Loneliness as an unresolved issue in social inclusion programs

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Abstract

Loneliness, social isolation and exclusion are worldwide social problems with negative effects which are exacerbated in marginalised groups and communities. From a qualitative perspective, this paper examines the approach to loneliness in 62 community-based social inclusion centres and programs for people experiencing exclusion in the Basque Country (Spain). The aim of the study was to identify good practice in dealing with loneliness in centres and programs and to understand the main challenges in providing support from the perspective of practitioners. The results show that best practices focus on individualised or person-centred interventions, the generation of interaction spaces that promote social relations, accompaniment as an intervention tool, empowerment and community participation, and employment and socio-professional training. The main challenges and difficulties are grouped into four levels. These include the users' own individual difficulties (lack of motivation, progressive deterioration and poor social skills, etc.). To a lesser extent, insufficient professionalisation of inclusion services, insufficient resources (lack of human and material means) and social problems such as stigma and social rejection are mentioned. Intervention implications that practitioners can take into account to mitigate the loneliness of people at risk and/or socially excluded are discussed.

Key words: loneliness; social isolation; social exclusion; social inclusion programs**;** community intervention.

Introduction

Loneliness, social isolation and exclusion are worldwide social and health concerns with the negative effects exacerbated in marginalised groups and communities (e.g. Jehoel-Gijsbers & Vrooman, 2008). Despite advances in psychosocial care, an increase in the availability of community-based services and programs, and great strides made in loneliness research, loneliness continues to be a burden today. This paper examines the approach to loneliness by professionals who are in social inclusion community programs for people experiencing exclusion in Basque Country (Spain).

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According to Peplau and Perlman (1982), loneliness is an unpleasant experience that occurs when a person's network of social relationships is deficient in some important sense, either qualitatively or quantitatively. As subjective emotional experience, it is mainly affective and cognitive in character (Heinrich & Gullone, 2006). It is worth mentioning Weiss's (1973) differentiation between emotional loneliness (loss of significant social relationships with feelings of emptiness and anxiety) and social loneliness (lack of a social network —family and friends supporting and involving the person in their interests and activities— with feelings of marginality, lack of support or help, etc.). Associated with the latter, a related concept is that of social isolation, focusing on both objective and quantifiable elements such as the number of social contacts (Dickens et al., 2011; Masi et al. 2011) and on subjective elements associated with the perception of the quality of social interactions (Cacioppo et al., 2011). Given the interchangeable use of social isolation and loneliness in much of the literature (Stanley et al., 2010), in this paper we will follow Cattan et al. (2005), by treating social isolation and loneliness as synonyms.

The negative effects of social isolation, including segregation from social, economic, political, and cultural systems within society, can be recognized as social exclusion (Wilkinson & Marmot, 2003). Indeed, the experience of living in relative poverty is often best understood in terms of the social exclusion that results. For measuring poverty and social exclusion, the AROPE (At Risk Of Poverty and/or Exclusion) indicator of the European Network for Combating Poverty and Social Exclusion is used as a reference. According to the latest report on the risk of poverty and exclusion by EAPN-Spain (European Anti-Poverty Network), in 2020, a total of 12.5 million people, representing 26.4% of the Spanish population, were at risk of poverty and/or social exclusion (Llano, 2021). The Spanish data is above the European Union average for practically all the variables of poverty, exclusion and inequality.

As the number of people at risk or in a situation of exclusion increases, the potential for social intervention professionals to interact with this population also increases. The fight against social exclusion and the promotion of inclusion is a key agenda for the Basque Government (Fantova, 2017). The Basque Social Services System constitutes an articulated public network of care, under public responsibility. Its purpose is to favour the social integration, autonomy and social welfare of all individuals, families and groups. It develops a promotional, preventive, protective and welfare function, through benefits and services of a fundamentally personal and relational nature. Together with the Basque Health System, they offer social and health care coverage to people with physical and/or mental health problems. In a recent study in the Basque Country with people at risk of exclusion, Villegas, Ibabe and Arnoso (2020) found that the social and cultural dimension of exclusion were the most relevant predictors of mental health problems. These factors related to participation, adaptation and social support contribute to mental health problems (Villegas et al., 2020) and influence overall well-being and quality of life (Heinrich & Gullone, 2006). Thus, approaches to tackling exclusion combine economic and social strategies (unemployment, immigration, etc.) with interventions emphasizing the importance of psychological and micro-social factors (social rejection, isolation, loneliness) on mental health, well-being and quality of life.

