Social Isolation in Canadian Older Adults

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# Introduction

Social contact and belonging can have a significant impact on well-being and health across the life course. Until recently, however, the extent to which health and well-being outcomes could be influenced by meaningful social relationships, social networks and feeling connected had yet to be characterized, especially in populations of older adults. As it turns out, by combining many years’ worth of data on social isolation and loneliness in older adulthood, evidence suggests that social isolation can have a significant impact to health and mortality rivalling and even exceeding that of smoking, alcohol consumption and obesity (Hold-Lundstat et al 2010).

Unlike the contributors to mortality listed above, both the causes and consequences of social isolation are much more varied and highly nuanced in nature. As such, one of the biggest challenges facing those studying social isolation is that there are many different definitions of what social isolation refers to and, in fact, that those definitions have also evolved over time. Within the Canadian context, the most often cited definition of social isolation in older adulthood is that of an undesired decrease in social contact and social roles, as well as an absence of mutually rewarding relationships with other people (Keefe et al 2006).

One of the most pragmatic challenges these shifts in definition produce is estimating prevalence. Within Canada and the US, the prevalence of social isolation is estimated to be close to 17% (Kobayashi et al 2009; Ortiz et al 2011) however globally there have been estimates ranging from 2% to 20% (Elder et al 2011).

While there may be no formal consensus definition of what ‘social isolation’ refers to precisely, there is general agreement that, as individuals get older, the risk and negative consequences of losing social connections increases.

What is particularly problematic about social isolation is that it creates a negative spiral of outcomes for individuals who experience it.

At an individual level social isolation can be both be a risk factor for or consequence of other conditions. Literature has reported that social isolation is associated with increased risk for Alzheimer’s disease, poorer overall health, chronic illnesses, impaired hearing, functional disability, lack of mobility, motor decline, poor self-reported functioning and depression (Cohen-Mansfield et al 2015). It is unfortunately a reality for many older adults that as their needs become more complex, in many cases due to illness, that the ability to easily participate in social activities becomes challenging. Conversely, individuals who suffer from illnesses, mobility, sensory or cognitive challenges in older adulthood can become in

From a systemic perspective, social isolation in older adults can translate into health and social service care systems being improperly utilized. While data within Canada on social admissions (or ‘acopia’) is sparse, there is data within the UK, for example, that points to older adults accessing emergency care because they are overwhelmingly lonely or because isolation and loneliness have altered their ability to manage illness. Thus, the risk of improper healthcare system utilization is only likely to increase as the number of individuals at risk of isolation grows.

Social isolation also prevents communities and economies from benefitting from the participation and voice of older adults. Often, components of age friendly cities – such as safe and accessible sidewalks, not only facilitate older adults being able to age in place and maintain strong community ties, but also these same sidewalks accommodate young children and those with mobility challenges. Additionally, social isolation poses a risk to the participation of older adults in a number of volunteer-based roles that provide an estimated $5.5 billion per year in labour value.

With such a broad scope of influences, social isolation can impact any individual across the life course. In older adult populations, there are nonetheless certain features that are possible risk factors for social isolation. In particular, sudden loss or changes to social networks, social role, physical or mental health, resources or residence have all been identified as points or situations in which older adults can be particularly vulnerable to becoming socially isolated.

In a Canadian study of older adults in British Columbia, risk factors included age, gender, self-reported health status, income, length of residence in BC and others were identified as predictors of risk for social isolation. Caregivers of older adults, many of whom are themselves older adults, may also become increasingly isolated as their partners or loved ones’ needs become complex or participating in social interactions becomes too burdensome.

There are also other systemic influences, such as the proliferation of technology, which offers great promise, but also creates an environment of risk for isolation for older adults unfamiliar with, intimidated by or unable to access technology. Online banking and even access to local newspapers are just two of many areas that directly impact the ability of older adults to navigate important touchpoints of modern society.

Fortunately, major initiatives, such as the Campaign to End Loneliness in the United Kingdom, for example, have added tremendously to the understanding of isolation as well as of its consequences. In addition to a wealth of information on programs and services, one of the most important contributions to come from this campaign is the framework for service organization.

The framework organizes service categories into four key layers: foundation services (services and strategies meant to engage individuals with the system), direct interventions (services that directly address isolation), gateway services (services that facilitate participation in other services) and structural enablers (approaches that support development of community structures). In doing so, there is a broader, systems level model for understanding how different and diverse components need to work together in order to properly address the multi-dimensional nature of social isolation.

Ultimately, one of the important takeaways is that there is not a one-sized fits all solution to addressing social isolation in older adults. A “menu-based” approach is increasingly emerging as a way in which to address many different ways in which social isolation can impact older adults.

Fortunately, though results may be varied according to intervention type or configuration, the data broadly supports the strategy of “doing something” to facilitate bringing older adults who are isolated or at risk of being socially isolated together with other members of the community. In fact, there may not be a need to start from scratch but rather fine tune or optimize existing programming to ensure that social isolation becomes part of a broader mandate for these programs to help address.

While there are certainly challenges that social isolation in older adults presents to communities and service planners, there are also undoubtedly a number of opportunities for innovative programming and interventions. Indeed, the biggest opportunity that social isolation presents is that of collaboration and integrated service delivery. It is a problem that requires different schools of thinking and different people coming together to address it and in doing so, will help create richer and more diverse social networks within Canadian communities.

