Social Inclusion
2024 • Volume 12 • Article 7438
https://doi.org/10.17645/si.7438

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ARTICLE

Open Access Journal

Ageing in Place, Healthy Ageing: Local Community Involvement in the Prevention Approach to Eldercare

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Submitted: 27 July 2023 **Accepted:** 6 November 2023 **Published:** 25 January 2024

Issue: This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

Abstract

The increase in ageing societies is posing new and urgent societal and political challenges to meeting people's medical, personal, and social needs in old age. Ageing should not be considered a uniform phase of life and at least three phases should be distinguished: (a) silver age, (b) the mildly frail age, and (c) those at risk of dependency. Policy tools and logics should prevent and support specific needs in a life-course approach and the preventive approach is seen as among the most useful interventions, with a baseline objective to promote ageing in place, minimize the institutionalization of care, and prevent psychophysical deterioration by supporting older people and their families through tailor-made approaches and policies. Our study focuses on the project Invecchiare bene/Bien vieillir (ageing well) funded by Interreg Alcotra France–Italy and implemented in the Valleys of Monviso in northern Italy. The project targets older people living at home in mountainous areas, where healthy ageing is difficult due to chronic diseases and social isolation. This article presents an analysis of preventive-based interventions and services that promote innovative ageing policies and investigates the involvement of the local community and how it can lead to the deployment of new preventive measures. The research covers the direct impact on the health and living conditions of the recipients (older people) and innovation by the local care model (among social workers and the local community). Qualitative (documentary analysis, semi-structured interviews, and focus groups) as well as quantitative (questionnaire and secondary data analysis) methods were used.

Keywords

active ageing; ageing in place; community building; local welfare; older population; preventive approach

1. Introduction

Western societies are currently dealing with the rapid ageing of their population. This has become a central issue in policymaking as new concepts, programmes, and services to fulfil the expectations of the older population—as well as service providers and policymakers (Iecovich, 2014)—are being developed. Two concepts have been dominating both the scholarly and public debate: active ageing and ageing in place. According to the World Health Organization (WHO, 2002, p. 12), active ageing is "the process of optimizing opportunities for health, participation, and safety to improve the quality of life of people as they age." Active ageing adopts an inclusive view of late-life health, capable of capturing the full range of factors that—beyond types of care—can positively influence the life course of the older population. The goal is to prevent the deterioration of health among people in their old age through the development of policies and services that enable the individual to consciously choose an ageing path more appropriate to their needs and motivations. Older age is a transitional period when people experience changes not only in physical health, but also in social roles (e.g., retirement), and successful ageing has been empirically defined to include a low probability of disease and disease-related disability, a high level of physical and cognitive functioning, and active engagement in life (Carr et al., 2013).

Alongside successful ageing and healthcare prevention, there has been a steady increase in the discussion of ageing in place in recent years. Ageing in place involves developing services and facilities that allow older people to stay in their homes or chosen environments for as long as they can as they grow older. Mainstream scientific and public discussion has underlined how most older people prefer to age in place rather than relocate to another place or residential care facility, as ageing in place allows them to maintain their independence, social engagement and networks, as well as to remain in a safe and comfortable environment (Whitney & Keith, 2006). Empirical studies have underlined how older people wish to stay in their homes as long as possible, but their demands are influenced by policies and their own individual needs (Means, 2007). Most older people are attached to their independence and prefer to live in the environment with which they are most familiar (Vermeij, 2016). Independent living also contributes to maintaining a sense of self-esteem and self-reliance (Milligan, 2009). In this framework, ageing in place means growing old in one's own home rather than in an institution (i.e., nursing home). It also means living independently in old people's homes and communities safely, autonomously, and comfortably regardless of age, income, or functional limitations (WHO, 2017). Broadly speaking, to age in place is to continue to live in the same "place" as always (Löfqvist et al., 2013).

This article focuses on the project Invecchiare bene/Bien vieillir (ageing well; hereafter INCL) funded by Interreg Alcotra France–Italy and implemented in the Valleys of Monviso in Piedmont, northern Italy (Agostini et al., 2023). It is based on primary sources such as original data collection (survey, semi-structured interviews, and focus groups; see Section 2) from the monitoring and evaluation activities conducted by the Observatory on Second Welfare and develops those results within the framework of an ongoing discussion, in the literature, about active ageing and ageing in place. INCL specifically targeted older people living at home in mountainous areas, where the possibility of ageing well is at risk due to chronic diseases and social isolation.

The literature recognizes a wide variety of definitions of social isolation. Biordi and Nicholson (2009, p. 97) defines social isolation as "an individual's distance, psychological or physical or both, from the desired or

necessary network of relationships with other people. Thus, social isolation takes the form of a loss of positioning within a group." More specifically, two dimensions of social isolation have been identified: a subjective dimension, which is a perceived deprivation of one's social resources, such as companionship or social support (and is thus closer to the concept of loneliness); and an objective dimension, which includes a lack of contact with others due to contextual factors (e.g., reduced social network size, rare social interaction, or lack of participation in social activity). Risk factors leading to social isolation can be psychological (e.g., a depressive state), physical (e.g., chronic illness), or, indeed, social (related to inequalities, economic or cultural aspects, transportation, social activities, etc.; see Biordi & Nicholson, 2009; Nicholson, 2009). Social isolation is therefore distinguished from loneliness, which relates to a subjective and negatively experienced discrepancy between the quality and quantity of existing relationships and a person's desires or standards regarding those relationships (Machielse, 2015). One can feel lonely while not being socially isolated. Nevertheless, the two concepts are related: Loneliness can be conceived of as a risk factor for social isolation because persons who deal with prolonged feelings of loneliness often see their social network shrink (Machielse, 2006); both loneliness and social isolation affect the physical and mental health and health-related behaviours of older people (Choi et al., 2015; WHO, 2021). Both problems are amplified in mountainous areas, which are experiencing depopulation, the closure of commercial and community activities, and lack of transportation (see Section 2).