In the international context, several studies have predicted the extent of loneliness (Cacioppo & Cacioppo, 2018; Pyle & Evans, 2018), with evidence of its higher prevalence among people without economic resources (Creed & Macintyre, 2011; Hawkley et al., 2008) and with higher levels of social exclusion. It shows that the analysis of this relationship is somewhat more complex and must be understood in conjunction with other variables (Cacioppo & Cacioppo, 2018): age, gender, marital status, income, functional diversity, health, number of adults in the household, care responsibilities, relationship with the neighbourhood, family and friends, feeling of belonging and satisfaction with the local area where they live. However, there is a need for studies to understand what can make people lonely and what keeps some people trapped in loneliness (Qualter et al., 2015). This is crucial for the development of successful

interventions to prevent and mitigate their effects. The results of the qualitative study by Arnoso et al. (2022a) with excluded people show limited social networks caused by marginalization. They experienced rejection, the loss of critical network members, including family rejection and lack of company, and poor, precarious relationships within the margined community. In the case of the women attending various social inclusion programs (Arnoso et al., 2022b), the subjective meanings and experiences of loneliness were also intertwined with gender and intersectional marginalization. These meanings constitute an iterative process, fraught with tensions between unmet need for meaningful relationships, lifetime violence suffered, unfavourable socio-economic conditions, and stigma and discrimination. Associated with residential exclusion, empirical evidence from older people shows that the prevalence and risk of social isolation and unwanted loneliness are higher for people living in nursing homes for the elderly than for those living in private homes within the community (Prieto-Flores et al., 2011). For institutionalized individuals, the variables that most explained loneliness were not being able to get together with family, friends and neighbours, unlike non-institutionalized people, whose loneliness was explained by sex and marital status (Prieto-Flores et al., 2011). Arnoso et al. (2022a), focusing on residential centres for social inclusion, showed that residents' unfulfilled need for meaningful relationships played a crucial role in feelings of loneliness, as well as loss of self-determination due to institutionalisation.

At the international level, this has led to the development of a number of interventions, but these are rarely implemented or evaluated on a large scale. Components associated with successful interventions have been identified, such as training and quality support by professionals (Findlay, 2003), as well as the need to involve people in the planning, implementation and evaluation of community interventions (Dickens et al., 2011; Cattan et al., 2055).

Community programs play an important role in social inclusion, and interventions focused on social involvement and support are effective in reducing loneliness (Stojanovic et al., 2017). The quality of relationships with neighbours was also significantly associated with loneliness and sense of community in people with mental health problems (Kriegel et al., 2020). For all these reasons, social inclusion services support people in situations of exclusion through personalized attention and collaborative work with local communities to improve participation and social adaptation (Huxley et al., 2009). Andrew and Meeks (2018) found an important relationship between person-centred care, particularly compliance with personal care and recreation preferences, and the socio-emotional needs of long-term care residents. It should be noted that social prescribing enables practitioners to signpost service-users to a range of non-clinical community activities (South et al 2008). It is increasingly promoted as an approach to address loneliness, social isolation and other psychosocial issues (Holding et al., 2020).

Methods

The data described below are part of a broader evaluation which used mixed methods. This paper focuses primarily on one aspect of the qualitative component of the evaluation and explores professionals' experiences in addressing loneliness in different social inclusion centres and programs in the north of Spain. It reports on the main findings of work teams with staff from a wide range of social inclusion centres and programs in Gipuzkoa, a region of the Spanish state with a long history in social policy and social services, with globally positive indicators in terms of situations of poverty and social exclusion.

In order to inform future services, the aim of the study was to identify good practice in addressing loneliness in the centres and programs and to understand the main challenges in providing support and the community resources and infrastructure needed for successful

delivery.