# What is Social Isolation?

One of the central questions in the conversations on aging is to ‘what degree social connection plays in health and well-being?’ Based on the extensive evidence collected to date, it is abundantly clear that being socially connected to others is incredibly important across a number of health outcomes and that this connection can influence how well or poorly one ages. Put another way, the absence of social connection (i.e. social isolation) has generally negative outcomes for individuals who experience it.

Despite being a seemingly intuitive concept, social isolation appears to be a much more complex phenomenon to define.

Over the past several decades, research by Nicholson (2009) has shown there have been close to twenty different adaptations to the notion of social isolation in the published literature. This demonstrates that not only has there not been a general consensus on a definition but that any definition is also subject to change over time according to multiple forces that shape the norms of the social world.

Within Canada, the academic and grey literature over the past 12 years or so (see Table 1) clearly demonstrates that within the same country, and even within the same province or territory, different groups can and do have different perspectives on what social isolation refers to exactly.

| Table 1: Definitions of Social Isolation Used by Canadian Research Groups | | |
| --- | --- | --- |
| **Report Author/Sponsor** | **Year** | **Definition of Social Isolation** |
| BC Ministry of Health, Children’s, Women’s and Seniors Health Branch | 2004 | *Social isolation* is objective and can be measured using observations of an individual’s social interactions and network. |
| Keefe (et al) for Federal/Provincial/Territorial Ministers Working Group on Social Isolation | 2006 | A situation of social isolation involves few social contacts and few social roles, as well as an absence of mutually rewarding relationships with other people |
| Federal/Provincial/Territorial Ministers Responsible for Seniors | 2007 | Less social contact than an individual wishes, and that may lead to negative outcomes such as poor health, loneliness or other emotional distress. |
| Medical Advisory Secretariat Ministry of Health and Long-Term Care | 2008 | Social isolation refers to the objective characteristics of a situation and has been defined as the lack of meaningful and sustained communication or as having minimal contact with family or the wider community. |
| City of Nanaimo | 2013 | Social Isolation is a loss of place within one’s group – people perceive themselves as disconnected from meaningful interaction with people who are important to them. |
| Institute of Marriage and Family Canada | 2014 | “an objective and quantifiable reflection of reduced social network size” and lack of social contact” (citing Steptoe et al 2013) |
| National Seniors Council | 2014 | Social isolation is commonly defined as a low quantity and quality of contact with others.  A situation of social isolation involves few social contacts and few social roles, as well as the absence of mutually rewarding relationships. (citing Keefe et al 2006) |
| Community Development Halton 2016 | 2016 | Lack of social belongingness, the perception of missing relationships, or a lack of lasting interpersonal relationships (de Jong Gierveld and Kamphus 1985)  “a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling quality relationships” (Nicholson 2009)  “social isolation is an objective measure of contacts with other people, while loneliness is considered to be the subjective expression of dissatisfaction with the level of social contact” (as cited by Havens, Hall, Sylvestre and Jivan 2009, 130)” |

Despite the multiple definitions of social isolation, there is a common recognition that social isolation involves:

* a reduction in the number and quality of social interactions (practical and emotional support) within an individual’s social network
* that reduction is undesired or unintentional

A more formal concept analysis (Nicholson 2009) identified the following five attributes associated with social isolation:

1. Number of contacts
2. Feeling of belonging
3. Fulfilling relationships
4. Engagement with others
5. Quality of network members

Based on the current policy landscape and the extensive attention given to social isolation in older adults by the Federal/Territorial/Provincial Ministers and the National Seniors Council, the most often cited definition of social isolation in older adults is from Keefe et al (2006) who states that social isolation is a situation which “involves few social contacts and few social roles, as well as an absence of mutually rewarding relationships with other people.”

What is important to highlight is that social isolation is being conceptualized as “situational.” This implies that modifying or anticipating the situations in which older adults may find themselves in could beneficially address social isolation. On the other hand, the notion of “loneliness” which often defined as a “perceived isolation” is experiential and is thus distinct from “isolation” per se.

It warrants clarifying that not all adults who are “isolated” or solitary experience loneliness nor is it the case that all adults who are surrounded by friends or family don’t experience loneliness. From a pragmatic standpoint, however, interventions to address loneliness and those to address social isolation have largely overlapped and the literature over time and across regions have often used these two terms interchangeably.

While the precise outcomes and even risk factors for isolation and loneliness may be distinct, there appears to be utility in drawing from evidence that addresses one or the other. An important example of this can be seen with the extensive work being done in the United Kingdom (UK) for their Campaign to End Loneliness. This initiative specifically targets loneliness in older adults however there is also an awareness of the important role that social isolation may play in contributing to loneliness and as such, many of the dozens of interventions currently being deployed address social isolation as a means to impacting loneliness.

Through the lens of Keefe et al’s (2006) definition, the interventions for loneliness also address social isolation since they are aimed at improving social contact, strengthening social roles and enhancing mutually rewarding relationships with other people.

When or if older adults are considered “socially isolated” therefore also relies somewhat on the degree to which an individual experiences the solitude in a problematic way i.e. to be “feeling lonely” as well as on sociocultural norms. Attitudes towards “normal” aging as well as theoretical explanations for natural contractions in the frequency or duration or social interaction may help to distinguish when being alone or seeking solitude is a part of healthy aging and when it may be problematic. This has important implications, not only for the individuals experiencing isolation, but also for their caregivers, communities and for service planners and providers when considering the extent to which individuals ought to be participating or engaging with services in a particular population (Wethington et al 2014).

