support) for the older age group to meet up and engage, so that they may form significant friendships. In this way the clubs can be seen to be empowering the older age group to tackle the experience of social isolation themselves. Therefore one can conclude that, in part, the effectiveness of the clubs in combating social isolation is how the members make effective use of the opportunity presented to them. This would appear to bode well for investing further in this type of intervention.

The above are also examples of how it is important to engage with older adults in the planning and delivery of effective services targeted at this age group rather than speculating as to what their needs may be and delivery without consultation – both enforcing older adults into a passive role and perhaps providing services that do not have an evidence base of effectiveness.

12:4 Volunteering

The volunteers were deemed crucial to the success of the clubs, appreciated by the organisation and the members themselves. Volunteers described the experience of volunteering as important for their well-being as they felt "useful" and "valuable" despite ceasing paid employment, this is similar to the findings of Gray and Smith (2005) and Cummins et al (2007). Volunteers also described the days at the club as providing structure for their week "something to get up for". They also felt that the

ongoing training and development process for volunteers that the charity organises regularly were extremely beneficial as well as enjoyable.

Through informal conversations with the volunteers at the clubs, further data extrapolated mirrored the findings of Warbuton (2006) eg. that this external focus is associated with personal agency and control; and it is important for positive development; plus the fact that as volunteering is a social activity which in itself reduces loneliness (Cattan 2002). Griffin (2010) states "Studies reveal that people who are engaged in service to others, such as volunteering, tend to be happier. Evolutionary psychologists point to evidence that altruism is an essential part of human nature..." (Griffin 2010, p. 28) hence a need that needs to be addressed for health and well-being.

13. Implications for practice

a) Working across sectors.

Leswijn et al (2011) highlight that currently there are many approaches to to healthy ageing eg. "medical, gerontological, psychological and sociological" (Leswijn et al, 2011, p.44). It would seem however that the general holistic and positive approach that the Brendoncare Organisation adopts has worked effectively, indeed, theoretically, it could be argued that the success of the Brendoncare clubs specifically lies in the facilitating of generalised resistance resources (GRR) in particular, the psychosocial resource social network. This would suggest perhaps a need for promoting cross and inter-sectoral interventions beyond that currently offered in the UK ie. Predominantly either health *or* social care (luncheon clubs) *or* charitable organisations - this suggested approach also seeking to develop a universal, more salutogenic (causes of health) approach to healthy ageing. This is supported by Age Concern (2006) who suggest "the majority of the changes that older people identify as important to their mental health and well-being can most effectively be addressed by activities at the local, community level. Local authorities and the NHS, voluntary organisations, commercial and business representatives, faith and other community groups can collaborate in the development of healthy ageing programmes which explicitly promote mental health and well-being." (Age Concern 2006, p.10) Furthermore, Age Concern 2006 recommends that policies "recognise and strengthen the existing positive relationships that older people have with friends, family, neighbours and significant others" (Age Concern 2006, p.8) The Brendoncare Clubs are an example of how this may be achieved, furthermore the report

addresses poverty by acknowledging that money alone is not the issue for many older people, but the what it can provide including social activities that allow participation in family and community life, the low cost of attendance at the clubs acknowledges this to good effect. (Age Concern 2006, p.9)

b) Reconsidering a needs-based approach to ageing.

Based on extensive enquiry into successful community initiatives in the U.S. Asset Based Community Development (ABCD) is articulated as a way of counteracting the predominant needs based approach to development (Kretzmann & McKnight 1999). In the needs based approach (an approach it could be argued that is adopted by health and social care providers) the well intentioned efforts of organisations have generated needs surveys, analysed problems and identified solutions to meet needs. In the process however they have presented a one sided and negative view of communities rather than contributed to capacity release. Communities that have been defined by their problems internalise this negativity, and the result is a cycle of seeking funding through competitions for who is the most `needy`. Older people are often defined in policy documents and the academic literature as `problems` with multiple complex needs, a drain on the rest of society rather than as assets and resources for each other and potentially for the whole community, it could be argued thus echoing a degree of stigmatisation and discrimination.

Reflecting on the following statement "Recognising the difficulties and constraints for loneliness interventions, and that the ultimate goal is the improvement of wellbeing of older adults, the challenge is to facilitate organisations in upgrading their loneliness intervention strategies, while fully respecting the mission of each of these organisations." De Jong-Gierveld (cited Victor 2001, p.46), led the research team to consider that perhaps Brendoncare as an organisation, by using their overarching well-being philosophy to good effect and thus not exclusively focusing on social isolation, allowed the clubs to develop and emerge organically as an effective intervention able to address many of the more subtle factors linked to social isolation and enhancing social support at an individual, personal value level eg. by providing opportunities for learning and support with and from each other. Moreover, research describes successful interventions as those which use indirect approaches, which are not perceived as social network activities or as having the intention of reducing social isolation and loneliness (Cattan et al, 2003, Age UK 2010b). Brendoncare also has the underpinning premise of

"fun and enjoyment" embedded within their club culture and group activities, and as Cattan describes (Cited Victor 2011,p 60) groups meet a variety of needs such as enjoyment, activity and social integration. "Often the emphasis is on shared enjoyable activities,"

In this way each individual who attends is a potential asset or resource for other club members and for the running of the clubs themselves. Expanding the ABCD approach in this way could see community members and their organisations, plus other organisations based within communities, as assets and attempt to build on what works in communities rather than looking for problems and objectifying and labelling communities and their members.