Concerning the current debate on services for older people and ageing, INCL has at least two main points. The first is understanding its target (older people) and the relative specificity of its needs and services. There is a growing awareness of how the people that comprise the "older population" are profoundly diverse among themselves and how the needs of people in their old age vary as they grow older and as physical, cognitive, and mental complications occur. Indeed, not all older people are in a state of non-self-sufficiency or are passive recipients of services: Some of them actively participate in social life and can be a resource for the entire community (Longo & Maino, 2021).

The life-course approach is a concept that has become widespread in rethinking the logic of intervention to support the older population. Looking at the long phase that begins with retirement (from age 65/67 onward), it is possible to identify three subgroups corresponding to the three main stages of old age: the silver age (aged 65–74), the mildly frail age (aged 75–84), and people at greater risk of non-self-sufficiency (aged 85 and older). These three profiles ideally reflect the exacerbation of needs related to increasing age. Ageing is characterized by an increase in the risk of frailty, disability, and sedentary conditions, the risk of social isolation, and depression. The likelihood that an older person may fall and injure themselves also increases. The three profiles must therefore be associated with different goals, tools, and services that better reflect the differentiation of care needs and responses (Maino & De Tommaso, 2021).

The transition from active life to non-self-sufficiency goes through different stages characterized by increasing frailty, which is largely also related to the condition of social isolation and loneliness to which older people are increasingly exposed (Maino & De Tommaso, 2021). The role of local welfare thus becomes that of supporting—through caretaking—older people from one stage to the other. It is thus a matter of flanking restorative interventions (which aim to offer answers to manifest needs) not only with preventive interventions (which aim to postpone the non-self-sufficient phase as long as possible) but also with "proximity" interventions based on "light" services that go beyond prevention and look to the well-being of older people. This third type of action is in line with the most recent transformations in local welfare, which

increasingly focus on the promotion of a model variously defined as proximity and community-based through generative and capacitating approaches. What these definitions have in common is the centrality of the community and the idea that territories are systems in which "first welfare" actors (public agencies) compete with "second welfare" actors (third sector, for-profit and non-profit entities, and also ordinary citizens) in the production of interventions aimed not only at responding to and preventing needs but also at promoting well-being in a broader sense (Longo & Maino, 2021; Maino, 2021). In other words, thinking about older people, it is necessary to combine care and assistance with preventive interventions and activities that can promote mobility and sociality, as well as autonomy inside and outside the home, to delay physical and cognitive decline as much as possible. Achieving this goal requires identifying the multiplicity of needs of individual older people and adopting specific and necessarily multidimensional interventions.

The second point of the INCL is related to community development, an alignment whereby individuals who are part of a community are committed to working together in the process of community evolution (Walter & Hyde, 2012). The active participation of local actors—public, for-profit, and non-profit or families—is aimed at innovating local public policies via renewed forms of local community participation. The final aim is to establish "structured" pathways of community empowerment to restore bonds of trust, sharing, and assumption of a community perspective that goes beyond individual interest; to strengthen the capacity of residents, associations, and organizations (private and public) to promote positive change through the creation of social ties among people; and to leverage spontaneous mechanisms of aggregation and mutual recognition that are based on the adoption of collective behaviours inspired by mutual responsibility (Berloto, 2021; Longo & Maino, 2021).

This study, therefore, investigated the impact of the INCL project on both older people ageing in place (and, indirectly, active ageing) and community development. The remainder of this article is divided into four sections. The next section outlines the research questions and methods. The third section briefly presents the background, objectives, and phases of the project. The fourth section focuses on the analysis of the direct impacts on the health and living conditions among the project's recipients and the local model innovation of care (i.e., on social workers and the local community). Conclusions are presented in the fifth section.

2. Research Question and Methodology

Starting with the results of the monitoring and evaluation activities, our analysis answers two research questions: How has the INCL project's model of care improved the health and living conditions of older people? How has the project fostered innovation in the local model of older people care (i.e., regarding community development)?

The research was structured into two parts. The first part investigated the impact that the INCL—as a typical project in the field of ageing in place—could have in fostering the transition from active life to non-self-sufficiency while mitigating and preventing dependency, as well as the role of local welfare in supporting older adults from one phase of life to another. The first part of the research interweaves and illustrates three dimensions: (a) the project's main characteristics and goals; (b) the experiences of both individual older adults and social workers to analyse how effective the project was in relation to its intended

objectives and recipients' satisfaction; and (c) the factors facilitating or hindering the project's success to determine areas where it could be improved.