The key takeaway is that the point at which changes to one’s social network and integration with said network becomes a problem will be different for different individuals and it can even change over time within the same individual. Thus, social isolation can impact an individual at any point during their life course. Encouragingly, it can also be addressed and curtailed in many different ways and at different points in an individual’s life journey (see Fig. 1).

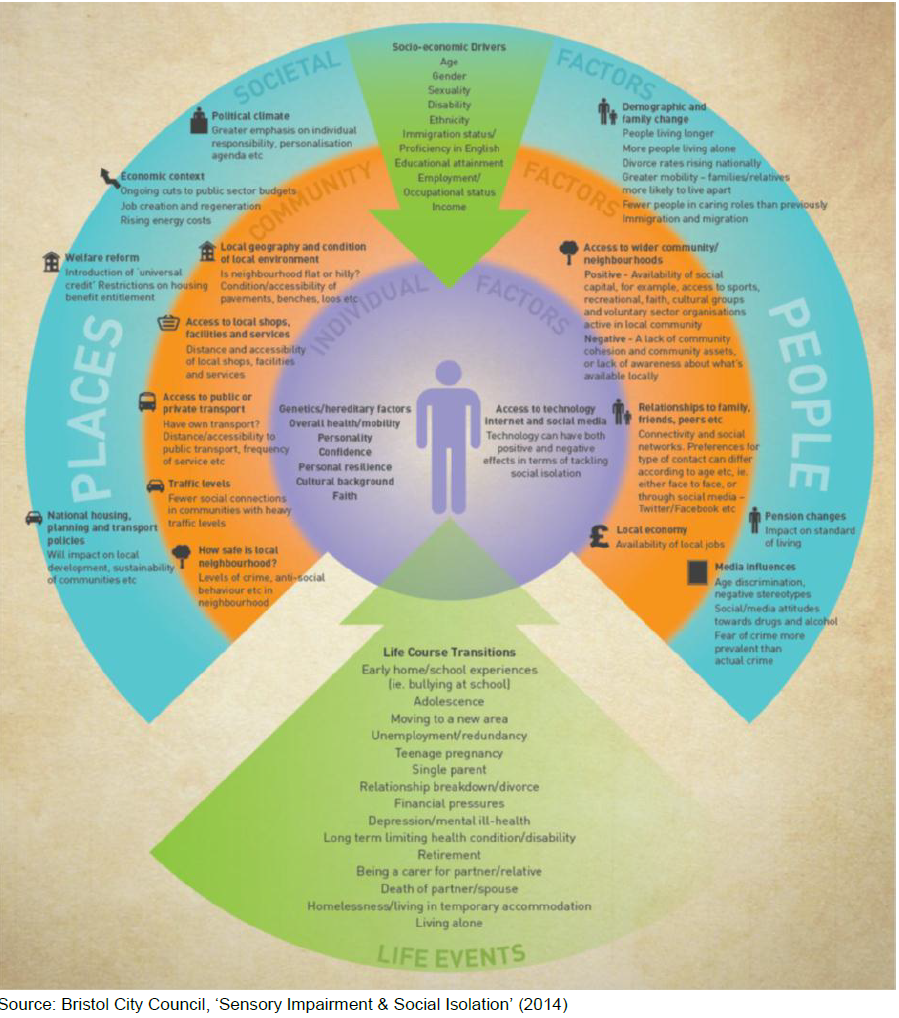


Figure 1: Factors that influence social isolation - Source: Bristol City Council, 2014

# Why is Social Isolation in Older Adults a Problem?

Internationally, as in Canada, there has been widespread recognition of the challenges an aging population may produce. Within 20 years it is estimated that almost 25% of Canadians will be 65 and over and by 2045, close to 40% of the senior population will be 80 years or above (Statistics Canada, As the number of older adult Canadians increases, so too will the numbers of those who are impacted by social isolation.

Unfortunately, the variety of definitions and interpretations on the exact meaning of social isolation makes it challenging to precisely estimate the scale of this impact. The number of individuals considered to be “socially isolated” is a moving target which is why currently global estimates of prevalence range widely (Elder et al 2012). Nonetheless, data from British Columbia (Kobayashi 2009) and another North American study (Ortiz et al 2011) estimate approximately one out of six (17%) older adults would be considered socially isolated.

Thus, one of the first problems that social isolation poses to individuals, communities and care systems is in its definition and measurement. It is challenging to coordinate resources as well as train individuals to identify social isolation when the exact nature of what to be vigilant of is open to interpretation.

As a result, resources may not be well-aligned to those who are experiencing isolation as well as to the caregivers in their network, the communities in which they live as well as the multiple levels of social and healthcare service infrastructure tasked to provide support and care.

## Individual Impact

In terms of individual impact, the importance of having social relationships to overall well-being cannot be overstated. In order to untangle the impact and potential causes or contributors to social isolation, however, it is instructive to pool together data from a number of different studies to investigate what, if any, patterns emerge.

A landmark meta-analysis by Hold-Lundstad et al (2010) that looked at 308,000 individuals across 148 studies (social isolation, as sub-component to the construct of social relationships, features prominently in this data) found that:

“the influence of social relationships on the risk of death are comparable with well-established risk factors for mortality such as smoking and alcohol consumption and exceed the influence of other risk factors such as physical inactivity and obesity.”