A key reflection from the above, suggests that for practice it should be considered that the members of the friendship clubs are valued (either as a volunteer or friend) and in this way not simply passive consumers of a service but active participants in a collaborative intervention.

14. Strengths and Weaknesses of the Research Methods Used in this Study

The strengths of participant observation include the researcher capturing the real and lived experience of being a participant at the clubs, by being a participant and reflecting on the personal experience as well as adopting the observer role and reflecting on independent observations. (The use of written and oral field notes and diaries helped capture the essences of both) This also facilitated relationship building with the clubs enhancing trust and understanding thus allowing meaningful involvement of all stakeholders. A weakness of this method includes the possibility that the presence of the researcher influenced the situation being observed eg. the club processes and dynamics. The researcher's own biases and subsequent (mis) understandings may also adversely affect the field notes (inaccuracies). However the constant dialogue within the research team, with all stakeholders and specialist senior academics sought to address this.

As well as the strengths pertaining to focus groups described elsewhere, this method also enables the study to glean the insights from more than one person at a time.
The weaknesses however recognise that group dynamics or intimidation may impact on what/how much the individual participant says as well as possibly following the guide (questions) from a biased facilitator. The guided framework was agreed through the dialogue described above and any deviation was to allow the participants to follow their own narrative freely. There was little noted as to the dynamics adversely affecting the data collection.

The beginning of the focus groups sought basic numerical/biographic data from the participants to establish key characteristics of the group under study. The small number of participants usually limits the inferences that can be drawn, however the wider collected quantitative data from the other clubs confirmed the participants to be typical of the group under study.

A benefit as to the use of individual interviews is that it may allow the participant to share private feelings and experiences that they would not wish to as part of a group. A weakness however is that this participant may feel pressurised into agreeing/disagreeing with the interviewer if the interviewer is not sensitive and approaches the interview appropriately for the setting.

In summary, the research team used a variety of methods and sources/resources (including available documentation from the organisation and individual clubs) for data collection to ensure a more comprehensive view of the issue under study (social isolation and friendship clubs) which added rigour to the study as each confirmed the findings from the other.

14:2 What this study may add.....

a) This study was successful in, and due to, its "participatory" approach – the staff and members of Brendoncare Clubs contributed considerably to the research process and data collection. There is little evidence for such extensive successful engagement within the research literature on similar studies.

b) The members themselves contributed fully to the data collection, sharing views and experiences without a reticence that has been described previously in the literature (eg. the giving of information that is perceived as what the researcher "wants to hear", or wishing to present only positive information that is considered to reflect well on themselves-their public account)

c) This data included narratives/stories which enhanced meaning and understanding as to the phenomenon of social isolation as experienced by the individual themselves – this elicited material not considered in the literature thus far eg. the sense of isolation can still be pervasive even when the individual is living with family. This strongly suggests that the concept of social isolation should be viewed from the perception of the individual, research thus far has merely suggested that this subjective view is a less explored and therefore perhaps a less relevant variable.

d) There are "new" concepts that arose from this study that have not been alluded to in the literature on social isolation in the older age group extensively eg.

   i. Considering older people as an asset and resource for example to provide information,

   ii. The loss of responsibility causing loneliness eg. childcare responsibilities as grandchildren grow up.

   iii. The importance of individual flexibility in being "permitted" to attend any club or activity, or not.

iv. Successful interventions such as these become widely known (and therefore attended) by word of mouth – not through formal contact with a traditional health/social care professional or generic advertising.

v. Feeling valued is an important factor to consider when seeking to reduce social isolation alongside friendships with peers as the most important element of what works to reduce social isolation.

vi. What this study also adds is the confirmation that a possible intervention has now been identified that successfully addresses social isolation in the older age group

15. Conclusion

This study provides evidence that that the friendship clubs offer a space for older people to meet and engage with each other meaningfully which not only positively impacts on the experience of social isolation, but also on health and well-being. The themes that emerged embodied the fact that the clubs enabled the establishment and maintenance of valued and satisfying interpersonal relationships. This has a positive impact on reducing social isolation by directly addressing the following "The loss of valued interpersonal relationships or inability to establish satisfying relationships can contribute to feelings of social isolation, despair, and loneliness." (Brownie and Horstmanhof 2011, p.1). This finding is further evidenced by the data collected echoing the literature suggesting that social networks indeed influence health and wellbeing through social capital which provides resources and advantages (sharing skills and experience), through social support (emotional support) and the influence of peer behaviours eg for communication and social skills (Berkman and Glass 2000). Furthermore, the WHO (2007) report states that participation in leisure, social, cultural and spiritual activities in the community, helps older people maintain self esteem, as well as maintaining or creating supportive and caring relationships by fostering social integration and is also the key to staying informed (WHO 2007, p.43).

