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RESULTS OF THE SOCIAL ENABLEMENT RANDOMISED CONTROLLED TRIAL

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EXECUTIVE SUMMARY

In 2001 a study of older people referred for home care services at Silver Chain found that 61.7% screened positive for depression. This was strongly associated with frequent feelings of loneliness, and indicated the need for programs to alleviate loneliness and depression for this population.

Based on this research and the success of an Age Concern UK Social Rehabilitation model, an 18 month trial of a Social Rehabilitation program was conducted within Silver Chain's northern service area between April 2006 and March 2007. This program was a volunteer based service that encouraged and supported older people to connect or re-connect socially.

The service targeted older home care clients who felt lonely, isolated, flat or depressed and wanted to do something about it. The service model used a goal setting and task-centred practice approach, in which clients were encouraged to identify goals and strategies to achieve them, with the support of a matched volunteer.

Participants who completed the program showed improvements in levels of depression, loneliness and wellbeing; and 86.3% of participants had achieved at least one or more of their set goals. However, some components of the model did not work well and it was therefore redesigned to increase the involvement of volunteers whilst reducing the time the co-ordinator spent with clients. Funding for two years to implement the refined model, renamed Social Enablement, was secured; while the evaluation was modified to a randomised controlled trial.

The aim of this new trial was to compare the outcomes in terms of loneliness, depression and wellbeing of older home care clients who participated in the Social Enablement program versus those who were waitlisted for the service. This would allow Silver Chain to determine whether any improvements in outcome measures demonstrated by clients participating in the program could be attributed to the intervention rather than spontaneous improvement or natural variations over time.

It was envisioned that the results of this research study would contribute to the limited body of evidence regarding the effectiveness of interventions intended to alleviate social isolation, loneliness and depression in older people. The primary hypothesis was that clients who participated in the program would show significantly greater improvement in measures of loneliness, depression and wellbeing, than those clients who were waitlisted for the service. A second hypothesis was also tested – that when the latter group of clients took part in the program after the waitlist period they would subsequently show similar levels of improvement in their social and emotional wellbeing compared to the original intervention group.

The Social Enablement trial began receiving referrals in February 2008 and continued until the end of July 2009. A total of 81 referrals were recorded by the Team Leader during the study period. Of these, 46 clients were randomised, and 39 participants' survey data were evaluable for the study. There were no differences between the two groups at post-test in any of the four measures in the actual treatment analysis. The intervention group had statistically significant improvements in loneliness and wellbeing compared to the control group in the intention to treat analysis, but no change in depression or social support scores. However inspection of the data showed that the intervention group and control group as randomised were already different at baseline on the measures of loneliness and wellbeing.

However, the intervention group showed statistically significant improvements in depression, wellbeing and social support at follow up in the actual treatment analysis. Statistically significant improvements were also found for loneliness at post test and wellbeing and social support at follow up in the intention to treat analysis. The control group sample was small and did not show any improvements over time in any of the outcome measures. For the overall cohort that participated in the Social Enablement program, statistically significant improvements in depression and loneliness scores were observed at follow up. There was no significant improvement in wellbeing or social support scores for the overall cohort over time.

While many program processes worked well in the refined Social Enablement model, there were still some processes that did not work as well as expected. The peer volunteer model, person centred practice, and informal goal setting and review were some aspects of the model that worked well. However, problems with referral processes resulted in a poor referral rate, clients had differing expectations on the level of service that was to be delivered by their volunteers, most clients would not formally record their goals or progress, and even while some flexibility was afforded, many clients ran well over the program time limit.

The results of the Social Enablement trial indicate that this volunteer led model of social support for older home care clients had a moderate impact on levels of depression and loneliness in the cohort of clients that participated in the program. However due to a small sample size it was not possible to conclude definitively that the improvements seen were due to the program alone and not spontaneous improvement or natural variations over time.

Since the completion of the Social Enablement trial, Silver Chain has obtained HACC funding to provide social support in some service areas. Many of the volunteers recruited to the Social Enablement program are now providing ongoing social support to Silver Chain home care clients who have been identified as needing ongoing social support by their care co-ordinator. The poor referral rate to the Social Enablement program and many clients preference for ongoing social support visits indicates that, while seen as beneficial in some cases, the Social Enablement model of care would be generally underutilised if implemented as a standalone service throughout Silver Chain. The model is however totally consistent with a Wellness Approach to home care and enabling people to connect socially is an important facet of enhancing independence and promoting wellbeing.

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1 INTRODUCTION

Australia has an ageing population, and ever increasing numbers of older people will continue to refer for home care services such as those provided by Silver Chain. Previous research has demonstrated that many older people newly referring for home care services are lonely and depressed, and as such may have an inappropriately high level of health and community care service utilisation. At the same time as the population is ageing, there are decreasing numbers of workers available to provide support. Silver Chain investigated a model of care that uses volunteers to help clients who feel lonely and depressed to connect or re-connect into the community and achieve their social goals. Based on previous research, it was anticipated that such a service would reduce feelings of depression and loneliness in older home care recipients, which in addition to improving the quality of life of the individuals concerned, has the potential to reduce the economic costs of inappropriate service utilisation. This report presents the results of the randomised controlled trial of the Social Enablement program, a volunteer based model of care that encouraged and supported older Silver Chain clients to re-connect into their social networks.

1.1 Background

Feelings of social isolation, loneliness and depression are frequently reported within the older home care population. In 2001, a study of older people referring for home care services at Silver Chain found that 61.7% screened positive for depression, which was strongly associated with frequent feelings of loneliness [1]. This indicated a need for programs to alleviate both loneliness and depression in the home care population at large, and within Silver Chain in particular.

Reviews of programs to prevent or alleviate social isolation and loneliness have generally only been able to identify quantitative studies with poorly designed evaluations that indicate there is inconclusive evidence as to the effectiveness of the interventions, and few have specifically targeted the older home care population [2-4]. However, a qualitative evaluation of a Social Rehabilitation program piloted in five locations by Age Concern UK indicated that the program was successful in assisting many older people to participate more fully in the life of their choosing [5].

1.2 Social Rehabilitation Pilot

Based on this research, an application for funding was made to the Silver Chain Foundation for an 18 month pilot of the Social Rehabilitation program. The aim of the pilot was twofold, firstly to see if running the program was viable within Silver Chain, and secondly to test its effectiveness in: reducing social isolation, loneliness, depression; and improving wellbeing. This second aim would incidentally fill the gap in knowledge in regards to quantifiable client outcomes associated with participation in the Social Rehabilitation program. The pilot was run within one service centre in the Perth metropolitan area. The psychometric measures completed by participants included the Geriatric Depression Scale 15 (GDS-15), UCLA Loneliness Scale (Version 3) and the Personal Wellbeing Index (PWI). In addition, participants were asked to rate their level of goal achievement.

Of the twenty two participants who completed the program, twenty one sets of measures were evaluable. Table 1 below shows the change in mean scores on the outcome measures between baseline, program end and three months follow up. Paired *t* tests were used to determine the statistical significance in depression and loneliness scores between baseline program end and three month follow up. Levels of depression and loneliness were reduced at the end of the program, both of which were statistically significant. Although there was a slight improvement in wellbeing at program end, this was not statistically significant. At three month follow up, levels of depression and loneliness had decreased further, and wellbeing had continued to improve. These changes from baseline were all statistically significant results. Additionally, 86.3% of participants felt they had achieved at least one or more of their set goals.