Sampling and recruitment

Between July and October 2019, written feedback was collected from professionals from a wide range of social inclusion centres and programs. Professionals were invited to participate after discussion with their work teams about their experiences as professionals in addressing loneliness, their perceptions of good practice and the main difficulties.

An email was sent from the Social Policy Department of the regional administration in Gipuzkoa (Spain) to those responsible for social inclusion centres and programs with an information sheet giving the contact details of the research team of the University of the Basque Country. Interested professionals were asked to contact the researchers directly for any questions or clarifications they might require.

Information was obtained from all professionals who agreed to participate, with an average of 3-4 professionals per centre (range from 1 to 8 professionals due to the diversity of the typology of the centres and programs), for a total of 217 professionals from 62 centres and social inclusion programs.

Of these, 14.5% (*n* = 9) were outpatient services, including specialised accompaniment programs, exclusion prevention programs (9.7%, *n* = 6), and the Social Emergency Coordination Service (1.6%, *n* = 1). This was followed by Day Care Centres, which include Day Centres (12.9%, *n* = 8), Occupational Centres (6.5%, *n* = 4), Other Day Care Services (8.1%, *n* = 5) and Night Shelters (3.2%, *n* = 2). Residential services for people in situations of exclusion, such as Supported housing for inclusion made up 9.7% (*n* = 6), Residential centres for social inclusion 6.5% (*n* = 4), Residential centres for people in a chronic situation 3.2% (*n* = 2), and Residential centres for women victims of male violence and other residential services for women 4.8% (*n* = 3). Programs to support employability, active inclusion and socio-occupational inclusion represented 8.1% (*n* = 5), Programs to support detoxification processes 9.7% (*n* = 6) and the Guardianship Service for incapacitated adults 1.6% (*n* = 1).

Table 1 presents a description of the main social inclusion centres and programs agreed with the public administration. This type of services is accessed by people with specific support needs, which are addressed by the system of specialised services within the social services system (provincial responsibility). All people who access this type of service would do so by virtue of a specialised assessment and diagnosis which would prescribe it.

On the other hand, there are the Exclusion Prevention Programs. The provision of these services is not the responsibility of the provincial social services. This means that users are not subject to this specialised assessment and therefore would not necessarily be in a situation of exclusion. These are services that are developed with the aim of preventing situations of exclusion and are usually configured with a more unidimensional character or of attention to specific groups: employability, drug addictions, and interculturality, among others. Different programs are included, such as the Programme for the Social Integration of Ethnic Minorities, the Programme for the Reception of Foreigners, the Programme for the Integration of People with Prison Experience, the Programme for the Integration of sex workers, the Food Bank Programme, and the Telephone of Hope, among others.

With the aim of gaining a better understanding of the reality of the centres, the number of people attended in 2019 and the percentage of women attended is also included, according to the 2019 Report of the Social Inclusion and Care for Women Victims of Gender Violence Service. It should be noted that the data provided may be over-represented, since the people

attended to are not always in a single service. The statistics are by services, not by people attended to, and therefore there are people who may be counted in different services during the same year.

At the end of the evaluation, a discussion group with 6 representatives from different social inclusion centres and programs compared the results and held a day of presentation of the main results, in which 150 people participated. Participants included political representatives, representatives from the university and from different public and private entities and centres.

Voluntary participation was ensured, and procedures were in accordance with the institutional ethical guidelines of the Provincial Council, both national and international (American Psychological Association).

Table 1. Social inclusion centres and programs, description of service and number of people served (% women)