While the exact definition of social isolation varies, there are compelling data points from numerous studies that point to broad based negative effects on health and well-being for individuals who are socially isolated and/or experiencing loneliness (see Table 2 below).

One of the problematic consequences of social isolation as well as loneliness is that withdrawing from social networks and individuals can be both a contributor to and a consequence of serious illness. As a result, regardless of whether an illness results in social isolation or withdrawal, or if social isolation results in deteriorating health, a negative spiral of well-being can ensue in which an individual’s quality of life can rapidly diminish.

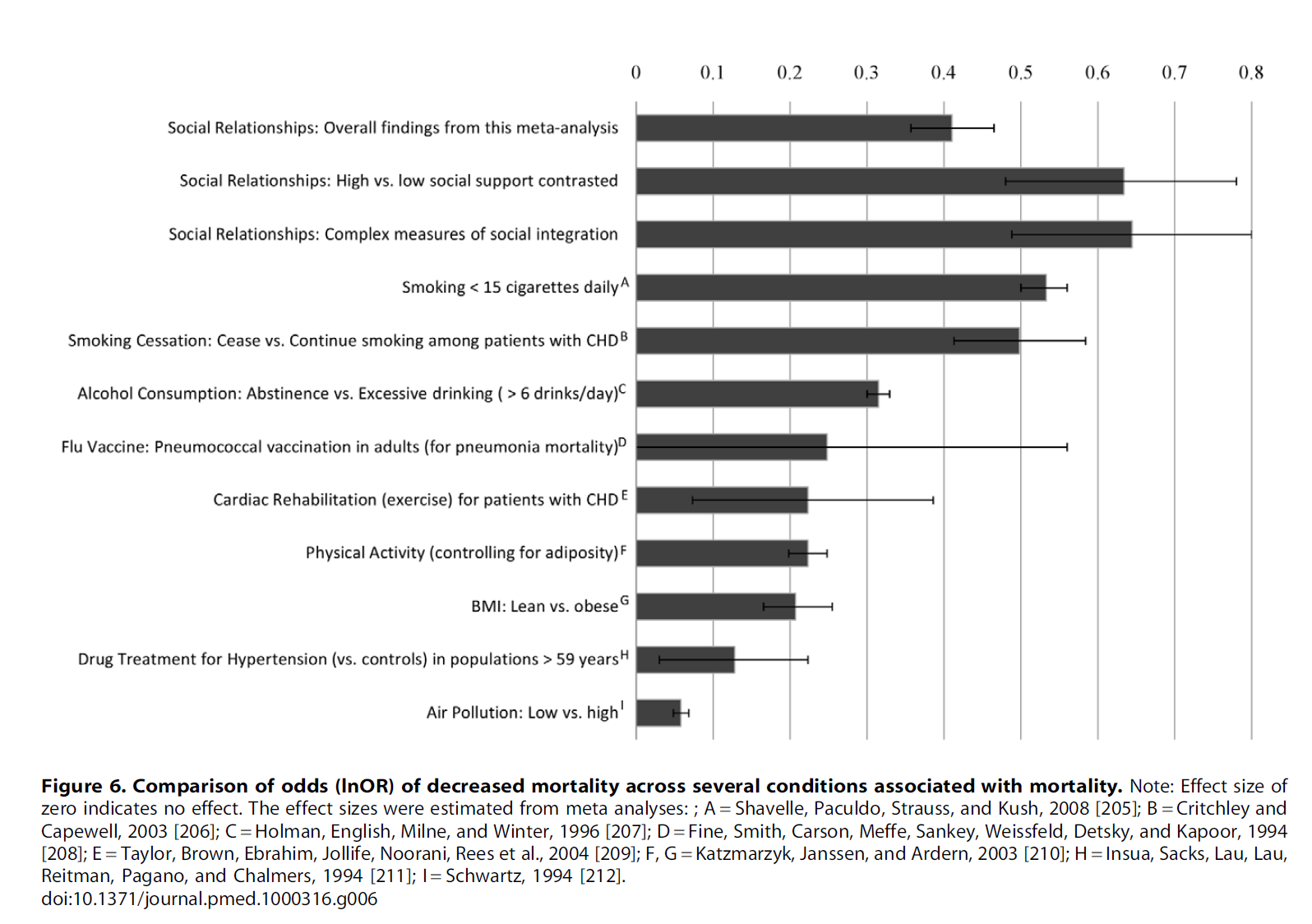


Figure 2: Comparison of odds of decreased mortality across several conditions associated with mortality (Holt-Lundstat et al, 2010)

An instructive illustration of a potential pathway to social isolation is seen in the example of older adults suffering from chronic pain (Wethington et al 2014). Specifically, chronic pain can negatively impact an older adult’s family relationships and as well as restrict mobility. As a result, older adults could find themselves withdrawing from participating in activities or being isolated because the support needed for them to participate in activities is too high. This, in turn, exacerbates being isolated which then may lead to a worsening of physical mobility and psychological well being.