Table 1: Social Rehabilitation Outcome Measure Scores at Baseline, Program End and Follow Up

n=21	Measure	Mean	Std Dev	95% CI		p
Depression	Baseline	5.7	3.4	4.1	7.2	
	Program End	4.2	2.4	3.2	5.3	0.027
	3-Month Follow Up	3.9	2.0	3.0	4.8	0.006
Loneliness	Baseline	45.1	10.5	40.3	49.8	
	Program End	40.3	9.8	35.8	44.7	0.033
	3-Month Follow Up	39.6	10.3	34.9	44.3	0.015
Wellbeing	Baseline	62.8	19.7	53.9	71.8	
	Program End	69.6	17.6	61.7	77.6	0.097
	3-Month Follow Up	72.9	15.5	65.8	79.9	0.027

p value in bold type indicates a statistically significant difference at the 5% level compared with baseline using a paired *t* test

1.3 New Social Enablement Model

Despite the positive results, a review of the operation effectiveness and efficiency of the program identified that process issues were impacting on the co-ordinator's delivery of the program, and that the model was not very cost effective. The model was then redesigned to increase the involvement of volunteers and free up the co-ordinator from working individually with clients. The revised program was renamed Social Enablement and was to be delivered by a Team Leader whose role was focused volunteer recruitment, training and support than on direct client co-ordination. Funding for a further two years to implement and evaluate the refined model was secured from the Silver Chain Foundation in 2007.

The evaluation design of the original Social Rehabilitation program was limited in its ability to definitively conclude that any positive client outcomes found could be attributed to the intervention. Application for funding for a control group to improve the rigour of the Social Enablement program evaluation was applied for from the Australian Association of Gerontology, and was granted in November 2007. Thus the evaluation of the model was modified to a randomised controlled trial, (RCT) with a waitlisted control group who would also participate in the intervention once their waitlist period had passed.

The aim of the Social Enablement RCT was to compare the outcomes in terms of loneliness, depression and personal wellbeing of older home care clients who participated in the program versus those who were waitlisted for the service. This would allow Silver Chain to determine whether any improvements in outcome measures demonstrated by clients that participated in the program could be attributed to the intervention rather than to spontaneous improvement or natural variations over time.

2 OBJECTIVES

The objectives of the Social Enablement RCT were as follows:

- 1 To determine if individuals participating in Silver Chain's Social Enablement program have improved outcomes in terms of loneliness, depression and wellbeing after completion compared to individuals who are waitlisted for the program.
- 2 To determine if, when this latter group of individuals take part in the program after the waitlist period, they subsequently show similar levels of improvement in these outcomes compared to the original intervention group.

- 3 To identify program processes that worked well and those that did not work well, in order to discover the potential for the model to be implemented throughout Silver Chain's metropolitan service delivery area.

3 METHODOLOGY

3.1 Study Design, Study Population, Sample Size and Power

The study was conducted as a small randomised controlled trial, where participants allocated to the control group subsequently had the opportunity to participate in the intervention. The target population for the Social Enablement program included independent older home care clients who had low to moderate care needs and felt flat, depressed, lonely or isolated and wanted to do something about it. The sample of individuals that participated in this study were those from the above target population who referred to Silver Chain's Social Enablement program. Between 50 and 80 clients were expected to successfully complete the program. It was calculated that 40 participants in each study group would give 82% power to detect a 0.25 effect size for the depression screening scores between the groups. This was the size of the effect found in the previous Social Rehabilitation pilot.

3.2 Eligibility Criteria

Eligibility for participation in this program was initially restricted to clients who self-referred to the program (or were referred through a proxy), and who met the following criteria:

- Over 65 years of age.
- HACC eligible.
- Current Silver Chain client.
- English speaking.
- No formal diagnosis of dementia.
- Streamed as independent by the Silver Chain HACC Needs Identification (HNI) tool, ie were self managing and did not require ongoing client care co-ordination.
- Living in the northern service centre catchment area.

Due to a poor referral rate the eligibility to the program was relaxed to the following:

- Over 65 years of age.
- HACC eligible.
- English speaking.
- No formal diagnosis of dementia.
- Living in the northern service centre catchment area.

The requirement that the client must be receiving Silver Chain services was revoked in July 2008, and the requirement that they were 'independent' was revoked in March 2009.

3.3 Recruitment and Assignment to Groups

The randomisation of 80 study numbers to either 0 (intervention) or 1 (control) was performed using SPSS. Secretive envelopes labelled with a study number from 1 to 80 were then filled with the group assignment as allocated by the randomisation process and were sealed closed. Participants were recruited into the study via self referral or referral from proxies such as family or Silver Chain staff members.

Referrals were screened for eligibility by Silver Chain's Customer Centre and were accepted by the Team Leader between 1 February 2008 and 31 July 2009. Suitability to start the program was assessed with the Team Leader and client in an informal face to face interview. Suitability to participate in the program was determined by the Team Leader in consultation with the client. Factors taken into consideration included the clients' reason for wanting to participate, their understanding of the new program, as well as their ability to participate in the program. Clients that were unsuitable for participation in the program were referred by the Team Leader to another service or other strategy suggested. Suitable clients were asked to read an Information Statement and Consent Form and invited to ask any questions about the study. If the client was happy to participate in the study, they were asked to sign the consent form. The Team Leader then opened the next sequentially numbered envelope and informed the client that they were randomised to either receive the service immediately, or were waitlisted to receive the service after three months. Controls had no further contact until the waitlist period had ended, after which the client was reassessed to ensure their suitability had not changed. Controls then participated in the intervention in the same manner as the original intervention group.

Recruitment to the study was unfortunately much slower than anticipated and because we were in danger of losing volunteers who we had trained to deliver the intervention, it was decided to abandon the randomisation after 46 clients. Subsequent recruited clients participated in the intervention immediately.

3.4 Intervention

The intervention was a social support intervention for older people named Social Enablement, a modified version of the Age Concern UK Social Rehabilitation model. The Age Concern UK Social Rehabilitation model includes three phases: assessment, time limited intervention and review, and has been described in detail elsewhere [19, 20]. Briefly, the assessment phase involves the client and a co-ordinator identifying the reasons for referral and outcomes they would like to achieve by the end of the program. During the time limited intervention phase, the co-ordinator and volunteer assists the client to support the client in achieving their agreed goals primarily by "doing with" and not "doing for" [20]. The intervention is time-limited in order to restrict the likelihood of clients developing a dependency on the co-ordinator and volunteer, and uses task centred practice to develop strategies to achieving their goals. Ongoing review accounts for unplanned events and circumstances that may provide obstacles to achievement of the set goals. In these instances, alternative strategies may need to be implemented, or the goal modified or abandoned altogether. While the review process is ongoing, formal review sessions can also be integrated into the program timeframe [20]. The Silver Chain Social Enablement model differs from the UK model in that the bulk of support is provided by volunteers with the guidance of a Team Leader. As described earlier the Team Leader focussed on volunteer recruitment, training and support than on direct client co-ordination.

3.5 Data Collection and Survey Measures

Demographic data were collected as part of the normal referral process using the HACC minimum data set (MDS). The GDS-15 and UCLA Loneliness Scale (Version 3) were used to measure levels of depression and loneliness. The PWI was used to measure subjective wellbeing. The 11 item Duke Social Support Index (DSSI-11) was used to measure objectively any change in participants' social interaction and support. The outcome measures used in this study have been used in many other evaluative studies. These measures have been demonstrated to be valid and reliable measures for the study population [6-9]. Goal achievement was assessed subjectively at both the post-test and follow up surveys. It was measured using a three point scale, including not completed, partially completed and fully completed.

3.6 Data Analysis

Analysis of the study results was performed on the basis of advice from a biostatistician from Curtin University and was performed using Stata (Version 11). The analysis comprised the following:

- 1 Demographics of the two groups was summarised descriptively and the equivalence of the groups at baseline tested using chi-square or *t* tests depending on the variable being examined.
- 2 Paired *t* tests were used to compare the outcomes of both the intervention and control groups over time.
- 3 Unpaired *t* tests were used to compare outcomes of the intervention group with the outcomes of the control group.
- 4 Paired *t* tests were used to compare the outcomes of the overall cohort that participated in the intervention over time.

Analysis was performed on both the raw change in scores and also using percentage change over time weighted by baseline score. Paired tests were performed on the sample of clients who completed all baseline, post-test and follow up measures.

Analysis of the data as described above was performed twice, firstly on an intention to treat basis and secondly based on the actual treatment each client received. The latter was necessary due to the cessation of the randomisation process in the latter half of the study. A p-value of less than 0.05 was considered as evidence for statistical significance in each test.