Description of the types of participating centres	Number of people served (% women)
Residential centre for people in chronic situations Centres for people with chronic situations and personal deterioration who require a long-stay service with an approach combining a vision of social inclusion with a slow pace of intervention.	74 people (12% women)
Supported housing for social inclusion Medium or long-stay residential services offering support aimed at improving the personal and relational skills and abilities of users with a view to their reintegration and progressive access to a normalised way of life. Offers 98 places in flats for young people aged 18 to 23, some of whom have been under guardianship.	330 people (25% women)
Residential centres for social inclusion Centres aimed at facilitating the social inclusion of people with acute psychosocial needs and/or facilitating the transition to stable housing for homeless people requiring high intensity psychosocial support.	380 people (22% women)
Residential centres for women victims of domestic abuse and other residential services for women These include emergency shelters, medium-stay shelters and the socio-legal and psychosocial care service for victims of abuse or acts against sexual freedom.	Emergency Shelters: 126 women Medium-stay shelters: 73 women
Day centres for social inclusion needs Centres offering a place to spend the day for people in situations of social exclusion, and a service aimed at their social inclusion. They offer individualised accompaniment in an insertion programme, combining interventions of an occupational, educational, therapeutic and socio-occupational inclusion nature in an integrated approach.	429 people (21% women)
Occupational centres Centres favouring the active participation of people with disabilities and/or mental illnesses in social life, through personal development programs that revolve around productive activity, with the aim of furthering their access to employment when possible.	1,191 people (37% women)
Specialised accompaniment programs These offer social, educational and psychosocial care in the community environment and are aimed at people in a situation of social exclusion or at risk of social exclusion and oriented towards social inclusion in order to achieve active participation in their environment.	447 people (23% women)
Programs to support employability, active inclusion and socio-occupational inclusion	3,300 people (76% women)

These are programs for the active management of inclusion, support for active employability and promotion of the generation of employment opportunities as a means of social inclusion for people in a situation of or at risk of exclusion.	
Social emergency coordination service A service operating every day of the year to provide immediate attention in situations of social urgency occurring in the Gipuzkoa	380 people (percentage of women not registered)

region.

Data collection and analysis

The discussion groups in the working teams of the participating centres and programs lasted 45-90 minutes. Thematic guides were developed covering the expectations of the workers regarding their role as professionals in addressing loneliness, the most vulnerable groups, the experiences of working with service users and their perceptions of good practice and the main difficulties in addressing loneliness. The heads of each service posted the most relevant conclusions discussed with their team.

An interpretive thematic analysis approach was used following the principles of open coding, followed by more detailed selective coding (Bryman, 2012). Once the findings were received from the centres and programs, they were read separately by three members of the research team before the initial coding frameworks were developed. An initial list was drawn up of emerging themes associated with the professionals' opinion on two issues: 1) Key points in the approach to loneliness, 2) Main difficulties in interventions to reduce loneliness. These were then assigned to larger categories of themes and subtopics based on similarity and overlap and subsequently refined and revised based on the original transcripts.

The coding frames were continuously refined. The research team met regularly to discuss any disagreements before the final coding frameworks were agreed and applied to the transcripts. Constant comparison, combining simultaneous coding and data analysis, was used to ensure the validity of the coding frameworks (Taylor & Bogdan, 1998). Standard procedures were used to estimate the reliability of the analysis using inter-judge reliability (Graziano & Raulin, 2004). The emerging themes were classified through inter-rater agreement, which made it possible to work with a highly reliable classification system. The trustworthiness of the study findings was enhanced by applying the Lincoln and Guba (1985) criteria: credibility, transferability, dependability and confirmability. These criteria were met through purposive sampling review of interviews by professionals from social inclusion services, and experts in qualitative research were used to ensure peer debriefing.

The agreement ratio was calculated in the categories of themes assigned by the three researchers. The number of citations with matching categories was divided by the total number of citations (matching and non-coinciding). The ratio obtained was 85%, an acceptable rate (Miles & Huberman, 1994).

Results

Key points in the reduction of loneliness

Social inclusion professionals indicate that individualized or person-centred interventions are the most important elements in the reduction of unwanted loneliness (50.8%, *n* = 31) by enhancing active listening and establishing a positive and trustful bond. This is followed in importance by the promotion of social relations, highlighted as a key aspect in more than half of the centres (47.5%, *n* = 29). They refer specifically to generating interaction spaces that promote social and community relations, maintaining family networks and generating spaces that allow connection with other participants through group activities that promote contact. They consider it essential to carry out individual counselling/accompaniment and social support (36.1%, *n* = 22). They emphasize the importance of community interventions as a prominent element (34.4%, *n* = 21) promoting empowerment and participation in community activities. Employment and socio-professional training are mentioned as being of secondary importance (9.8%, *n* = 6). The quotes corresponding to these key points can be found in Table 2.