Data collection was conducted via the monitoring forms filled out by operators at the beginning of the project (61 forms), an online structured questionnaire that professionals filled out for each of the recipients whose projects were still active as of 7 September 2022 (52 questionnaires). Each questionnaire collected data on specific analytical dimensions (personal health and well-being, interpersonal skills and sociability, housing, daily life, relations with territorial services) and focused on four parts: achievement of the objective of the project; satisfaction among older adults with the activities; difficulties encountered by the operators; and services/activities that should be enhanced and/or included. Each questionnaire was completed by the professionals who managed the individual projects. The professionals carried out the evaluation (and related completion). This choice was intended to compensate for the difficulties that older people may have in completing the questionnaire on their own and, on the other hand, to enhance the overall view of the project's effects, which could be offered by the operators involved in the activities. Moreover, six in-depth semi-structured interviews related to relevant case studies were conducted to delve into the factors that facilitated the success of the intervention. The interviews concerned six older women and men involved in the INCL project who were signalled by the members of *gruppi integrati di presa in carico* (GIPIC, groups composed of different professional figures, such as social workers, nurses, health workers, and professional educators in charge of providing care to older people) for their good level of participation in the project activities and because they were able to talk about their experience clearly and comprehensively.

The second part of the research investigated the impact that INCL—as a typical project promoting community development—could have in experimenting with new forms of participation by public and private actors at the local level. The analysis focused on (a) the characteristics of the services that the INCL model provided in the face of a substantially new target (frail older adults with a non-severe clinical picture), (b) the intervention model implemented to run these services and its effects on the social workers, and (c) the improvement of local care services generated by INCL. This part of the research was carried out based on the analysis of project documentation and by making use of qualitative methods such as in-depth interviews and six focus groups. The interviews involved members of the technical project committee, while the focus groups addressed the six GIPIC teams supporting the valleys targeted by the intervention.

3. INCL: Project Description and Goals

This article analyses the model of the intervention tested within the INCL project, implemented between June 2021 and September 2022 in a partnership led by the Consortium Monviso Solidale (CMS) in collaboration with the Local Health Enterprise of Cuneo (ASLCN1) and the Cuneo Social Welfare Consortium. CMS is a public body established by the will of 58 municipalities and is responsible for the associated management of social and welfare services. INCL is part of the PITER Terres Monviso Integrated Territorial Plan and is funded by the European Regional Development Fund, Interreg Alcotra Programme 2014–2020. INCL involves a territory that includes, in Italy, the mountain community Valli del Monviso (composed of Varaita, Po-Bronda, and Infernotto) together with the three mountain unions of Valle Grana, Valle Maira, and Valle Stura; in France, the project involves the local communities of the Guillestrois–Queyras, Serre–Ponçon, and Ubaye–Serre–Ponçon municipalities. This section illustrates the project's background and context (Section 3.1) as well as its dimensions, goals, and phases (Section 3.2).

3.1. Background and Context

INCL is a project that promotes ageing in place, or "the ability of older people to live in their own homes and communities safely, autonomously, and comfortably, regardless of age, income, or functional limitations" (WHO, 2017, p. 6). The project targeted older people whose possibility of ageing well was at risk due to health issues and the social isolation derived from living in mountain villages. While the processes of physical and cognitive deterioration, as well as the feeling of social exclusion, are typical of ageing, one's specific context exacerbates the living conditions of older population: Consider, for instance, scarcely populated villages far from city centres, poorly connected to them—if at all, and the resulting difficulty in accessing social, commercial, health services. The "INCL territory" shares common sociodemographic trends. In recent years, this area has suffered a slow—but progressive—demographic decline, determined by the constant depopulation of the high valleys, mainly due to the geographical marginality of the mountain territory, the lack of job opportunities, and the scarcity of services in rural areas. Further social dynamics are linked to the persistence of a digital divide between urban and rural areas, which has spread a deep disadvantage for those living in marginal areas where access to digital services remains limited. However, while the socioeconomic context seems more fragile in the higher villages, the social relationships are also stronger. Indeed, community and neighbourhood social ties are more present and effective in small towns and upper valley areas, where all community members know each other and there is a constant monitoring of the situation of the more fragile and isolated individuals. The reference persons are doctors, pharmacists, and social workers, but neighbours and relatives are also ready to report situations of criticality or distress. While active ageing activities in some territories had never been attempted, in others (Valle Varaita and Valle Grana) they were successful, especially with the involvement of volunteers. Moreover, during the Covid-19 lockdown (in 2020 and 2021) in Val Varaita, older people were taught to use new technologies to, for example, send SMS, make video calls and send emails, using both tablets and mobile phones.

3.2. Core Goals, Dimensions, and Phases

INCL had two main objectives: (a) to implement an innovative mode of taking care of older people with identified physical and cognitive frailty (and, thus, a quasi-severe clinical profile) and (b) to test, albeit on a small sample compared to the width of the recipients in the main target, an individualized plan of care, allowing the older people and the whole local community to identify social needs while co-designing possible responses. The project involved 61 beneficiaries: 36 women and 25 men, aged 60–95 years (28 of them were between 80 and 90 years old). Half of them did not have any caregivers. Most of the beneficiaries enjoyed a good level of independence in activities of daily living and instrumental activities of daily living. They had minor health problems but needed support for therapy/care management. Beneficiaries of the INCL project had no economic problems but experienced loneliness (reported in 70% of cases) and needs related to the partial and progressive loss of their autonomy. Of the beneficiaries, 21 lived in inadequate housing (e.g., with architectural barriers or no hot water) and 13 in partially adequate housing (e.g., isolated or in need of housekeeping).