3.7 Ethics

All clients gave informed consent before participating in this trial. Ethical approval for this study was granted by both the Silver Chain Human Research Ethics Committee (Application 048) and the Curtin Human Research Ethics Committee (HR181/2008).

4 RESULTS

4.1 Referrals

A total of 81 referrals were recorded by the Team Leader, Social Enablement during the study period (Table 2). Nine clients were ineligible (11.1%) and 24 were assessed as unsuitable (29.6%). Eighteen clients (22.2%) withdrew from the study whilst either waitlisted or receiving the intervention. One client (1.2%) that had referred to the program died before completing the baseline survey measures. This male client had repeatedly delayed completing the baseline survey measures due to illness. At the end of the study, a total of 29 clients (35.8%) had completed the program as determined by the assessment of their volunteer and the Team Leader, Social Enablement. Although 29 clients completed the program, only 27 were included in the randomised controlled trial. These participants received the intervention but refused to be part of the randomisation and evaluation processes.

Table 2: Referral Outcomes

Status	Number	Percentage
Completed Program	29	35.8%
Unsuitable	24	29.6%
Withdrew	18	22.2%
Ineligible	9	11.1%
Deceased	1	1.2%
Total Referrals	81	100.00%

4.2 Demographics of Study Participants at Referral

Routinely collected demographic data from the HACC MDS were analysed to test the similarities of the two groups at randomisation. These demographics included age, gender, Australian ethnicity, country of birth, living arrangements, carer status, language spoken and pension benefits.

As seen in Table 3, most clients were female, not Aboriginal or Torres Strait Islander (ATSI), were born overseas, lived alone, had no carer, spoke English and had a pension of some kind. These demographics are typical of most Silver Chain clients, excepting that most clients lived alone. This may reflect a common reason for referral to the program.

The equivalence of the two groups at baseline was tested for gender, carer status living arrangements, pension status and country of birth¹. Table 3 shows that there were no significant differences between the groups at baseline on these items.

Table 3: HACC MDS at Referral

MDS Item	Category	Intention to Treat				p	Actual				p
		Intervention	Control				Intervention	Control			
Gender	Female	19	79.2%	17	77.3%	0.876	27	81.8%	9	69.2%	0.289
	Male	5	20.8%	5	22.7%		6	18.2%	4	30.8%	
Carer Status	No Carer	23	95.8%	20	90.9%	0.467	31	93.9%	12	92.3%	0.641
	Carer	1	4.2%	2	9.1%		2	6.1%	1	7.7%	
Living Arrangement	Alone	23	95.8%	21	95.5%	0.733	32	97.0%	12	92.3%	0.490
	With Family	1	4.2%	1	4.6%		1	3.0%	1	7.7%	
Pension	Pension	24	100.0%	20	90.9%	NA	32	97.0%	12	92.3%	0.490
	No Pension	0	0.0%	2	9.1%		1	3.0%	1	7.7%	
Country of Birth	Australia	10	41.7%	10	45.5%	0.796	14	42.4%	6	46.2%	0.818
	Other	14	58.3%	12	54.6%		19	57.6%	7	53.9%	
Language	English	24	100.0%	22	100.0%	NA	33	100.0%	13	100.0%	NA
	Other	0	0.0%	0	0.0%		0	0.0%	0	0.0%	
Ethnicity	Not ATSI	24	100.0%	22	100.0%	NA	33	100.0%	13	100.0%	NA
	ATSI	0	0.0%	0	0.0%		0	0.0%	0	0.0%	

The equivalence of the age of the two groups was also tested at baseline. The mean age of the intervention group was 80 years while the control group mean age was 83 years. Table 4 shows that although the control group was slightly older there was no statistical difference between the two groups in both the intention to treat and actual treatment analysis.

¹ Chi² tests were not performed on demographic items where a cell count was zero. Pearson's chi² was used where the expected count in each cell was 5 or above. Fisher's exact test was used where an expected cell count was between 1 and 5.

Table 4: Mean Age

Analysis	Group	Obs	Mean	Std Dev	95% CI		p
Actual Treatment	Intervention	33	80.48	8.25	77.56	83.41	0.212
	Control	13	83.62	5.41	80.35	86.88	
Intention to Treat	Intervention	24	80.17	8.57	76.55	83.79	0.269
	Control	22	82.68	6.40	79.84	85.52	

4.3 Withdrawals

A chi-squared analysis was performed to determine if clients in the waitlisted control group were more likely to withdraw from the study than those who began the intervention immediately. Table 5 below displays the number of clients in each group by randomised allocation and actual treatment. There were no significant differences in the proportion of clients who withdrew or completed in either the allocated or actual treatment groups using a chi-square test. It did not appear that being allocated to the control group predicted withdrawal from the study.

Table 5: Completion and Withdrawal Status of Study Participants by Intention to Treat and Actual Treatment Groups

		Status				Pearson chi ²	p
		Completed		Withdrawn			
		n	%	n	%		
Intention to Treat	Intervention	14	60.87%	9	60.87%	0.0148	0.903
	Control	13	59.09%	9	40.91%		
Actual	Intervention	19	59.38%	13	40.63%	0.0180	0.893
	Control	8	61.54%	5	38.46%		

Table 6 below displays the reasons why clients withdrew from the study. The most common reason for withdrawal was that the client decided they were not interested in the service after all (n=7), either during the intervention for group 1 or after completing the waitlist and then commencing the intervention for group 2. In some cases, the decision for a client to withdraw was made at the discretion of the Team Leader in the case of social or mental health complications (n=2), refusal of same-sex volunteer (n=1), or the client never being home when the volunteer had arranged a visit (n=1). Clients who withdrew voluntarily cited various reasons, including family reasons (n=1), medical reasons (n=2), and moving out of the catchment area (n=1) and one client died before completing the baseline survey measures.

Table 6: Reasons Why Clients Withdrew

	Intention to Treat				Actual			
	Intervention		Control		Intervention		Control	
	n	%	n	%	n	%	n	%
Not interested after all	2	20.00%	5	55.56%	4	28.57%	3	60.00%
Social/mental health complications	1	10.00%	1	11.11%	2	14.29%	0	0.00%
Family reasons	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Activity costs and surveys	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Client denied they received the service	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Client died	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Client never home	0	0.00%	1	11.11%	1	7.14%	0	0.00%
Medical issues	1	10.00%	1	11.11%	1	7.14%	1	20.00%
Medical issues and forgot after waitlist	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Refused same sex volunteer	1	10.00%	0	0.00%	1	7.14%	0	0.00%
Moved out of area	0	0.00%	1	11.11%	0	0.00%	1	20.00%
Total	10	100.00%	9	100.00%	14	100.00%	5	100.00%

Analysis of the baseline data for clients that withdrew from the intervention or waitlist was compared to the group of clients that completed the program. This analysis showed that the clients who withdrew scored similarly at baseline to those that completed all measures and therefore their withdrawal did not impact on the study results overall.

4.4 Final Sample

A total of 39 participants' survey data was evaluable for this study of the 46 clients randomised. This included 26 clients that completed the baseline measures in the intervention group (group 1) and 13 clients who completed the baseline measures in the control group (group 2). Figures 1 and 2 show the number of clients included in the intention to treat and actual treatment analyses.