The first theme shows that the relevance of the person-centred approach as a tool for tackling loneliness through an Individualized Intervention Plan, covering their needs, their history and objectives. This is an unguided personal support which is agreed with each individual through the Individualized Intervention Plan and individual reflections. This approach is necessary to create a space in which the person and their circumstances can be accepted; a space where participants feel emotionally safe in order to put into practice those indications aimed at modifying and/or acquiring attitudes, habits and skills.

The second theme focuses on expanding support networks and social interaction. Here it is worth differentiating activities aimed at expanding external social networks, strengthening or maintaining the family network and relationships between participants themselves through the promotion of cooperative interactions in the facility. They believe that it is essential to create meeting spaces through group activities, share spaces in common areas and attend weekend activities to interact.

The third most relevant theme that appears as a key element in reducing loneliness focuses on the importance of accompaniment as a tool in inclusion processes. This form of intervention is complemented by the person-centred approach. It is about detecting personal needs to participate in community spaces through the promotion of social skills that help clients integrate socially.

A fourth topic refers specifically to community interventions aimed at promoting resources, self-management and the empowerment of the community itself. It is considered essential to develop activities to promote social support, awareness and social participation. These meetings promote multiculturalism, local culture and the conditioning of neighbourhoods and cities through a collective culture of care for the common good. These are activities that generate a great feeling of belonging and community that help reduce the feeling of loneliness. In this process, the involvement of volunteers is especially valued, in addition to community care by families in the town where the inclusion centres and programs are located.

A less frequently identified fifth topic referred to activities which aimed at promoting work/training objectives as a key element to reduce loneliness.

Table 2. Key points in the reduction of loneliness

Coding frameworks	Quotes
Person-centred approach-Individualized Intervention (50.8%)	*"To create a space of acceptance of the person and their circumstance. Not avoiding the reality of the situation but making it part of their history. Thus, finding a positive value in their own experience. From this starting point the person accepts us and that helps them to be more comfortable. All this helps to activate the person".* ***(Residential care facilities for social inclusion).*** *"Group and individual sessions with each professional figure - educator, social worker and psychologist".* ***(Residential care facilities for social inclusion).***

Support networks and social interaction (47.5%)	*"Loneliness is one of the biggest problems seen in most of the people who participate in the programs. The search for external groups as well as reference groups is oriented towards promoting personal interests; this is an objective that in many cases is difficult to achieve".* ***(Residential care facilities for social inclusion).*** *"The aim is to create spaces for people from the centre to relate to each other. Many of the activities we carry out are at the weekends (football games, leisure activities). Group activities (football teams, rugby) are reinforced and facilitated".* ***(Housing with supports for social inclusion).***
Accompaniment as a tool in inclusion processes (36.1%)	*"Accompaniment as a key tool in daily intervention. This includes tutoring, taking steps, sharing household chores, holding weekly group meetings, and designing leisure and free time activities on weekends".* ***(Housing with supports for inclusion).***
Community interventions (34.4%)	*"Awareness activities. Participation in community and social activities (Rices of the World, Women's Day, etc.), creation of a football team, scheduled activities (cinema, weekend outings, excursions). We collaborate with other entities and associations in the community".* ***(Residential care facilities for social inclusion).***
Promoting work/training (9.8%)	*"Professional training, academic empowerment, social integration activities in standardized environments".* ***(Residential care facilities for social inclusion).***

Main difficulties in the loneliness approach

In relation to the difficulties encountered in addressing the issue of loneliness, the professionals offered different answers which can be grouped into 4 levels: individual difficulties of the participants (68.9%, *n* = 42), insufficient professionalisation of inclusion services (22.9%, *n* = 14), insufficient resources (34.4%, *n* = 21), and difficulties associated with society and the community (21.3%, *n* = 13). The quotes corresponding to the main difficulties in the loneliness approach can be found in Table 3.

As for the participants' own difficulties, the professionals note the lack of motivation to participate in the proposed activities, leading to low participation or absenteeism of some people. A profile of progressive deterioration, the high incidence of mental illness and the personal isolation associated with some mental illnesses that make it difficult to maintain the relationships they establish in the medium-long term.