There are two main dimensions at the core of the project. The first involves the design of policy tools specifically calibrated to the project's priority target, notably frail older people (Maino & De Tommaso, 2021). The second requires innovation of the local model of care through the deployment of intersectoral (thus involving multiple policy sectors) and multidimensional interventions, aiming to intervene simultaneously for

the different needs of older people and in the direct participation of local communities with a view towards community building (Zazzera, 2021) and proximity welfare. In fact, Maino (2021, pp. 50–51) defines proximity welfare as:

> A set of co-defined public–private interventions and measures that aim at sharing welfare among people within the same community. It starts from a shared reading of needs and common goals, providing for the advocacy of the local actors involved….It involves the enhancement and promotion of formal and informal territorial networks (composed of public actors, private actors, associations, and citizens) which attempt to respond to local and shared social needs.

To select the appropriate model to achieve these objectives, the implementation of the project was preceded by an accompanying activity (lasting about six months and conducted with the support of an external consultant) that led to the creation of the GIPIC in charge of providing care to older people. INCL established a GIPIC for each territorial area involved in the project—a total of six teams, three of which were active in the Cuneo area and three in the Saluzzo area. Each GIPIC met, on average, every three weeks to carry out its activities. In addition, collective meetings were held between GIPIC teams to discuss, among operators, the local best practices and specific training activities—that is, the management of health issues, the professional skills required to work in multidisciplinary teams, and the socio-relational strategies necessary to promote dialogue with older people.

The local intervention of the GIPIC teams consisted of two phases. The first, carried out between July and September 2021, concerned the definition of "individual projects," i.e., a project for each older person, tailored to their needs and resources. It included the following steps: (a) assessment of the older person's needs and the recognition of the services/activities with which they were already provided; (b) the identification of the professional figures that could manage the individual project; (c) the identification of the objectives of the individual projects (groupable in the macro area of health and well-being, interpersonal skills and sociability, quality of housing, everyday living and continuing relationships with local social services); (d) the definition of the services and activities to be implemented, which had to contemplate the participation of the three sectors (health services, social services, and the local community), and the implementation timeframe (maximum 9–12 months); and (e) the identification of the indicators useful in evaluating the fulfilment of the stated objectives.

The second phase, carried out between September 2021 and September 2022, encompassed the project implementation—and related services—envisaged by the individual projects. The main services concerned improvement of autonomy, health monitoring, prevention of loneliness, personal and house hygiene, transport, and grocery shopping services. Aside from health and social services, the local community was directly involved in the activities. The involvement and cooperation between the local community and public services in a structured programme were one of the main innovations of the project. Community members were asked to activate a territorial network able to care for older people and prevent their social isolation with several activities (e.g., community lunches, musical evenings, out-of-town trips, art and photography workshops, home reading). From a community-building perspective, these activities often involved other older people in the area, including "more active" older people and retirees, with free time and willingness, who proposed the activities and took on the burden of organizing and leading them. These activities required strong coordination with social welfare consortiums, public administrations, and voluntary associations. The ASLCN1 also asked to participate directly in local meetings to combine aggregative

activities with moments of health prevention such as the "Health Education in Pills"—a health education opportunity managed by the ASLCN1 and based on a playful mode of learning.

4. Analysis of Results

This section presents and analyses the results. Section 4.1 presents the data about the recipients, while Section 4.2 presents the results from the perspective of operators and service providers.

4.1. Services: Assessing Effects on Health and Living Conditions Among Recipients

This section presents data collected via the monitoring surveys filled out by operators at the beginning of the projects (61 recipients) and a structured questionnaire only addressed to recipients whose projects were still active as of 7 September 2022 (52 recipients). Although the subject of the questionnaire was the recipient, the evaluation (and related completion) was carried out by the operators. The project addressed frail older people affected by mild physical and cognitive decline (i.e., the partial loss of their independence) who were socially isolated. Most of the individual projects focused on improving autonomy (49), followed by health monitoring (39), prevention of social isolation (35), and maintenance of personal and household hygiene. Fewer projects addressed the provision of transport (15) and grocery shopping services (14; see Figure 1). The most common interventions involved the ASLCN1 (55 individual projects), followed by social services (49) and the local community (33). However, social services and the community are the two fields in which professionals invested more hours per recipient.

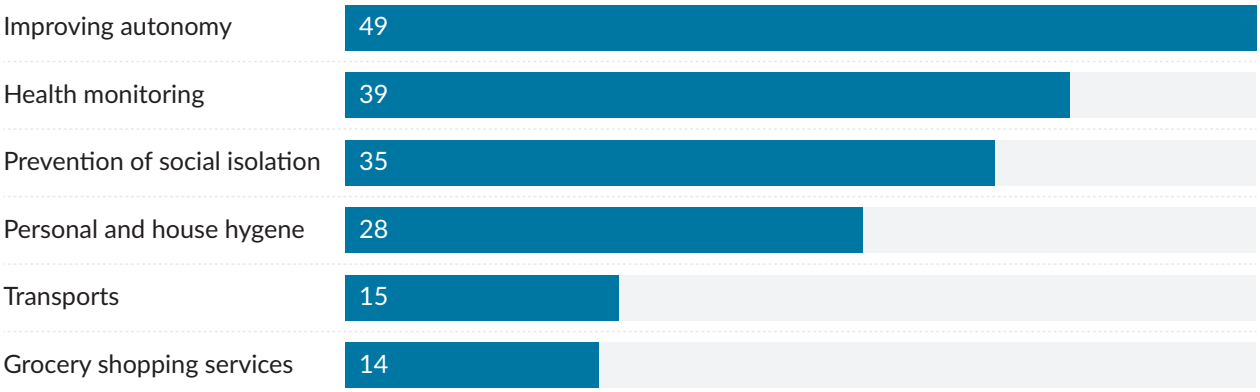

Figure 1. Frequency of individual projects launched per areas of project intervention.