Some of the more severe manifestations of social isolation can result in rapid motor decline, depression, increased risk for onset of Alzheimer’s and chronic illness – including cardiovascular diseases (see Sorkin et al 2002 cited in Cohen-Mansfield et al 2015). Because of multiple co-morbidities, older individuals may present a challenge to the health care system. Social isolation can further magnify the challenges, however, if not considered by healthcare workers as a possible underlying cause of worsening health.

|  |  |  |
| --- | --- | --- |
| Table 2: Impact of Social Isolation and Loneliness on Individual Health and Well Being | | |
| **Impact** | **Correlated Source** | **Reference** |
| Rapid motor decline | Loneliness | Buchman et al, 2010 (cited in Centre for Policy on Ageing 2014) |
| Risk factor for physical inactivity and increases the likelihood that physical activity will be discontinued over time. | Loneliness | Hawkley et al, 2009 (cited in Centre for Policy on Ageing 2014) |
| Contributor to mortality | Social Isolation | Steptoe et al, 2013 (cited in Centre for Policy on Ageing 2014) |
| Correlated with depression | Loneliness | Cacioppo et al, 2006 (cited in Centre for Policy on Ageing 2014) |
| Alzheimer’s disease, poorer overall health, chronic illnesses, cardiovascular impact, impaired hearing, functional disability, lack of mobility, motor decline, poor self-reported functioning | Loneliness | Cohen-Mansfield et al, 2015 |
| Mental health issues include hopelessness, depressed mood, lower levels of well-being, psychological distress, psychiatric morbidity and depression | Loneliness | Cohen-Mansfield et al, 2015 |

Another important stakeholder to consider in the discussion about negative impacts of social isolation are informal caregivers.

For many older adults, their primary caregiver is also an older adult, typically a spouse (Elder et al, 2012). As a result, individuals with higher and more complex care needs may themselves be restricted from participating in a number of activities but also restrict the participation of their more able-bodied partners or caregivers. In turn, this restriction of social participation may contribute to the isolation of a caregiver too (Wethington et al, 2014).

Whether the cause or the consequence, the impact of social isolation on the individual as well as their caregivers can be significant. The problems with social isolation, however, also surface at the systemic level.

## System Level Impact

One of the system-level concerns regarding social isolation in older adults within Canada relates to accessing of healthcare services. Specifically, service planners are concerned that socially isolated older adults might “use the health care system in either inadequate or “inappropriate” ways (e.g., underutilize services resulting in unmet need or over utilize services resulting in a burden on the system)” (Kobayashi et al 2009).

Unfortunately, Canadian data on service utilization by socially isolated older adults is not clear. On the one hand, as part of their investigation into health care usage in British Columbia by socially isolated older adults, Kobayashi (2009) sampled older adults who were deemed to be at risk for social isolation and found that “socially isolated people are not more likely to see their physicians on an annual basis. Indeed, in the model, use of physicians, use of home care and use of the BC NurseLine are not significantly associated with social isolation.” That said, more data is required on the patterns of healthcare system usage by older adults, in particular those who are socially isolated or suffering from loneliness.

In other studies, however, there is evidence to suggest older adults who either are socially isolated or lonely may be accessing healthcare services as “social admissions.” Data from the UK showed the in-hospital mortality rate for a diagnosis of “acopia” (i.e. failure to cope) to be as high as 22% however only 6% of individuals labeled with “acopia” were actually found to have no acute medical issues after a proper workup (Andrew et al 2016). This, as pointed to by Andrew et al (2016), indicates that physicians and health care staff need to be constantly vigilant for underlying causes to individual distress rather than allow for bias to guide a diagnosis. Systemically, however, if the training and support aren’t made available to health care and front-line workers regarding recognizing or diagnosing social loneliness, these issues are “invisible” to the support system as a whole.

Within the context of social isolation, the interface between the individual and the health care system at its most common touchpoints, such as primary care or emergency departments, could help uncover individuals who are socially isolated or who are particularly vulnerable. According to Andrew et al (2016) social admissions are “an important marker of frailty, and more generally, vulnerability.” Having systems in place for health care providers to be able to recognize and respond appropriately to social isolation is clearly an important component to any systems-level discussion of healthy aging.

## Societal Level Impact

In addition to the individual and care system impacts of social isolation, communities can also be impacted by social isolation of older adults. Activities such as volunteering and social participation help to support vibrant communities in which older adults are able to fully interact with fellow community members.

One key area in which older adults contribute significant value, as well as derive significant sense of purpose and worth, is in volunteering. Within Canada, older adults collectively volunteered more than 372 million hours in 2010 with an estimated economic value of least $5.5 billion dollars (Cook et al, 2013). Social isolation, and failing to address or prevent isolation, deprives communities and community organizations of the ability to engage with older adults as well as to have them play meaningful roles.

# Who is Socially Isolated?

Given the variability of what exactly defines social isolation across regions, there are different data points that describe the “typical” profile of socially isolated older adults. Within the Canadian context, it is therefore more advantageous to explore what social isolation looks through a Canadian lens by looking at influential Canadian studies.

Within the Canadian context, two important studies that have shaped the policy-level and academic discourse on social isolation for older adults. The first is a study by Keefe et al (2006) on pan-Canadian older adult data from the 2002-03 National Population Health Survey. Rather than measure social isolation directly, this study used a “social vulnerability” index to measure risk of social isolation. A second study, by Kobayashi et al (2009) looked specifically at older adults in small cities and towns in British Columbia and provides a granular view of factors that distinguish socially-isolated older adults from their non-isolated counterparts.

It is noteworthy to mention that the measures used by Keefe et al to measure social isolation, while appearing to have face validity, have not been widely validated. Similarly, in Kobayashi et al (2009), a shorter modified version of the well-validated LSN was used and suggest some measure of caution must be used when interpreting the findings.