Figure 1: Data Analysis by Actual Treatment

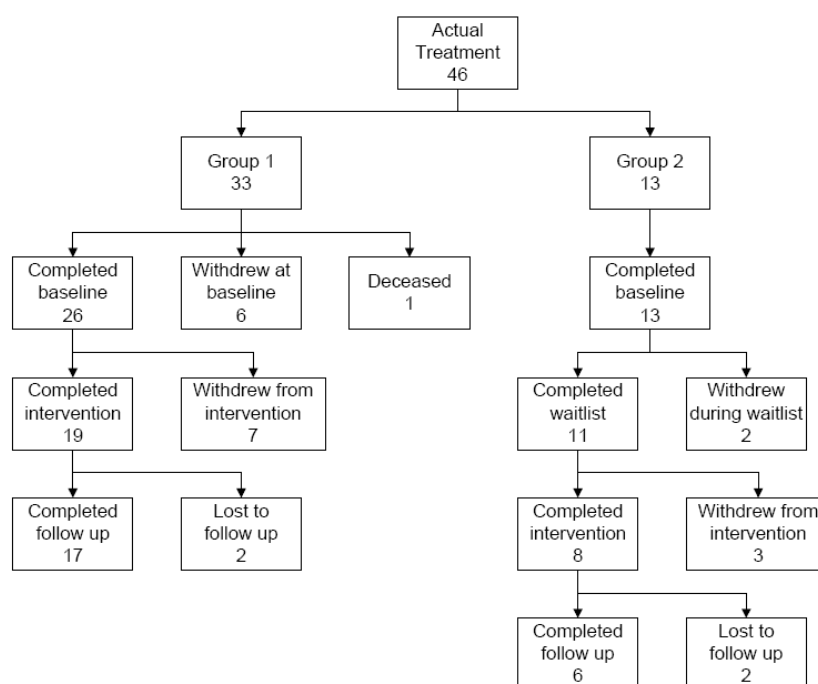
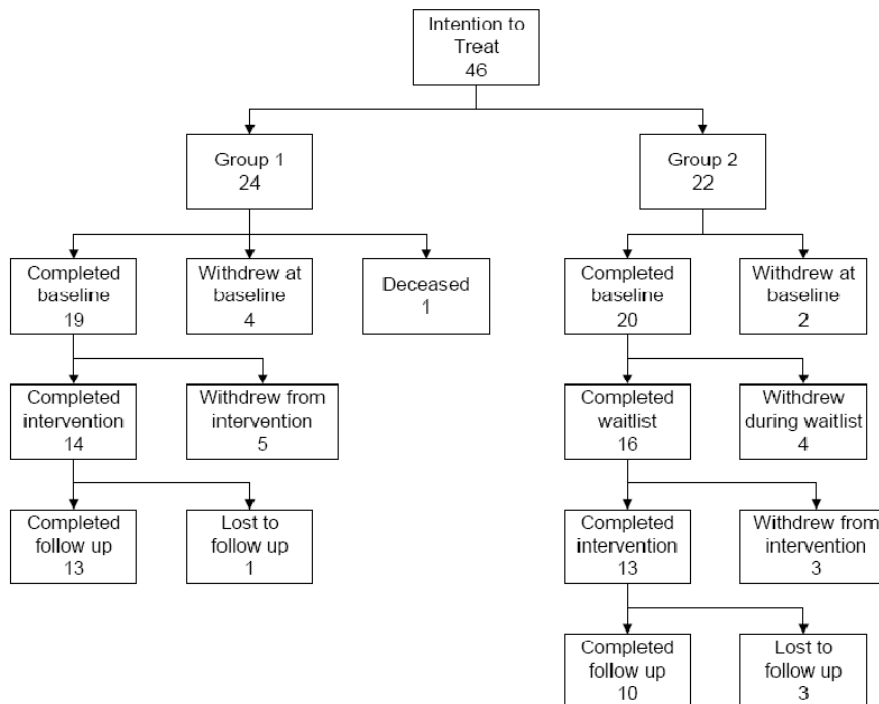


Figure 2: Data Analysis by Intention to Treat



4.5 Results of Study Objectives

The results for the trial are presented in respect to each of the study objectives in turn. The study objectives can be found on page 6.

4.5.1 Objective 1

Comparison between Intervention Group and Control Group by Intention to Treat

The intention to treat analysis found that the control group had lower scores for depression and higher mean scores for social support than the intervention group at baseline. However, these differences were not significant. The control group also had lower mean scores for loneliness and higher mean scores for wellbeing than the intervention group, and these differences were statistically significant (Table 7). While greater improvements were seen for the intervention group than the control group for depression and social support, there were no statistically significant differences between the groups at post test, nor for the raw change or weighted change over time for these measures. However, the difference in the raw change for loneliness and wellbeing between the groups was statistically significant, as was the percentage change for loneliness.

Table 7: Comparison between Intervention Group and Control Group – Intention to Treat

Intention to Treat								
Outcome	Measure	Group	Number	Mean	Std Dev	95% CI		p
Depression	Baseline	Intervention	14	5.9	3.4	3.9	7.8	0.253
		Control	16	4.4	3.2	2.7	6.2	
	Post Test	Intervention	14	3.7	2.3	2.4	5.1	0.879
		Control	16	3.6	3.0	2.0	5.1	
	Raw Change	Intervention	14	-2.1	3.8	-4.3	0.1	0.275
		Control	16	-0.9	2.4	-2.1	0.4	
	Percentage Change	Intervention	14	-8.5	81.5	-55.5	38.5	0.939
		Control	16	-10.3	45.1	-34.3	13.7	
Loneliness	Baseline	Intervention	14	49.1	13.3	41.4	56.7	0.004
		Control	16	36.6	8.4	32.1	41.0	
	Post Test	Intervention	14	43.2	9.9	37.5	48.9	0.222
		Control	16	38.6	10.5	33.0	44.1	
	Raw Change	Intervention	14	-5.9	7.9	-10.4	-1.3	0.009
		Control	16	2.0	7.4	-2.0	6.0	
	Percentage Change	Intervention	14	-9.5	15.0	-18.2	-0.8	0.026
		Control	16	6.4	20.9	-4.8	17.5	
Wellbeing	Baseline	Intervention	13	57.6	23.2	43.6	71.6	0.007
		Control	16	77.7	13.4	70.6	84.8	
	Post Test	Intervention	13	66.7	19.6	54.9	78.5	0.196
		Control	16	75.3	15.3	67.1	83.4	
	Raw Change	Intervention	13	9.1	18.8	-2.3	20.5	0.047
		Control	16	-2.4	10.6	-8.1	3.3	
	Percentage Change	Intervention	13	35.5	80.8	-13.3	84.4	0.073
		Control	16	-2.6	13.3	-9.7	4.5	
Social Support	Baseline	Intervention	12	31.9	6.2	28.0	35.9	0.104
		Control	16	35.4	4.7	32.9	37.9	
	Post Test	Intervention	12	34.3	4.8	31.3	37.4	0.274
		Control	16	36.3	4.3	34.0	38.5	
	Raw Change	Intervention	12	2.4	4.9	-0.7	5.6	0.309
		Control	16	0.9	2.9	-0.7	2.4	
	Percentage Change	Intervention	12	11.3	24.9	-4.5	27.1	0.224
		Control	16	3.0	8.6	-1.6	7.6	

Comparison between Intervention Group and Control Group – Actual Treatment

When analysed by the actual treatment received, the control group was found to have lower scores for depression and loneliness, and higher mean scores for wellbeing and social support than the intervention group at baseline. However, these differences were not statistically significant. While greater improvements during the first three months were seen for the intervention group as compared to the control group, there were no statistically significant differences between the groups at post test. There were also no significant differences between the groups for the raw change or weighted change for all outcome measures between baseline and post test (Table 8).