On the one hand, the project achieved very good results overall for personal health and well-being, particularly with respect to the objective of "encouraging a proper use of therapeutic procedures" (e.g., taking medications), which was rated fairly or very effective in almost all cases where it was implemented. The sphere of interpersonal skills and sociability, on the other hand, was controversial, representing both the project's main opportunity and criticality, although the experience was evaluated positively overall. Indeed, the project was rated fairly/very effective in "promoting socialization by reducing the risk of isolation" in 64% of cases, but also not very or not at all effective in 36% of cases. For 72% of respondents it was fairly or very effective in "maintaining/improving interpersonal relationships," although for 28% it was little or not at all effective (Table 1). Activities and services that relate to personal health and well-being, such as

"activities/services to monitor health status" and "help with the correct taking of medications and the correct use of medical devices," were the most appreciated by older people (Figure 2). Judgements on social activities were also rather fragmented: They were not at all or little appreciated in 48% of the cases for which the activity was carried out (with 24% not appreciating it at all) and fairly/very much appreciated in 52% (Figure 2).

Table 1. Recipients' assessment of achievement of the project's main objectives.

Objectives	Not effective at all	Hardly effective	Fairly effective	Very effective
Personal health and well-being				
Promote proper personal hygiene	3%	27%	32%	38%
Encouraging the proper use of therapeutic procedures	0%	3%	61%	37%
Promoting proper nutrition and hydration	0%	33%	48%	19%
Promoting adequate mobility	2%	36%	33%	29%
Initiate/enhance personal autonomy	0%	28%	53%	19%
Maintain/improve the quality of life of the older person	0%	10%	65%	25%
Interpersonal skills and sociability				
Promoting socialization by reducing the risk of isolation	5%	31%	27%	37%
Maintaining/improving interpersonal relationships	4%	24%	39%	33%
Quality of housing				
Creating a more comfortable and safe home environment	3%	35%	35%	27%
Promoting adequate hygiene in the dwelling	4%	42%	31%	23%
Everyday living				
Facilitating the handling of paperwork/commissions/shopping	3%	6%	54%	37%
Facilitation of transport	9%	26%	26%	40%
Relationship with local social services				
Improving the trust of older people in operators	2%	2%	29%	67%
Guiding older people to available services	2%	7%	27%	64%

On the side of interpersonal skills and sociability, both goals of the activities—promoting socialization by reducing the risk of isolation and maintaining/improving interpersonal relationships—were rated as hardly effective (31% and 24%) and fairly effective (27% and 39%). These activities were highly appreciated among recipients (43%), although 48% of them declared that they were not at all or only poorly satisfied with these activities (Figure 2).

Another important issue for the project, which aspired precisely to encourage older people to stay in their own homes, was housing. The goal of creating a more comfortable and safe home environment was not achieved, or was achieved poorly, in 38% of the cases, while that of promoting adequate hygiene of dwelling was not achieved in 46% (Table 1); hygiene activities/services related to the home were poorly appreciated by 48% of participants—almost half (Figure 2). This result can be explained, first, by the difficulty of being

supported by strangers in personal care and living environment activities—reported in 15 cases—which was slightly more prevalent among those who are quite autonomous and probably have more difficulty accepting the help of an external, unknown caregiver. Finally, it should be noted that 21 recipients lived in inadequate housing (e.g., with architectural barriers or without hot water); 13 lived in partially adequate housing (e.g., isolated or in need of housekeeping), where making the environment more comfortable and safer would require restructuring interventions.