**Key Study: Keefe et al 2006**

One of the most influential depictions of social isolation in Canadian older adults to be generated comes from the study by Keefe et al (2006) which measured a “level of social vulnerability” as a proxy to social isolation.

According to Keefe et al (2006), “social vulnerability” measures a composite of risk factors that “describes someone’s vulnerability to be socially isolated.” The portrait of who was considered vulnerable was based on the 2002-03 National Population Health Survey – a longitudinal study that surveyed a cohort of 17 thousand individuals of all age groups across Canada. The index was comprised of 33 variables grouped into five dimensions to measure social vulnerability:

1. Perceived IADL support
2. Perceived emotional support
3. Autonomy-control
4. Leisure-physical activities
5. Living arrangements

Based on linear regression analysis, Keefe et al (2006) found that social vulnerability increased with:

* Age
* Decreased education
* Chronic illness presence
* Setting

It is important to note that prevalence data of social isolation was not directly stated. Rather, according to the analysis, there were about 33% of older adults who would be considered at high risk for being socially vulnerable.

Further analysis done by measuring associations between individual characteristics (sex, age, location and comorbidity) and social vulnerability dimensions (see image below) revealed statistically significant relationships for certain combinations of features. Thus, gender is a factor in social isolation for perceived IADL support, leisure and physical activities as well as for living arrangements but not significant for perceived emotional support or autonomy-control.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Table 3: Significance of associations between individual characteristics and social vulnerability dimensions | | | | | |
|  | Perceived IADL Support | Perceived Emotional Support | Autonomy-Control | Leisure-Physical Activities | Living Arrangements |
| Sex | X |  |  | X | X |
| Age | X | X |  | X | Not available |
| Rural | X | X |  |  | X |
| Co-Morbidity |  |  | X | X |  |
| Source: Keefe et al 2006 - *(X denotes statistically significant relationship)* | | | | | |

Clearly, the portrait of social isolation in older Canadian adults is complex and nuanced. With this in mind, there is likely no “one size fits all” solution or approach. Rather, the case in the literature points to a selection of diverse and targeted interventions that have crucial integration points as the framework for approaching social isolation.

**Key Study: Kobayashi et al 2009**

Kobayashi et al (2009) conducted a telephone survey of 1064 older adults (aged 65 or older) in British Columbia using a shortened version of the Lubben Social Network Scale (LSNS-6) to determine which respondents were socially isolated (or not) and compared this information against sociodemographic, socioeconomic, health status and health service utilization data. This analysis has, to date, provided a much more detailed picture of the socially isolated seniors.

The prevalence rate observed for socially isolated older adults in BC was 17%, a rate that coincidentally was identical to data observed by Ortiz (2011) in the US. (Wethington et al 2014; Elder et al 2012).

Three different levels of statistical analysis were conducted (see table) to uncover a constellation of factors that showed statistically significant differences between the characteristics of older adults who were or were not socially isolated.

This is important in that it demonstrates that many combinations of factors may contribute to the risk of becoming socially isolated. It also highlights the challenge of measurement and analysis of factors that are reported in the literature and how ‘evidence’ can shape social and health policy. Specifically, there are factors that appear to be statistically significant in one analysis but not in another and so caution must be used to interpret findings.

Based on the data from both Keefe et al and Kobayashi et al, there is clearly no “typical” portrait of who is socially isolated within Canada. That said, there are key markers that could help to establish who is at risk or who is suffering from social isolation.

|  |  |  |  |
| --- | --- | --- | --- |
| Table 4: Summary of Factors Associated with Social Isolation in Older Adults Using Different Statistical Methods | | | |
| **Statistical Method** | **t-test** | **Chi-square** | **Logistic Regression** |
| **What the test measures** | Are socially isolated seniors different than non-socially isolated seniors? | Is there a relationship between a characteristic and presence of social isolation? | Can the presence of social isolation can be attributed to these factors? |
| **Traits Identified** | * Age * # of chronic conditions * # of ADL requiring help * Annual consultations with dentists * Days in past month physical health not good * Days in past month mental health not good * Days health kept you from usual activities * Bradburn Positive Affect Scale * Bradburn Negative Affect Scale * Length of time in current home | * Marital Status * Birth country * Religious attendance * Living alone * Household income * Home ownership * Self-reported health status (poor physical or mental health within past month) * Need help with:   + meal preparation   + Appointments, errands and shopping   + Personal care   + Moving within the house * Cataracts (yes) | * Age * Gender (male) * Marital status (single or widowed) * Birth Country (UK or Other) * Religious attendance (not at all, one to four times per year) * Length of residence in BC * Total household income * Home ownership (rental) * Self-reported health status (fair or poor) |

# What are the Risk Factors for Social Isolation?

Insofar as the risk of becoming socially isolated is concerned, there is an increasing recognition in the literature that the “tendency toward social isolation in old age, and perhaps loneliness as well, is developed over the course of life experiences, not just events unique to the later years of life.” (Wethington et al, 2014). The notion of risk, therefore, is a complex concept because there are both proximal and distal factors to consider. Further, it is important to highlight that social isolation exists along a continuum. Some individuals may be more socially isolated than others and as such, the degree to which an individual is socially isolated impacts how risk factors can be approached.