Table 8: Comparison between Intervention Group and Control Group – Actual Treatment

		Actual Treatment						
Outcome	Measure	Group	Number	Mean	Std Dev	95% CI		p
Depression	Baseline	Intervention	19	5.5	3.3	3.9	7.0	0.431
		Control	11	4.5	3.6	2.1	6.9	
	Post Test	Intervention	19	3.9	2.9	2.5	5.3	0.487
		Control	11	3.2	2.2	1.7	4.7	
	Raw Change	Intervention	19	-1.6	3.5	-3.3	0.1	0.801
		Control	11	-1.3	2.4	-2.9	0.4	
	Percentage Change	Intervention	19	-7.6	73.2	-42.9	27.7	0.835
		Control	11	-12.7	44.8	-42.8	17.3	
Loneliness	Baseline	Intervention	19	44.8	13.7	38.2	51.4	0.172
		Control	11	38.3	9.1	32.2	44.4	
	Post Test	Intervention	19	41.2	10.1	36.3	46.0	0.772
		Control	11	40.0	11.1	32.6	47.4	
	Raw Change	Intervention	19	-3.6	8.2	-7.6	0.3	0.097
		Control	11	1.7	8.2	-3.8	7.3	
	Percentage Change	Intervention	19	-5.1	17.4	-13.4	3.3	0.147
		Control	11	5.9	22.6	-9.3	21.1	
Wellbeing	Baseline	Intervention	18	63.2	22.4	52.0	74.3	0.066
		Control	11	77.7	14.4	68.0	87.4	
	Post Test	Intervention	18	67.0	17.8	58.1	75.8	0.080
		Control	11	78.7	15.2	68.5	88.9	
	Raw Change	Intervention	18	3.8	19.0	-5.7	13.3	0.652
		Control	11	1.0	8.2	-4.5	6.6	
	Percentage Change	Intervention	18	22.2	71.8	-13.5	57.9	0.361
		Control	11	1.8	10.8	-5.5	9.1	
Social Support	Baseline	Intervention	17	32.4	5.9	29.3	35.4	0.067
		Control	11	36.3	4.3	33.4	39.1	
	Post Test	Intervention	17	34.4	4.3	32.2	36.5	0.118
		Control	11	37.1	4.6	34.0	40.2	
	Raw Change	Intervention	17	2.0	4.4	-0.3	4.3	0.443
		Control	11	0.8	3.0	-1.2	2.8	
	Percentage Change	Intervention	17	9.2	21.4	-1.8	20.2	0.343
		Control	11	2.6	8.9	-3.4	8.5	

Intervention Group: Change Over Time by Intention to Treat

When analysed by intention to treat, as seen in Table 9 below, loneliness was the only outcome measure that showed a statistically significant difference between the baseline and post test scores. Significant differences were also found at follow up for the raw change in wellbeing and social support, and the percentage change for social support.

Table 9: Impact on Intervention Group Over Time – Intention to Treat

		Intention to Treat					
	Measure	Obs	Mean	Std Dev	95% CI	p	
Depression	Baseline (B)	12	6.2	3.4	4.0	8.3	
	Post-test (P)	12	3.8	2.5	2.1	5.4	
	3 Month Follow Up (3)	12	4.3	4.3	1.6	7.1	
	Raw Change (B-P)	12	-2.4	3.9	-4.9	0.1	0.056
	Raw Change (B-3)	12	-1.8	4.5	-4.7	1.0	0.185
	Percentage Change (B-P)	12	-23.0	59.6	-60.9	14.9	0.208
	Percentage Change (B-3)	12	-25.5	62.4	-65.1	14.1	0.185
Loneliness	Baseline (B)	13	48.2	13.4	40.1	56.3	
	Post-test (P)	13	42.4	9.7	36.5	48.3	
	3 Month Follow Up (3)	13	43.2	13.1	35.3	51.1	
	Raw Change (B-P)	13	-5.9	8.2	-10.8	-0.9	0.024
	Raw Change (B-3)	13	-5.0	8.4	-10.1	0.1	0.054
	Percentage Change (B-P)	13	-9.5	15.6	-18.9	0.0	0.034
	Percentage Change (B-3)	13	-9.0	17.2	-19.4	1.4	0.084
Wellbeing	Baseline (B)	12	59.8	22.8	45.3	74.2	
	Post-test (P)	12	70.0	16.3	59.7	80.3	
	3 Month Follow Up (3)	12	68.4	16.9	57.7	79.2	
	Raw Change (B-P)	12	10.2	19.2	-2.0	22.4	0.092
	Raw Change (B-3)	12	8.7	13.2	0.3	17.0	0.043
	Percentage Change (B-P)	12	39.6	83.0	-13.1	92.4	0.127
	Percentage Change (B-3)	12	30.4	58.0	-6.5	67.2	0.097
Social Support	Baseline (B)	11	32.3	6.4	28.0	36.6	
	Post-test (P)	11	34.6	4.9	31.3	37.9	
	3 Month Follow Up (3)	11	35.9	5.0	32.5	39.3	
	Raw Change (B-P)	11	2.4	5.2	-1.1	5.8	0.160
	Raw Change (B-3)	11	3.6	4.2	0.9	6.4	0.016
	Percentage Change (B-P)	11	11.4	26.1	-6.2	28.9	0.180
	Percentage Change (B-3)	11	14.5	20.6	0.7	28.3	0.041

Intervention Group: Change Over Time by Actual Treatment

The intervention group were followed at post test and again three months later to determine the impact of participation in the Social Enablement program over time and compare the results with the previous Social Rehabilitation pilot. As seen in Table 10 below, no significant differences were found between the mean baseline and post-test scores for any of the outcome measures. However, significant differences were found at three month follow up for the raw change in wellbeing and social support, and the percentage change from baseline for depression and social support.

Table 10: Impact on Intervention Group Over Time – Actual Treatment

		Actual Treatment					
Outcome	Measure	Obs	Mean	Std Dev	95% CI		p
Depression	Baseline (B)	16	5.8	3.3	4.0	7.5	
	Post-test (P)	16	4.1	3.1	2.5	5.8	
	3 Month Follow Up (3)	16	3.9	3.9	1.8	5.9	
	Raw Change (B-P)	16	-1.6	3.7	-3.6	0.4	0.101
	Raw Change (B-3)	16	-1.9	3.9	-4.0	0.2	0.073
	Percentage Change (B-P)	16	-14.1	55.9	-43.9	15.7	0.328
	Percentage Change (B-3)	16	-31.8	56.7	-62.0	-1.6	0.040
Loneliness	Baseline (B)	17	44.3	13.9	37.1	51.5	
	Post-test (P)	17	40.4	10.2	35.2	45.6	
	3 Month Follow Up (3)	17	40.5	12.8	34.0	47.1	
	Raw Change (B-P)	17	-3.9	8.5	-8.3	0.5	0.079
	Raw Change (B-3)	17	-3.8	7.9	-7.8	0.3	0.067
	Percentage Change (B-P)	17	-5.5	18.1	-14.8	3.8	0.224
	Percentage Change (B-3)	17	-6.8	16.6	-15.3	1.8	0.112
Wellbeing	Baseline (B)	16	64.6	22.2	52.8	76.5	
	Post-test (P)	16	70.3	15.2	62.2	78.4	
	3 Month Follow Up (3)	16	71.2	16.7	62.3	80.2	
	Raw Change (B-P)	16	5.6	19.3	-4.7	15.9	0.263
	Raw Change (B-3)	16	6.6	12.3	0.0	13.2	0.050
	Percentage Change (B-P)	16	27.3	74.7	-12.5	67.1	0.164
	Percentage Change (B-3)	16	22.9	51.6	-4.6	50.4	0.096
Social Support	Baseline (B)	15	32.9	6.1	29.5	36.2	
	Post-test (P)	15	34.8	4.4	32.4	37.2	
	3 Month Follow Up (3)	15	35.6	4.5	33.1	38.1	
	Raw Change (B-P)	15	1.9	4.7	-0.7	4.5	0.133
	Raw Change (B-3)	15	2.7	4.5	0.3	5.2	0.032
	Percentage Change (B-P)	15	9.2	22.9	-3.4	21.9	0.141
	Percentage Change (B-3)	15	11.2	19.2	0.5	21.8	0.041

4.5.2 Objective 2

As seen in Figure 2 (page 13), only six clients' data were evaluable for this part of the study. As this sample size was so small, it was not statistically rigorous to determine the impact of the program on this small cohort over time, nor was it statistically rigorous to compare the outcomes of the control group with those of the original intervention group over time. Instead, the impact of the program was evaluated based on the actual treatment received for the overall cohort of clients who completed the intervention as described in the following section.

All Social Enablement Participants: Change Over Time

For the cohort of clients that participated (whether immediately or after three months wait) in the Social Enablement program, no statistically significant improvements were seen in any of the outcome measures at post test, whether measured in terms of the raw change or weighted percentage change.