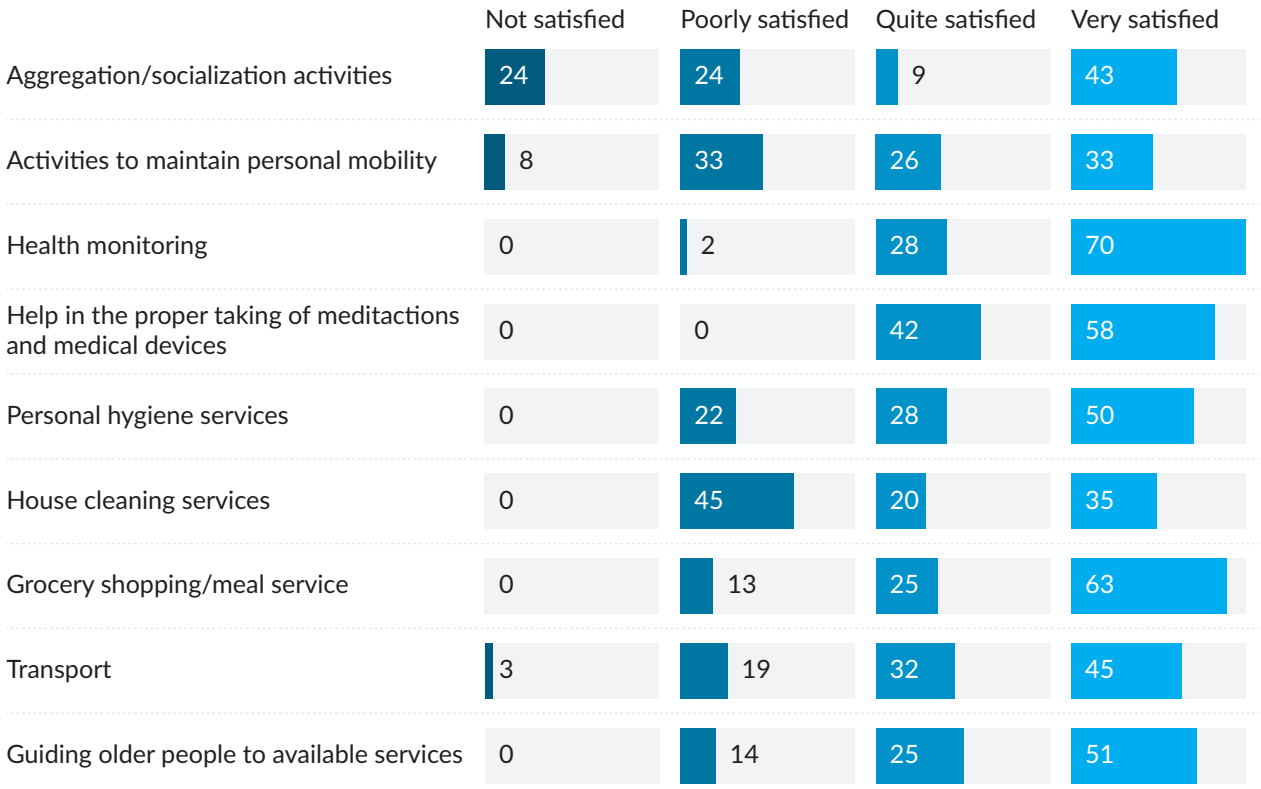

Figure 2. Rate of satisfaction with activities/services among older people, in percentage values.

In the daily life sphere, the project was effective in facilitating the handling of paperwork/commissions/shopping, which was rated positively in 91% of cases, and quite good in the facilitation of transport—the transportation service received a negative rating in only 22% of cases (Table 1). The shopping/meal service was also highly appreciated, receiving positive ratings in 88% of the cases for which this activity was carried out (Figure 2).

Regarding the relationship with local social services, the project achieved excellent results (although the figure may be conditioned by the fact that the operators carried out the assessment). The goal of improving the trust of older people towards operators was considered to have been achieved in 96% of cases (Table 1). In this sense, a very delicate stage was the engagement of people in old age who had not connected to the services before, as revealed in the interviews. In this regard, emblematic is the case of one interviewee who recounted that she was initially wary because she thought she had been "hooked" by social services to be taken away from home. The objective of addressing older people towards the services available in the area was achieved in 91% of cases (Table 1). These activities were fairly/very much appreciated in 86% of cases (Figure 2).

Obstacles reported in 26 cases (half) concerned reluctance to participate in social/collective activities or to leave home for 20 cases (Figure 3). Another factor that emerged from the interviews was older people's desire to protect their independence, a sentiment often conditioned by the presence of close relatives. Although with some difficulties, as mentioned above, social/collective activities and services were appreciated and—according to interviewees—considered beneficial, because they allowed respondents to get to know new people. Furthermore, when asked what services/activities should be improved/strengthened, the most needed was strengthening aggregation and socialization activities, reported in 30 cases—more than half. This response was given mainly by those who are fully or fairly autonomous (about 60% for both combined), further confirming that, for socialization activities, there is a need to invest precisely in this target group, which emerged as the most critical.

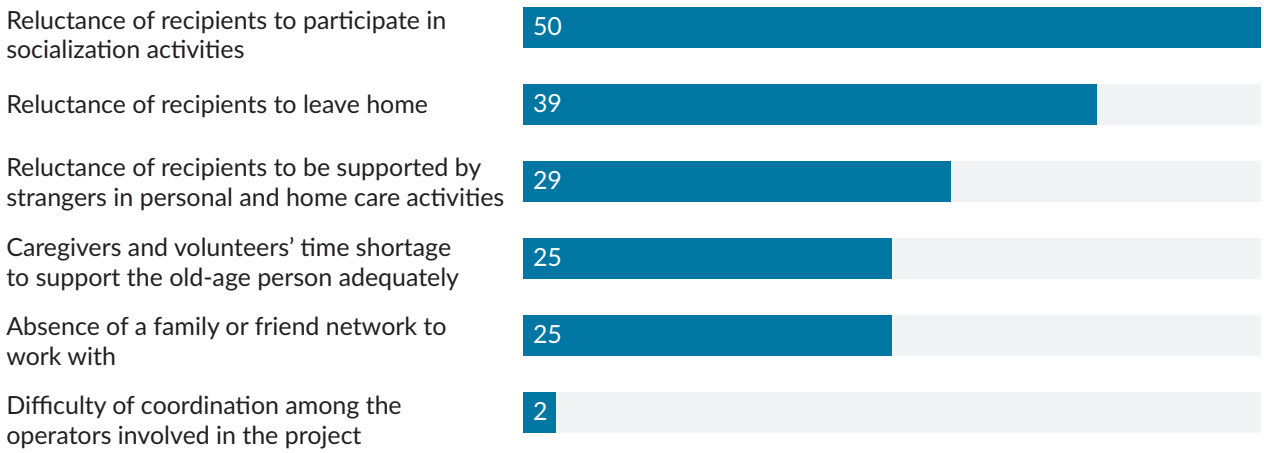

Figure 3. Difficulties experienced by the operators involved in the project.

Finally, regarding the services that could be strengthened/included, older respondents underlined the need to invest in socialization activities (58%), transport services (44%), and improvements in the number of paid social workers (35%) and volunteers (33%). A small quota—2% of respondents—asked for assistive home automation tools (Table 2).