With many factors contributing to social well-being, the impairment of any or all of these components could be considered a risk factor for social isolation. For example, the decision to purchase a home or to rent, the decision to find a spouse or partner or to live alone or the decision to stay close to family or to live further away to pursue other interests or opportunities can all be tied to known risk factors for isolation later in life even though these decisions are typically made much earlier in one’s lifetime.

Nevertheless, there are some characteristics and situations across the life course of an individual that appear to be more directly linked to social isolation than others. At the individual level there are clearly links between health status, age, living arrangements and risk for social isolation. (Kobayashi et al, 2009; O’Keefe et al, 2006)

Another perspective that highlights both the risks and opportunities regarding social isolation is in major life transitions. According to a report from the AARP (Elder et al, 2012), the following events are also areas in which changes to or losses of these factors can change an individual’s risk profile:

* Social network
* Social role
* Physical health
* Mental health
* Resources
* Residence

Thus, it is important to recognize that social isolation may evolve as the result of multiple risk factors interacting over an individual’s lifetime that would leave individuals susceptible to isolation later in life, especially during transitions or changes in the abovementioned areas.

At a societal level, the risk factors for social isolation specifically are much less well established. Factors such as access to transportation or perceptions about availability of washrooms, for example, have been referenced as concerns in the qualitative literature (North Sky Consulting Group, 2013) however quantitative studies linking these factors to social isolation in older adults are sparse and tenuous.

Instead, societal level risk factors for social isolation are also likely to be risk factors for a number of other negative health or quality of life outcomes. A lack of transportation infrastructure to accommodate the needs of older adults, for example, not only impacts social participation but also the ability to access primary care, a critical component to managing health, as well as simple tasks such as getting to a grocery store or going to the bank which can be important components to the determinants of well-being.

From a programmatic perspective, the risk of social isolation may be higher in areas where there are few opportunities for social participation – such as an absence of programs directed specifically towards older adults. Thus if there is nowhere to go or no way to get there or nobody to engage with, the risk, at a social level can impact the degree of social isolation of populations of older adults.

An especially salient topic, housing affordability within parts of British Columbia and Ontario could play a significant role in increasing risks for social isolation both directly and indirectly. Home ownership may be a marker for social integration (Kobayashi et al, 2009) because individuals will be embedded in their community for longer, benefitting from the ties of neighbours who can provide assistance or awareness of habits. Individuals who are renters are at risk of being displaced based on affordability and as a result would conceivably be faced with the burden of resettling and re-establishing community ties at a point where it would be more challenging to do so.

At the policy level, addressing social isolation can be equally as challenging and unintended negative consequences of certain potentially beneficial policies can emerge.

For example, there is a deeply entrenched position that promoting independence and all of its associated benefits, such as aging in place and social integration, for older adults. That said, actively creating structures, systems and messaging around independent living can also increase the risk of becoming socially isolated (e.g. for older adults who choose or desire to live alone). Thus, the goal of living independently in later life needs to also consider the potential consequences of increasing risk factors for social isolation, especially as social networks of older adults tend to shrink with age.

Finally, in addition to the risk factors stated above, there are certain subgroups within older adult populations that the literature has identified to be at greater risk for social isolation. Included in this group are older women, those older adults who provide care to other people (i.e. informal caregivers), non-married baby-boomers, ethnocultural minority older adults, LGBT older adults and lower income older adults (Wethington et al, 2014).

# What are the Protective Factors?

Isolation or loneliness are not inevitable outcomes of aging nor are solitary or non-social pursuits necessarily harm inducing (Cloutier et al, 2011). For many older adults there are a number of factors, within and around them that better enable them to manage the myriad of risk factors associated with social isolation.

It is useful to once again reiterate that the complex and multifactorial nature of social isolation suggests many opportunities to protect against it and emphasizes the benefit of taking a life course approach to understanding protection against social isolation. For example, seeking to improve physical health and social relationships can potentially help to reduce levels of loneliness even though the pathway to this improvement may not be fully understood. (Victor et al, 2012; as cited in Centre for Policy on Ageing, 2014)

In terms of more immediate protective factors, one important dimension of social isolation identified is the ability to cope with and manage relationships.

According to a study of close to 1200 older adults aged 62 to 100 in Amsterdam (Longitudinal Aging Study Amsterdam) individuals who were employed in mid-life and who had higher self esteem tended to suggest “active coping” by improving relationships. Conversely, “regulative coping” which suggests lowering expectations about relationships, tended to be suggested as a strategy to address loneliness by individuals who were older, had lower education levels or who had low self mastery (Schoenmakers et al, 2012; cited in Centre for Policy on Ageing 2014). Thus, distal factors to older adulthood, such as employment programs or interventions to enhance self-esteem, or proximal strategies, such as enhancing coping skills, appear to offer promise for protection.

Qualitative data gathered by (Cloutier et al, 2011), which took a life course perspective of social isolation of older adults in BC also appears to support this perspective. They stated that “relationships between family and friends are dynamic and changeable over time often taking on different degrees of importance in the context of other losses and experiences.” This is noteworthy because it highlights that subjective assessments of relationships, and the degree to which an individual may wish to maintain or pursue relationships (i.e. the extent to which they actively cope), can vary over time and across circumstance. In terms of “protection” this suggests services or interventions be both diverse in nature and reasonably accessible even though usage levels may vary.