At three month follow up, there was a statistically significant reduction in depression and loneliness scores. The weighted percentage change for depression was also significant at follow up, where the mean depression scores were reduced by 30% of the original mean baseline scores (Table 11).

Table 11: Impact on Cohort Over Time

	Measure	Obs	Mean	Std Dev	95% CI	p	
Depression	Baseline (B)	22	5.2	3.2	3.8	6.7	
	Post-test (P)	22	3.8	3.1	2.5	5.2	
	3 Month Follow Up (3)	22	3.6	3.6	2.0	5.1	
	Raw Change (B-P)	22	-1.4	3.3	-2.9	0.1	0.059
	Raw Change (B-3)	22	-1.7	3.4	-3.2	-0.2	0.031
	Percentage Change (B-P)	22	-18.6	52.9	-42.1	4.9	0.114
	Percentage Change (B-3)	22	-30.0	50.9	-52.6	-7.4	0.012
Loneliness	Baseline (B)	23	43.7	13.3	37.9	49.4	
	Post-test (P)	23	40.1	9.1	36.2	44.0	
	3 Month Follow Up (3)	23	40.0	11.4	35.1	45.0	
	Raw Change (B-P)	23	-3.6	8.3	-7.2	0.0	0.052
	Raw Change (B-3)	23	-3.6	7.4	-6.8	-0.4	0.030
	Percentage Change (B-P)	23	-4.4	18.9	-12.5	3.8	0.283
	Percentage Change (B-3)	23	-5.9	16.7	-13.1	1.3	0.104
Wellbeing	Baseline (B)	22	67.0	20.4	58.0	76.1	
	Post-test (P)	22	70.8	14.6	64.3	77.3	
	3 Month Follow Up (3)	22	71.4	16.7	64.0	78.8	
	Raw Change (B-P)	22	3.8	16.9	-3.7	11.3	0.304
	Raw Change (B-3)	22	4.4	11.6	-0.8	9.5	0.090
	Percentage Change (B-P)	22	19.5	64.6	-9.1	48.2	0.171
	Percentage Change (B-3)	22	15.9	45.4	-4.2	36.1	0.115
Social Support	Baseline (B)	21	34.1	5.9	31.4	36.7	
	Post-test (P)	21	35.4	4.1	33.6	37.3	
	3 Month Follow Up (3)	21	35.6	4.2	33.6	37.5	
	Raw Change (B-P)	21	1.4	4.5	-0.7	3.4	0.178
	Raw Change (B-3)	21	1.5	4.4	-0.5	3.5	0.129
	Percentage Change (B-P)	21	6.8	20.4	-2.5	16.1	0.140
	Percentage Change (B-3)	21	6.9	17.8	-1.2	15.1	0.100

4.5.3 Objective 3

Program Process That Worked Well

The following program processes were found to have worked well:

- The person-centred and individualised approach meant that volunteers got to know the clients before setting goals and developing strategies to achieve them.
- Informal goal setting and ongoing review kept both clients and volunteers focused on what the client wanted to achieve by the end of the program. Some examples of the goals that clients have achieved are:

- Walking independently or attendance at exercise classes.
 - Accessing and using public transport independently.
 - Learning computing skills such as sending digital photographs to family and friends via email.
 - Developing new friendships through community groups such as seniors clubs, church groups, day centres, and the University of the Third Age.
- Task centred practice allowed clients to take 'baby steps' towards achieving their greater goals.
 - Targeting clients with low care needs meant these clients were more likely to complete the program successfully compared with clients with complex care needs.
 - Doing 'with' not 'for' meant that at the end of the program clients had gained confidence and new skills.
 - The volunteers gave each other support and assistance when needed.
 - The volunteers felt rewarded when they saw their client become more independent, adopt positive changes in their wellbeing and attitude and achieve their goals.
 - The volunteers enjoyed moving onto the next client for a new challenge.
 - The Team Leader enjoyed building relationships with the volunteers, care staff, other community organisations such as the Independent Living Centre, Commonwealth CareLink, Transperth and local councils.
 - Positive impacts were seen in clients not just by the volunteers and research team but also by some clients' care staff. An example is provided below:

"My home help raised concerns for the wellbeing of a client - this client was streamed as independent and was receiving home help services only on a fortnightly basis. The home help's concerns prompted me to visit to assess the situation. The client presented quite teary, it became apparent that she was depressed following the sudden death of her husband. I had concerns for her physical and mental wellbeing. She was struggling physically with her activities of daily living and was focusing on negative feelings. She clearly missed her 'old life' with her husband of many, many years where they were active socially. After initial assessment I put in additional services for personal care, respite and a referral to our Social Enablement Program, I also raised bereavement counselling. I re-visited the client today - her whole focus on life has changed for the better. Personal care has assisted her pain management which is now more bearable; respite has allowed her stimulating conversations, interaction and the ability to do small amounts of gardening, cooking etc with assistance and encouragement from our care aide. The Social Enablement Program has supported her to focus on her social goals and assisted her to take the steps to achieve them. She is now currently attending a Day Care Centre and is instrumental in assisting others there that are less fortunate. It was wonderful seeing her today smiling, joking and having a real zest for life. Silver Chain has assisted to minimise the loneliness, social isolation and the depression of this client." (Care co-ordinator, personal communication).

Program Processes That Did Not Work Well

The program processes that did not work as well as was expected are listed below:

- The biggest challenge of this trial was the poor referral rate to the program. Considering the previous Silver Chain research that indicated high levels of depression and loneliness in the Silver Chain older home care population, the rate of referrals received was far lower than expected. This may be because the referral pathways relied on care aides, home help staff, and care co-ordinators who acted as gatekeepers. The Team Leader attended many staff meetings and encouraged staff to discuss the program with their clients and make a referral. However, in the few instances in which clients were referred by staff, they were frequently ineligible due to complex support needs.
- Strict eligibility criteria, while intended to give better targeting, reduced the size of the pool of eligible clients from which referrals could be drawn.
- There were some instances where staff in the Customer Centre did not follow the documented referral process and as a result some referrals were not received by the Team Leader as intended.
- Considering the target group was older people who are receiving home care services, many of the clients who came onto the program had developed a tendency to expect that in all services they received, including Social Enablement, things would be done for them. This then contradicted the independence paradigm driving this model of care, which made life for some volunteers difficult when they tried to do things 'with' the client as opposed to doing it 'for' them. An example of this is where a handful of clients expected the volunteer to provide a taxi-like transport service as required.
- Clients were generally unwilling to formally record their goals at the beginning of the program and their progress towards achieving them.
- A small number of clients hoped to use the program to find a future spouse or had romantic intentions toward their volunteer. One client refused to have a same sex volunteer citing a fondness for the opposite sex. The service was terminated for this client.
- More often than not, clients ran over the time limit of three months. Even considering that there was some flexibility to account for illness, holidays and other commitments, many clients' program duration extended well over the intended time limit.
- The Team Leader had difficulties in having regular and comprehensive group training sessions for the volunteers, and then retaining the volunteers once their training was complete, when there were few clients to link volunteers with.
- The Team Leader was constantly challenged in perfecting the volunteer training and delivering it in the best way for the volunteers to have a good understanding of what was expected of them once they were linked with their clients.
- The Team Leader needed to keep up to date with all the changes in service provision throughout the community, which were sometimes affected by changes in different levels of government.

Client Satisfaction Survey Results

Of the 27 clients who completed the Social Enablement program, 25 completed the satisfaction survey (Appendix 1). As seen in Table 12 most clients were satisfied with most program aspects. However, fewer than one third agreed or strongly agreed that their confidence in social situations had increased as a result of participating in the program. Approximately 70% agreed or strongly agreed that the number of social contacts had increased and that they had gained new skills, and three quarters felt more involved in their community. All other aspects of the program had high satisfaction of above 80% or 90%.