They also explain how progressive deterioration and repeated failure contribute to the process itself, leading to participants who end up feeling blocked, guilty and without a purpose. The absence of social networks and lack of social skills to relate to other people are shown as added difficulties in working through loneliness. In the case of female victims of male violence, professionals highlight the lack of awareness of the problem, overburdening of children, few personal skills, little social and family support, as well as personal and transgenerational stories

of exclusion.

Other difficulties in dealing with loneliness are related to the insufficient professionalisation of the sector. They refer to the problem that professionals at the centres sometimes do not have the necessary training to assist users. The lack of empathy or difficulty in putting themselves in the place of the participants is also pointed out, as well as difficulties associated with the professional role, such as the inability to set limits, or the management of impotence and frustration of not being able to change the lives of users. They also point out difficulties in user-professional interaction related to the cultural distance between participants (in the case of migrant people) and professionals.

Insufficient resources are also highlighted as difficulties faced by the organization of the centres and programs themselves, such as prioritization of administrative and urgent issues, the scarcity of night-time resources and limitations on participants' length of stay. Lack of time and limited staff numbers are further problems encountered in dealing with loneliness.

Social difficulties reflect the rejection of society, difficulties in accessing the world of work, the lack of collaborative structures at the local level and possibilities of generating spaces for social exchange. They also point to social rejection through exclusion, especially towards immigration from north African countries.

Table 3. Main difficulties in the loneliness approach

Coding frameworks	Quotes
Individual difficulties of the users (68.9%)	*"The progressive deterioration that people are presenting for various reasons: long stay in prison, undiagnosed or misdiagnosed mental health to be able to approach the correct treatment, long periods of drug use, among others".* ***(Housing with supports for inclusion).***
	"The full awareness of the person of their right to decide on the direction of their own process. The decoupling of previous difficult relationships and the background that caused them (exclusion environments, drug addiction networks, toxic personal relationships), their lack of motivation and activation of personal processes related to hobbies, entertainment, and time management once the most critical need for survival of shelter and food disappears". ***(Housing with supports for inclusion).***
	"People who have been in exclusion for many years have gone through many stages of failure, a lot of guilt. All this means that they do not see the positive things in life, they do not feel like it or they feel that they do not deserve them". ***(Residential care facilities for social inclusion).***
	"Tendency to isolate, communication difficulties, lack of social skills and little interest of the participants in the community". ***(Housing with supports for inclusion).***
	"In many cases the lack of a social network, deterioration in relationships or lack of adaptive relational styles of the users, risk awareness, symptoms associated with violence mean that other needs become a priority (self-protection, reduction of symptoms), conflict resolution, communication styles, emotional containment and regulation)". ***(Centre for women who are victims of male violence).***

Insufficient professionalisation of the sector (22.9%)	*"People who provide community reception often do not have the training that allows them to deal with some situations adequately: mental health, affect management, etc.".* ***(Residential care facilities for social inclusion).***
Inadequacy of resources (34.4%)	*"Lack of time. Low worker ratio. Prioritization of administrative and urgent issues".* ***(Residential care facilities for social inclusion).*** *"The characteristics of the resource, given that it is a medium stay centre, do not allow us to complete the objectives that could be developed in another long stay resource".* ***(Centre for women who are victims of male violence).*** *"There are very few resources that street youth can access without being referred through the basic social services. It is open 4 hours a day, but it would take much more since those 4 hours do not cover the need that many have. Also, there are very few night-time resources".* ***(Housing with supports for inclusion for youth).***
Difficulties associated with society and the community (21.3%)	*"The residents and we as professionals have difficulties in generating spaces for social exchange that are outside the institutional networks. In other words, difficulties in recovering or generating new primary support networks".* ***(Residential care facilities for social inclusion).*** *"The vast majority of young people we work with are born outside our country; in general, their support network (friends, people of reference) is much smaller than that of a young person born here, a priori".* ***(Housing with supports for inclusion for youth).***

Discussion

Some key points for interventions aimed at reducing unwanted loneliness can be extracted from the reflection of professionals in social inclusion programs. As the most important element, approximately half the centres for social inclusion consider individualized, person-centred intervention to be essential. They also mention the promotion of interaction spaces that promote social and community relations, the maintenance of family networks and the generation of spaces that allow connection with other participants through group activities promoting contact, and individual or social accompaniment. A third highlighted element is the importance of participation and community intervention.