When considering the current economic climate and the evidence within this report, it would seem pertinent to add that Age UK (2010b) within its evidence review, state that "The loss of a service which has had success at alleviating loneliness is worse than never having had the service at all..."(Age UK 2010b, p.3)

A final thought.....*Human beings do not thrive when isolated from others as we are social creatures in general. Developmental psychology emphasizes the social formation of the mind and the role of the other in development throughout life (Leiman, 2002). We define ourselves and find our voices through the responses of another and vice versa.*

Appendix A

Table 3 Stakeholder Involvement Strategy

Activity	Research Process	Information Generated
a) Researcher to attend/participate the Friendship Clubs informally	1. Introduce the rationale for the study and research team members. 2. Participant Observation	1. To encapsulate the meaning of social isolation for the older person, the perceived value of studying the concept. 2. Observational field notes 3. Key thematic framework to be identified for interviews and focus groups drawn from informal discussion with members, leaders and volunteers at the clubs.
b) Consent Forms and Participant Information Sheets to be sent to one of the experienced club leader for discussion with the members.	1. Documents to be emailed to club leader.	1. Consent Forms and Participant Information Sheets to be amended and approved by an experienced club leader.
c) To identify "Best practice" as to process to ensure all members are able to take part in study.	1. Discussions to take place with relevant club leaders as to environment and number of participants for each group/interviews at each club.	1. No more than 10 participants per group, in an accessible (mobility) area away from distractions and other noise – interviews where preferred.
d) To have ongoing "conversations" with key stakeholders and members as to the findings, checking for understanding. Formal and informal processes – reports and informal conversations.	1. To echo findings back to participant groups, stakeholders and academic experts – addressing trustworthiness and rigour.	1. Confirmation as to the findings and interpretations of them.

Table 4 Summary of Project Data Collection and Analysis Plan

Data Source	Method of Data Collection	Method of Analysis
Clubs	Participant Observation	Thematic analysis of field notes
Attendees at Clubs	Formal (and informal) Individual Interviews and Focus Groups	Thematic analysis of field notes and recording transcripts
Club Leaders/ Manager	Numerical geographical and biographical data using existing data collected by the charity	Descriptive Statistical Analysis
Volunteers at Clubs (Club Leaders)	Individual /Group Informal Interviews	Thematic analysis of recording transcripts

Table 5 Summary of Guided Questions

a) Quantitative Questions

Gender Age = 60s/70s/80s/90s/100s Post Code Living Situation – Alone? Describe Who, if anyone only comes to this Brendoncare Who, if anyone, goes to another Brendoncare? Who, if anyone, attends any other social group or activity?	

b) Qualitative Questions

1) General Overview a) Is social isolation a problem for the older age group?	**Prompts** Living alone or not? Loss of roles? Carer responsibilities? Transport issues? Physical limitations.
2) Contributors to Social Isolation a) Cultural changes? b) Intergenerational differences?	How you think society views older people? Does this impact on social isolation? Do you think society changed over the years? How does this impact? Examples? – behaviour/neighbourliness/walking or driving/pace of life..... Loss of local amenities
3) Loss of confidence as one ages	Physical frailties generally – travelling-driving - walking Feeling frail in a harsh environment – hills – busy roads Inability to regain confidence once lost (perhaps due to an adverse event) Loss of *personal* confidence to venture out and meet new people?
4) Safety Concerns	Physical frailties Darkness Walking/falling Speed of Life Feeling threatened by others
5) The importance of friendship a) Are friends more important as you get older? b) What are the benefits of friends/friendships?	 Moving from family and area/bereavements Loss of roles The role of "friendship" clubs Self/Identity? Talking and sharing life experiences Sharing club outings and experiences "Meaningful" conversations

	Having/being in company (not just television) Other aspects.....
c) Does the age of friends matter?	Losing friends (age related) The "business" and unavailability of younger friends A shared worldview with those of a similar age....growing up, war experiences etc.
d) What *is* "friendship"?	Issues of equality Being treated as an individual Being treated with respect and dignity Being listened to Feeling able to talk about anything and not be judged Feeling others have time for you Other aspects.....
6) About the Brendoncare Clubs How did you come to attend this club? How easy was it made for you (or otherwise)? What expectations did you have?	
a) What would you describe as the impact of attending the clubs?	New friends Maintaining existing friendships Facilitating socialising/contacts outwith the club too ie. Widened your social network? The importance of transport Impacts on well-being, physical and mental
b) What would you describe as the value of the club activities, generally, if any?	Value of chatting Learning Interest/enjoyment
c) What is the impact of attending the club for YOURSELF?	Self identity/regardless of age ("still feeling 18!") Pride in oneself Maintaining and using well developed social skills for friendships – no need to be "found friends" by other organisations. Respect for gender identity Appreciation of feeling "welcomed" back if non attendance had been necessary.
7) Addressing Social Isolation	
a) Do you think attending the clubs can reduce the possibility of becoming, or reducing the effects of being socially isolated?	Risks of becoming "introverted" Providing an event in the week "to look forward to"
b) If *you* didn't attend the this Brendoncare Club, do you think you would be at risk of becoming isolated?	

8) Any other comments you wish to make?	

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