Table 12: Results from the Client Satisfaction Survey

Satisfaction...	Total Satisfied
That the program met your initial expectations	88.0%
That you were actively involved in setting your goals	87.5%
That you were actively involved in making decisions	96.0%
With the Social Enablement program overall	96.0%
Agreement...	Total Agreed
The program was flexible	95.8%
The program has helped you to be more independent	87.5%
You had enough time to achieve your goals	82.6%
Your social contacts have increased since being on the program	69.6%
Your confidence in social situations has increased	62.5%
You feel more involved in your community since being on the program	75.0%
You have gained new skills and abilities from the program	70.8%
You enjoyed participating in the program	95.8%
You achieved your goal/s	82.6%
The Team Leader gave you a good explanation of what to expect from the program	91.7%
The volunteer had the skills to assist you	96.0%
The volunteer gave you the support you needed to achieve your goals	95.8%
The volunteer gave enough time to support you	92.0%
The volunteer was available when you needed them	84.0%
The volunteer encouraged you to work towards achieving your goals	95.8%
You felt comfortable working with the volunteer	96.0%

5 DISCUSSION

5.1 Objective 1

The first objective of this trial was to determine if individuals participating in Silver Chain's Social Enablement program had better outcomes in terms of loneliness, depression, wellbeing and social support at post test compared with the control group, as well as improved outcomes compared with their own baseline scores.

Analysis of the data obtained from the trial showed that based on the actual treatment received there were no statistically significant differences between the intervention group and control group for depression prevalence at baseline. However, as no controls were lonely, the prevalence of loneliness was statistically significantly greater in the intervention group at baseline. Although the control group had lower mean scores for baseline depression and loneliness, and higher mean scores for baseline wellbeing and social support, these differences were not statistically significant.

At post test, the raw improvement in the intervention group on all four outcome measures was greater than for the control group, but neither these nor the percentage change weighted by initial score achieved statistical significance. These results do not match what was originally expected for the study. The study was expected to find that the groups would be similar at baseline and in addition that at post test the intervention group would have statistically significantly greater improvement in raw scores than the control group. This would yield a lower mean post test score for depression and loneliness measures and higher scores for the wellbeing and social support measures in the intervention group compared with that of the control group. Although the results did not show a statistically significant improvement in the mean outcome scores, marginal improvements were shown in the intervention group. These small changes could be of personal or emotional significance, or even clinical significance, given that quantifiably small changes in depression scores over time may reflect a clinically significant increase in depressive symptomatology [10]. Additionally the small sample sizes may have prevented the attainment of statistical significance, a larger sample size would address this shortcoming.

In the intention to treat analysis there were no statistically significant differences between the groups at baseline for the prevalence of depression or loneliness. Likewise there were no statistically significant differences on the mean scores for depression and social support. However, there were statistically significant differences at baseline for the mean loneliness and wellbeing scores between the two groups, where the control group had higher mean scores for loneliness and wellbeing than the intervention group. At post test, there were no differences between the groups on depression and social support, but there were statistically significant differences in the raw change in loneliness and wellbeing scores. Given that the two groups were already different at baseline on these measures, the percentage change weighted by baseline score showed a statistically significant difference between the groups for loneliness only. As was found in the actual treatment analysis, the raw changes in the control group for all outcome measures were not as large as the changes for the intervention group. However, the control group was still less depressed, less lonely, and had better wellbeing and social support than the intervention group at post test, and again these findings contradicted the expected results.

There are few studies that have utilised volunteers to deliver an intervention that aimed to assist clients address their social goals using task centred practice and thus reduce feelings of loneliness and depression, and so comparison of this research with other studies is problematic. The Age Concern UK Social Rehabilitation program was evaluated qualitatively and so comparison with the current study cannot be made. Two studies that measured the impact of group internet training on depression and loneliness in older people have been identified. In one of these studies there was an absence of statistical differences in raw change scores between the intervention and control groups [11]. The authors reported that the CES-D depression scores and UCLA loneliness scores were equal at baseline using non-parametric tests. At post test, the intervention group had not improved as much as had been expected, and in fact scored similarly to the control group [11]. Baseline differences that favoured the control group were also found for depression and loneliness in a later and similar study of the impact of an internet based intervention on older people [12]. By equalising the groups at baseline a statistically significant improvement was seen in the intervention group for both depression and loneliness, but the adjustment method was not described [12].

5.2 Objective 2

The second objective of the study was to determine if, when the waitlisted individuals took part in the program after the waitlist period, they subsequently showed similar levels of improvement in the outcomes measured as the original intervention group.

It was originally planned that a sufficiently large sample would be recruited to allow comparison between the scores of the control group once they had also participated in the intervention with

those of the original intervention group, along with comparison of the control group's scores over time. However, due to a low referral rate, high attrition, and cessation of randomisation into the waitlisted control group, there was only a very small sample of control clients who completed all four sets of measures (n=6). Analysis of this objective was therefore not conducted, and instead the data for the control group were combined with the data from the original intervention group. This enabled the impact of the Social Enablement program on the whole client cohort to be tested over time. These results showed that depression and loneliness had decreased at three month follow up, but that there were no other statistically significant findings over time in any of the outcome measures. This result was not expected considering that in the Social Rehabilitation trial of a similar sample size there were statistically significant improvements seen for depression and loneliness at post test and for depression, loneliness and wellbeing at three month follow up. The lack of statistical significance at post test for all measures and some measures at follow up may be explained by an insufficient sample size, as the magnitude of change over time is similar to the results from the Social Rehabilitation pilot, which had a larger sample.

Given that the intervention was designed to reduce prevalent loneliness, it was also surprising to find that for the overall cohort, no client's loneliness had resolved and that emergent loneliness was high at post test and follow up. Other studies have found that while uncommon, the resolution of loneliness could at least be detected over time in 3.8% [13] and 6% [14] of the samples. The emergent loneliness rate in this study of 21.7% at post test is similar to the 26% rate found in a previous Welsh longitudinal study [14], while the emergent rate of 13% at follow up is slightly higher than the Finnish emergent rate of 9.8% [13]. However, both the Welsh and Finnish studies measured longitudinal changes in the prevalence of loneliness and participants did not receive any intervention. In contrast to loneliness, resolution of depression in our study was high at 26.1% at post test and 34.8% at follow up, while emergent depression was low at 4.3% at post-test and 8.7% at follow up. The depression resolution rate at follow up is almost equal to the rate found in the same home care setting by McCormack [15] and the emergent depression rates are similar to the rate found by Harris et al of 8.4% [16], but again both of these studies were not intervention based. These findings indicate that amelioration of depression that was evident may well have been due to factors other than participation in the Social Enablement intervention.

5.3 Objective 3

The third objective of this study was to identify program processes that worked well and those that did not work well in order to assess the potential for the model to be implemented throughout Silver Chain's metropolitan service delivery area.

While the Social Enablement program had some program processes that worked well and clients were generally satisfied with the program, the decision was made to cease the implementation of the program as a discrete service once this trial ended. Silver Chain has recently adopted a Wellness Approach across the organisation, a paradigm in which all services are delivered in a way that enhances clients' capabilities and encourages independence. This approach, coupled with the results of this trial, has identified the benefits of including Social Enablement as one the ways of providing a social support service to Silver Chain clients. These clients referring to Silver Chain for social support who have specific aspects of their lives they wish to change without needing ongoing home visits, are linked with volunteers with Social Enablement training. These volunteers are supported by the Volunteer Team Leader, who was previously the Social Enablement Team Leader. The Volunteer Team Leader now also supports all Silver Chain volunteers (hospice respite, home visiting, transport etc), a position which became vacant at the time the Social Enablement program trial ended.

5.4 Strengths of the Study

5.4.1 Control Group

The results of the previous Social Rehabilitation trial were not robust due to the lack of any control group. The inclusion of a control group in the Social Enablement study allowed the controlling of confounders such as the impact of the home visit by the members of the research team to collect the survey data and the examination of any spontaneous resolution of symptoms.