The main difficulties in addressing the issue of loneliness are grouped into four levels. The most outstanding among them are the users' own individual difficulties (demotivation, progressive deterioration and poor social skills, etc.). To a lesser extent (a third of the centres), insufficient professionalisation of inclusion services, inadequacy of resources (lack of human and material resources) and difficulties typical of society such as stigma and social rejection are mentioned.

Community workers who are involved in the care of people in situations of exclusion should take these findings into account by creating interventions that can alleviate loneliness. Consistent with the results, the proposals aimed at reducing loneliness imply that change must be implemented at different levels, analyzed and executed from the inside out.

At the individual level, professionals detected some difficulties: lack of motivation to participate

in the proposed activities, people's resistance to changing their situation, their level of deterioration, and the lack of skills in establishing social relationships. The fact that they mainly highlight demotivation and low participation in activities suggests that, rather than understanding loneliness as a subjective feeling, professionals associate it more with objective elements such as participation. Understanding the experience of loneliness for the individual, in the context of the person and identifying barriers and difficulties can help guide towards a workable solution to loneliness. Therefore, workers can and should respectfully ask users whether they have specific concerns around these issues, thus normalising the issue and giving the user permission to talk about it (Emlet, 2006). In this sense, person-centred solutions such as counselling can be highly relevant to mitigate loneliness. In addition, the use of a person-centred approach (Andrew & Meeks, 2018) can further promote participation and facilitate retention in these programs (Lim, Eres & Vasan, 2020).

At the group-relational level, it is essential to promote meaningful relationships and social networks that allow social contact thanks to the sustainability and support that connection with people can offer (Snethen, McCormick & van Puymbroeck, 2012; Stojanovic et al., 2017). Previous research (Arnoso et al., 2022a) highlighted loneliness associated with the absence of meaningful relationships, and the importance of the quality of closer ties and family attachment in meanings of loneliness. Therefore, rather than focusing solely on the extent of the social network in terms of objective characteristics, a serious professional effort should focus on improving the quality of closer relationships (Shiovitz-Ezra & Leitsch, 2010). Considering the contributions of the professionals, it seems relevant to facilitate contact scenarios and the organization of group activities to help generate social networks. However, if person-centred care is emphasised, it is essential that professionals working in social inclusion programs pay close attention to participants' preferences, favouring the development of 'meaningful' activities that promote meaningful relationships within the community (Neale & Brown, 2016).

At the organizational level, it involves considering the characteristics of the organizations, allocating more resources to improve the user-professional ratio, enabling more training for professionals, and more reflection in terms of interculturality. Indeed, quality training and support from professionals is presented as a predictor of intervention success (Findlay, 2003). In our context, there is little professionalisation of social services aimed at people in situations of exclusion, compared to other areas of social services that are more professionalised (e.g., childhood and family). In most of the inclusion services, people are attended by workers coming from the charity sphere, voluntary staff with little professionalisation to care for people with multiple problems. There is also a lack of resources and adequate space for supervision of professional practice.

One of the key issues at the social-community level, as pointed out by the professionals of the centres for social inclusion, is to promote interaction spaces based on commitment to values of mutuality. This consists of involving society in various initiatives in our daily life through activities with groups of volunteers and neighbourhoods (Kriegel et al., 2020) to reduce the social stigma and rejection that exists towards people in situations of exclusion, generating social networks with people from the general population. The 'social prescribing' model, which aims to facilitate the connection of participants to community sources of support (Bickerdike et al., 2017) has a variant of the compassionate communities model that brings networks closer to people (Abel, 2018). The implementation of a compassionate community intervention model may hold promise for combating loneliness and reducing social isolation, as has been proven in initiatives with people from different backgrounds showing increased confidence in finding and sharing resources for self-care (Lindau, 2019).