Table 2. Services/activities that should be strengthened and/or included.

	N	%
Aggregation/social activities	30	58
Transport services	23	44
Number of paid social workers	18	35
Number of volunteers	17	33
Volunteers' skills	5	10
Telemedicine	5	10
Social care	4	8
Paid social workers' skills	1	2
Nursing caretaking	1	2
Assistive home automation tools	1	2
Other	9	17

4.2. Networks: Assessing the Innovation of the Local Model of Care for Older People

The innovations introduced through INCL have had significant impacts on how care is provided, on the professionals' work, the management of services for older people, and the construction (or consolidation) of territorial networks. The innovative target group—which involved frail older people—was associated with integrated caretaking on three fronts: health, the social sector, and community. The project adopted a multisectoral perspective and aimed at social and health integration: The GIPIC teams brought together practitioners with social and health skills and volunteers, and the projects focused on objectives and interventions that covered both sectors. Most projects involved the integration of ASLCN1, social services, and the local community—or two of these together.

While there are long-lasting structural issues at play (Longo & Maino, 2021), in Italy, as in many other countries, integrating health and social care services has become a central aim of welfare policies (Tousijn, 2012). Two important factors have acted as the main drivers of change: the growing number of people affected by multiple and chronic diseases who require more holistic care (Tousijn, 2012) and the de-institutionalization and de-hospitalization of social and health services to contain costs and keep people as much as possible in their own home and community (Burau et al., 2009). Third sector—mostly, voluntary—organizations have long offered support services to older people to fill existing gaps in public provisions. The various institutional actors involved in healthcare and social care are now being asked to cooperate, providing a proper institutional framework for more effective and efficient care. New models and structure are needed to coordinate, merge, and foster new processes that have been separate for a long time: Members of different professions are expected to integrate their work practices (Tousijn, 2012).

This is the case of INCL. This local innovation allowed for a multidimensional response to both manifest and hidden old-age needs, which tended to be neglected by traditional social services. Social and healthcare integration would not have been possible without establishing GIPIC teams (see Section 3). Teamwork was a valuable experience for the operators for several reasons. First, the synergy with professionals from other areas allowed them to reflect critically on their internal capabilities, while minimizing the routinization of professionals' tasks from a learning perspective. In one interviewee's words:

> This model is certainly valid. It should be more and more like this, more and more networked. When I think about professional diversity, the fact that she [points to another colleague] is from a different cooperative than I am, I find it very enriching. We are often used to building comfort zones that teamwork forces us out of. You can also put yourself in the other operator's shoes because it is not necessarily the case that if you have been doing it for 30 years then you do it well or you always have to do it that way. Still, you can also learn from others. (Social worker, CMS, translated from Italian)

On the one hand, the INCL process guaranteed a deeper understanding of the individual and contextual situations of people in their old age in the area, unveiling their neglected needs. On the other hand, it shared an emotional—more than professional—burden in caring for complex individual situations, improving both professional care and the lives of individual older people. The absence of volunteer workers in the GIPIC teams (because they were involved only in the implementation phase) was considered a limitation because they would have facilitated the identification of needs, given their close relationship with older people living in the area. As reported in interviews, the role of volunteers is central in defining population needs because

they are actively involved on the ground 24/7. Voluntary associations have—and should continue to have, based on the prospect of social and health care integration—a key role in taking care of older care recipients.

However, two shortcomings—and, therefore, areas for potential improvement—emerged. The first concerns strengthening human resources—that is, the number of operators and volunteers involved (about the latter, the need to improve their skills was also reported). The second concerns the fact that accompaniment has improved the social relations for older people, but their volunteer network has often been limited to the closest neighbourhood. Hence, there is a need to enhance community involvement to achieve proximity welfare that can widen the network of "caregivers" for mildly frail older people. In any case, the innovations generated by the mode of work in GIPIC teams have improved the quality of services offered to older people: The holistic approach to the person makes it possible to observe latent and manifest needs. In addition, intervention time was reduced, because professionals could carry out their tasks more quickly by working together in synergy:

> With INCL, we carry out a comprehensive assessment of the person through the team, which has different professional skills within it. This allows us to understand their needs and situation. Before INCL, we used to respond to specific requests. Now we try to understand, for example, if the older adult needs a meal, if he has a health situation that is better to keep under control, for example, because he has diabetes….So the nurse does her part, the social worker does hers…and if we see that the person has needs related to socialization, then we activate the educators and try to structure specific moments. So, the assessment and the responses are 365 degrees. (Child and families social service manager, Technical Project Committee, CSAC, translated from Italian).

Finally, INCL also had an impact on territorial networks, consolidating them where they were already present or promoting their construction where they were not. This has been possible for two main reasons. The first is that, through collaboration with local public and civil society, INCL practitioners have become a point of reference for the community. According to some interviewees, INCL fostered mutual helping relationships among older people. Socialization activities made it possible to bring together people with shared needs who otherwise would have never met on their own.