5.5.2 Individually Tailored Intervention

The intervention each client received was unique and support was delivered at a level appropriate for each client's needs. Some clients' intervention consisted of high amounts of volunteer input while others had minimal contact, such as one or two face to face sessions with the remainder of the program delivered via telephone support. Many previous studies aimed at reducing levels of depression or loneliness have been the subject of group based interventions [17], activity based interventions [11, 12] or have targeted a specific demographic such as women or the recently bereaved [18]. While this study was not conclusive, it is one of the first to attempt to fill the gap in knowledge regarding the quantifiable outcomes of individually tailored interventions to reduce the impact of both depression and loneliness on older people's lives.

5.5.3 Independent Research Team

The evaluation and research component of the trial was separate from the Social Enablement intervention. The Team Leader received all referrals and co-ordinated all client and volunteer matters. The research staff assisted the Team Leader in identifying process issues such as the number of referrals received each month, the hours of service delivered to each client, as well as providing feedback on any clients who were not suitable for the trial at the baseline visit. The research staff were not involved in co-ordinating client or volunteer matters but did pass on any concerns or issues identified during data collection.

5.5.4 Dedicated Volunteer Team

The volunteers led by the Team Leader were incredibly dedicated and supportive of their clients' needs. Volunteers demonstrated many times that they could problem-solve client issues independently or by calling on fellow volunteers for advice and assistance. They also displayed loyalty to the program and to Silver Chain. Although they were disappointed that the program came to an end, many volunteers asked if they could continue volunteering within the organisation along other avenues such as HACC social support (home visiting) or hospice respite volunteering.

5.6 Limitations of the Study

5.6.1 Sample Size

The sample size and power for this study were calculated on the basis of 40 clients in each group. Only 81 referrals to the program were received which combined with a high attrition through eligibility requirements, suitability requirements and withdrawals resulted in a considerably smaller than expected final sample. Small sample sizes would be associated with high variability within each data set. The power of the study to detect differences between the two groups, within each group, and within the cohort over time, without error was therefore limited. A larger sample size would reduce the variation with the data sets and allow more reliable and robust interpretation of the impact of the program.

5.6.2 Cessation of Randomisation

The randomisation process was ceased in late February 2009 due to a number of factors, as previously mentioned in section 3.3. From then all clients followed the process as described for clients allocated to group 1, irrespective of their assigned intervention. This further limited the size of the control group against which comparisons could be made.

5.6.3 Data Collection

Due to lack of resources it was not feasible for the research assistant collecting the survey data to be blind to each participant's study group assignment. Additionally the data collection for post intervention and follow up was sometimes delayed beyond the planned three month intervals. Some clients were ill, on holiday or not contactable at the time their interview was due. In some cases clients had not yet completed a sufficient amount of the intervention when their interviews were due, and thus the post test data collection was delayed.

5.6.4 Baseline Differences

The intervention group and control group were statistically significantly different at baseline on some measures. In the intention to treat analysis the control group were less lonely, and had higher wellbeing scores and more social support than the intervention group. This was likely due to the small sample sizes, as no systematic bias in group allocation was likely, due to randomisation process.

5.6.5 Measurement of Goal Achievement

It was intended to use the number of clients who achieved their social goals as a measure of program success. However, most clients did not formally record their goals or progress and did not adopt or express 'goal' oriented terminology. Further work is needed to determine the best possible way to frame 'goals' in a context that is easily understood and can be practically used by older people and that can be easily and reliably evaluated without adding to survey burden.

5.6.7 Mean Depression Score at Baseline

In this study a cut off score of 4/5 was used to discriminate between non-case/case depressive screen results. At baseline around half of each of the two groups in both treatment analyses and overall sample screened positive for depression. This indicated that there was potential to show a reduction in depressive symptoms. However, the mean baseline depression score in this study was relatively low. There have been similar findings elsewhere in previous studies of the impact of internet training on older people using the CES-D scale [11], which reduced the potential for a large effect size.

The clients who withdrew from the study were not found to be more or less depressed than the clients who remained in the study. This is not consistent with arguments that depressed or lonely people are less likely to complete individualised interventions. The low depression scores at baseline also indicated that people who could have most benefitted from participating in the program did not self refer or were not referred by others. It is possible that the clients who self referred or were referred to the program through family or staff were distinct type of person and were more motivated to do something about their mood than many others. It is also possible that the level of depression and loneliness in the home care population has been over-estimated and specialised stand-alone programs meant to address these feelings will always be under-utilised.

6 CONCLUSION

The Social Enablement randomised controlled trial was designed to contribute to the body of evidence regarding the effectiveness of social interventions intended to alleviate depression and loneliness in older people. Specifically the trial aimed to fill the gap in knowledge as to the impact of a volunteer led and task centred model of social support on feelings of depression and loneliness in older home care clients.

The primary hypothesis tested was whether clients who participated in the program would show significantly greater improvement in measures of depression, loneliness and wellbeing than those clients who were waitlisted for the service. A second hypothesis was also tested, whether the latter group of clients would subsequently show similar levels of improvement in their social and emotional wellbeing once they took part in the program after the waitlist period, as the original intervention group.

Analysis of the data did not show any statistically significant improvements in the intervention group on any outcome measure when compared with the control group in the actual treatment analysis. While some significant differences were found in the intention to treat analysis for loneliness and wellbeing, it was also found that the two groups were already different at baseline on these measures. A small sample size made it impossible to definitively conclude that the mild improvements seen in the intervention group compared with the control group were due to the program alone and not spontaneous improvement or variations over time. Similarly the size of the control group was small which reduced the value of comparisons between the intervention and control groups. For the overall cohort of clients who participated in the program, there was evidence that this volunteer led model of social support for older home care clients had a moderate but statistically significant impact on levels of depression and loneliness. However, this was at three month follow up only.

Many program processes worked well in the refined Social Enablement model such as the peer volunteer model, person centred practice, and informal goal setting and review. There were still some processes that did not work as well as expected. For example, problems with some referral processes resulted in a poor referral rate, and many clients had differing expectations on the level of service that was to be delivered by their volunteers. Additionally most clients would not formally record their goals or progress, and even while some flexibility was afforded, many clients ran well over the program time limit.

While the testing of the two hypotheses was problematic due to small sample size, there is some evidence that the program did have a positive impact on participant levels of depression and loneliness. As a result of the small sample size, this study was unable to significantly contribute to the current gap in the knowledge of the effectiveness or otherwise of interventions that use an individualised task centred approach to alleviating depression and loneliness in older home care clients. A larger and more robust study is needed to address this shortcoming.

The poorer than expected referral rate to the program and many clients' preference for ongoing social support visits indicates that, despite the potential for positive client outcomes, the Social Enablement model of care would be under-utilised if implemented as a discrete service in home care agencies similar to Silver Chain. The Social Enablement model of care could instead be adopted by home care agencies as part of a suite of social support services, and be made available to those people who self identify as feeling depressed or lonely, are motivated to do something about it, but lack skills or confidence that would otherwise enable them to achieve their social goals independently.

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APPENDIX 1: CLIENT SURVEY

**SOCIAL ENABLEMENT PROGRAM
SURVEY 5**



Silver Chain aims to provide a quality service to its clients. As you have recently received The **Social Enablement Program** from Silver Chain we ask that you complete the survey below. The information you provide will be used to determine how well the service assisted you, and how it can be improved in the future.

PROGRAM ASPECTS

How satisfied are you:	Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied
That the program met your initial expectations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
That you were actively involved in setting your goals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
That you were actively involved in making decisions	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
With the Social Enablement Program overall	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

How much do you agree that:	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
The Program was flexible	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The Program has helped you to be more independent	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You had enough time to achieve your goals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Your social contacts have increased since being on the Program	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Your confidence in social situations has increased	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You feel more involved in your community since being on the Program	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You have gained new skills and abilities from the Program	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You enjoyed participating in the Program	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You achieved your goal/s	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Questions continue over the page

Please turn over ►



STAFF AND VOLUNTEERS

How much do you agree that:	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
The Team Leader gave you a good explanation of what to expect from the Program	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The volunteer had the skills to assist you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The volunteer gave you the support you needed to achieve your goals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The volunteer gave enough time to support you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The volunteer was available when you needed them	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
The volunteer encouraged you to work towards achieving your goals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
You felt comfortable working with the volunteer	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