Another societal approach increasing in popularity around the globe is the use of large-scale public awareness campaigns to increase awareness of loneliness, reduce stigmatisation, and

promote positive social behaviours (Lim et al., 2020). Indeed, the promotion of prosocial behaviours is aligned with the promotion of positive social interactions and can facilitate the development and maintenance of beneficial relationships (Friedman et al., 2017).

An eco-systemic approach must not forget the macro level intervention, promoting public policies related to employment or other measures that guarantee sufficient material conditions when there is no guaranteed employment. It is true that at present and until now, employment has been the main way by which people access the most basic material needs (food, clothing, housing, etc.), and in addition, this provides a space for socialization, social relationships and belonging. However, more and more voices predict a post-capitalist scenario where the market has shown itself unable to offer such guarantees for a significant social majority (Srnicek & Williams, 2017). Given this scenario, it seems there is an urgent need for social policies aimed at ensuring the material conditions that allow a dignified life for all people beyond their employment. Some initiatives with unconditional basic income or other unconditional social benefits are gaining momentum in the fight against poverty and social exclusion (Standing, 2018).

The limitations of this study are related to the sampling and to local character of the study. First, the information obtained from the questions and the discussion group was provided by professionals. Although the professionals have been critical of the working conditions and their skills, the methodology used does not allow to detect their social desirability bias. Secondly, the discussion group that compared the results included political representatives, representatives from the university and from different public and private entities and centres (heads of services). They were people who know the centres and the programs, but it would have been interesting to obtain information about other professionals involved in direct care and the users of the services themselves. In relation to these two limitations, in future research it would be interesting to complete the information with the opinion of the people who use the centres and social inclusion programs, and to conduct another group with the professionals who make up the different teams.

Nevertheless, a strength of the study is the sample of social inclusion centres and programs representative of the centres in Gipuzkoa, a region of the Basque Country (Spain) with a recognised track record in social policy. They have shared their good practices and difficulties in dealing with loneliness. In coherence with Basque Social Services System's action model, we consider that research contributes to the institutional task of making the participation and cooperation of different social actors in the reflection and strategic development of the public agenda possible and operative. If we want to promote new strategies that effectively and efficiently address the objective of reducing loneliness and promoting social inclusion, efforts aimed at fostering meaningful relationships and community programs, as well as guaranteed employment policies, are just as relevant.

Conclusion

Social inclusion traditionally oriented towards covering material needs are particularly important, but they should also be oriented towards more inclusive elements, incorporating a preventive approach, the promotion of spaces for greater participation and co-governance, the development of neighbourhood programs and civic activities that generate a sense of belonging and meaningful links that allow people to integrate. A more cross-cutting approach with the aim of ensuring that loneliness is not so unfocused.

To conclude, we would like to highlight a finding with important implications for interventions aimed at mitigating loneliness in social inclusion centres. While unsatisfied meaningful relationships, rejection associated with the stigma derived from the situation of exclusion, the situation on the street and socio-economic conditions appear prominently in the subjective

experiences of loneliness among people in centres for inclusion (Arnoso et al., 2022a; 2022b), social inclusion program professionals appear to place an over-responsibility in the person at the expense of considering the social dimension of exclusion. This effect may have important implications for social inclusion processes because the strategies that are considered most appropriate in attempting to mitigate or reverse the situation will differ depending on the causal attributions that are made (Vázquez, Panadero & Zúñiga, 2017). Shirazi and Biel (2005) have argued that those attribute poverty to individualistic causes have less favourable attitudes towards the development of the welfare state and the implementation of social policies than people who tend to attribute it to societal causes. As key points for loneliness interventions, professionals consider it relevant to promote individualized support and care, and relationships with the community, while less importantly also pointing out the need for training and socio-occupational interventions and promoting public policies related to employment and economic benefits that allow economic autonomy. We are convinced that the work carried out through psychosocial intervention plays a fundamental role in social transformation and overcoming social inequality. In this sense, it would be necessary to share reflections and practices in addressing loneliness in order to offer a comprehensive response to the multiple problems faced by people at risk and/or in a situation of exclusion.

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