The second is that the project promoted the building of relationships between the mildly frail older people in charge with other older people in the area who participated in the animation activities. In any case, the development of community activities was strongly conditioned by the pre-existent development of local networks: In valleys where networks were already built, the implementation of territorial animation was easier; in valleys where they were not already in place, sometimes the territory welcomed and promoted INCL's actions, while in other cases institutions and local realities were reluctant to support the project and the GIPIC teams. Social and healthcare integration developed an extensive local network. Respondents reported that the GIPICs fostered a great stimulus to community development:

> If we look at the territory, the networks activated are a great asset. For example, if tomorrow there were no more GIPIC, I know that the social worker is still there, who has seen the mayor many times for this project, who knows the nurses, and so on….The volunteer who goes today to bring the groceries or who anyway sees the shutter down but knows that the older person is there and rings the doorbell…these relationships have been created over time, and when you create the relationship, automatically you create the network. (Project manager, CMS, translated from Italian)

Changing local conditions have affected the likelihood of people becoming involved in community development while working to improve humanistic aspects of community life. While citizen participation is not synonymous with community development, it is a means to realize the humanistic elements of community development through compelling involvement by public and private actors to foster self-help efforts among all segments of the population (Dillman, 1983). As we delve into the conceptualizations of community inherent in the theories of community development, Phillips and Pittman (2015) point out that, within this theoretical area, communities are, first and foremost, a group of people and the ties exist between these individuals. It is territory per se—not only because of its physical texture and boundary definition but also because it hosts a series of social actors and resources, both tangible and intangible—that determines its facticity and it is the relationships between these actors and objects that constitute its identity (Goldenberg & Haines, 1992).

5. Conclusion

In the field of old-age policies—more specifically, ageing in place—INCL focused on promoting home care by adopting a multidimensional, and proximity approach. The project has tried to address the issue of ageing by considering it not only from the point of view of better management of needs that have already occurred but also of risk prevention through early identification and care provision for fragile individuals. The initiative has, therefore: (a) attempted to broaden the perimeter of care from the individual family or the "older people–caregiver–family triangle" to the broader territorial community of reference; (b) sought to mobilize a plurality of public and private resources, both formal and informal, that the community can make available; (c) introduced new professional figures, fostering community and proximity welfare (Lodi Rizzini & De Gregorio, 2021; Maino, 2021) through the reinforcement of tailor-made responses; (d) created new services (or reformed existing ones) and/or created (or adapted) physical spaces dedicated to older people to facilitate their relational opportunities; and (e) in line with Maino and De Tommaso (2021), fostered the development of more coordinated interventions between socialization and response to ageing-related needs.

This approach was translated into goals and consequent activities and services that focused on promoting health and independence in and out of the home, as well as creating an "older people-friendly" environment. The project efficiently facilitated physical mobility inside and outside the home; the meal supply service and help with grocery shopping were also highly appreciated. This latter is an essential achievement because proper nutrition is a prerequisite for healthy ageing (e.g., preventing diabetes, cardiovascular disease, and obesity), but inaccessible in mountain villages that, given the scarce presence of grocery stores, can be considered "food deserts" (USDA, 2009). Because the project sought to encourage older people to stay in their homes, an important aspect concerned housing quality, especially regarding hygiene and creating a safe and comfortable home environment. On this point, the project has not been very effective, which requires further attention. Even if there are "structural" reasons the project could not have changed (older people often live in obsolescent buildings with architectural barriers), other elements could be addressed, such as the difficulty—reported by some beneficiaries and operators—for older people to let "a stranger" into their house, which could be overcome by intervening in social relationships and mutual trust. Finally, the effect on the development of relations and the contrast of loneliness was controversial, representing both the project's main opportunity and area for improvement—however positive the overall assessment was. The difficulties encountered can be traced to the attitude of older people towards participating in

aggregative/socializing activities, leaving their homes, and, at other times, being determined to protect their independence.

Integrating the social and health dimensions improved the quality of services because it provided operators with a complete picture of older people's situation and allowed submerged needs to be brought to light, enabling a holistic approach to the older person's well-being. Working in teams was a valuable experience for professionals: The confrontation and fostering of a holistic approach allowed them to learn and improve their work. A second aspect of interest is the aggregative activities and related community involvement. Thanks to the provision of these activities, the project fully promoted the shift from traditional "on-demand" welfare to proactive welfare (Longo & Maino, 2021). The first describes the user's (i.e., the recipient) and individual demands for welfare services. Recipients manifest their needs by applying for welfare services. The second one refers to a proactive, own-initiative welfare services approach in which social services analyse, know, and identify (new) social targets and implement social services to tackle their needs. This is a multidimensional analysis of needs that involves proactive scouting, user orientation, and user accompaniment. This transition had already begun in the territory. For this reason, the responses were differentiated in all of the valleys that took part in the experiment. In some valleys, a developed network facilitated the implementation of INCL, while in others, a local network still needs to be created, although the local community got involved anyway. In others, however, there was a certain reluctance among the institutions and local actors or of the older people. Beyond the peculiarities of each context, the project has generated essential legacies because of the results achieved and because it shows how individual local projects can represent real laboratories for social innovation. The need for a "sense of community" was recognized as the need to create networks and social relationships among people within a community context, not necessarily in the sense of community as a group of persons living in an area, thus generating "communities of purpose" (Mannarini, 2004). Proximity—and community-based approaches—align with these purposes to reduce the distance between citizens and (public and private) services.

Acknowledgments

We thank all the professionals, public workers, experts, and old-age recipients involved in the INCL project. We would also like to thank Chiara Agostini, Ester Bonomi, and Alessandra Motta for co-conducting this research at Percorsi di Secondo Welfare (https://www.secondowelfare.it). Finally, we want to thank all reviewers for their kind comments and suggestions.

Conflict of Interests

The authors declare no conflict of interests.

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