With regards to relationship building for older adults, what appeared to be of particular importance was the type of relationship formed. Specifically, “non-kin ties serve an important function in building individual social networks, and can help protect against social isolation and loneliness.” (Cloutier et al, 2011). Thus social ties beyond the family network, such as friends, a community group or faith-based organization, appear to be important to cultivate in order to widen the network of individuals who can offer support and buffer against an individual becoming isolated or lonely (Fiori et al, 2006). These ties can facilitate increased participation in health promoting practices, such as physical activity and seeking out social or medical care when required or, conversely, to discourage engaging in damaging behaviours, such as smoking. (Gilmour, 2012)

Quantitative data also appear to confirm the importance of relationships to self-perceived health, a reasonably strong indicator for social isolation risk. Specifically, several important findings related to social participation and possible protective factors for Canadian older adults can be found as part of the Canadian Community Health Survey (CCHS) conducted in 2008/09 (Gilmour, 2012). One of the key measurements of the survey was self-reported health status, a factor that Kobayashi et al (2009) identified as a significant predictor of social isolation in older Canadian adults.

Gilmour (2012) reported that older adults with high social support (as based on the Medical Outcomes Study Social Support Survey), tended to report positive self-perceived health. A more pronounced impact of social support appeared in measures of loneliness, with high positive social interaction, high tangible support, high emotional/informational support and high affection each showing dramatically lower loneliness scores than individuals who indicated they were at the low end of each of those parameters.

Another key finding was that as the number of frequent social activities increased, positive self-perceived health scores increased and measures of loneliness also proportionately decreased. Significant positive health increases were observed when individuals were involved in between two and five frequent social activities. Even when controlling for sociodemographic and health variables, this relationship persisted.

Additional bivariate data analysis appears to show that retirement status, and specifically individuals who are not fully retired, have better self-reported health, decreased loneliness and less life dissatisfaction than individuals who were retired. When controlling for age, sex, sociodemographic and health characteristics but not social support, retirement status was significantly associated with self-perceived health and not loneliness or life dissatisfaction suggesting that individuals’ perceptions of available support may influence the ability to continue working. While paid work may not be a possibility for many, the notion of volunteerism and specifically its ability to provide role-identity and a mechanism for formal participation does provide evidence of improving well-being (Greenfield et al, 2004).

In addition to social participation and social engagement, other categories of protective factors that have been identified have been physical activity, cognitive stimulation/remediation, diet/nutrition, complementary/alternative medicine and positive psychological traits (Harmell et al, 2014).

# What are the Barriers to Social Inclusion?

Social inclusion can be defined as the ability to participate adequately in society, including education, employment, public services, social and recreational activities (Litman, 2003). While not the direct opposite to social isolation, the components that prevent or hinder social inclusion offer insights into what may contribute to social isolation more broadly.

The barriers to social inclusion are, like social isolation itself, multifactorial. Components such as economic exclusion, lack of access to public/state institutions, spatial segregation and cultural exclusion (Victor et al, 2012; as cited in Centre for Policy on Ageing, 2014) provide a framework through which to conceptualize the barriers older adults can encounter. Not only can these factors impact older adults in isolation, but often these factors act in concert and are mutually reinforcing creating an amplified impact.

Within the Canadian context, barriers to social participation were described in detail by Gilmour (2012) as part of the 2008/2009 CCHS. Of the older adults surveyed, 24% reported the desire to participate in more social, recreational or group activities, suggesting that there is a desire on the part of individuals in the community to participate but that there may be impediments to them doing so.

Approximately one third of older adult respondents indicated a health limitation as preventing participation, while family responsibilities accounted for 10% of older adults not participating. It is noteworthy to point out that as part of the CCHS results only about 8% of individuals 65 or older reported not having a disability that was either mild (45.8%), moderate (19.5%) or severe (26.8%). This indicates that the vast majority of individuals who are participating in activities are doing so even in spite of disabilities. In a Finnish study by Rantakokko et al (2014), it was shown that environmental barriers played a larger role in contributing to loneliness rather than physical difficulties with walking, suggesting that individuals living close to barriers such as hills or who live at long distances away from everyday services are at particular risk of not being able to participate in desired activities.

Interestingly there were some categories of responses that highlight that barriers to participation may be different or experienced differently between men and women.

For example, “being too busy” was cited as a reason for not participating much more often for men (28%) than for women (16%), whereas more women than men reported not wanting to attend an event alone (17% vs 9%). Transportation problems were also quite disproportionately reported with 11% of women citing this as a reason for non-participation compared to 4% of men. In a report commissioned by the City of Nanaimo to investigate social isolation, qualitative interview data specifically cited the importance of transportation services, such as the Handy Dart, for older adults in the community:

*“Without exception transportation related issues were the most common reasons given for remaining at home. Only a couple of seniors said they still occasionally drive, the majority said they have to rely on friends, family, neighbors and others for transportation. Some seniors noted that in the past members of their church group or social clubs were very helpful in getting them to and from events, but they said ageing is creating special needs that cannot always be easily accommodated.” (North Sky Consulting Group, 2013)*

External factors were also cited by respondents with approximately 4% to 9% of individuals reporting availability of activities or suitability of time or location as prohibiting participation.

For immigrant older adults, language, and more specifically, not having services in or service providers who can speak their native language can be a barrier.

Another area which should be of increasing concern for social participation is technology. With the trend towards digitization a number of previously available services and service experiences are moving online. As such, individuals who lack the access to or understanding of computers and the internet are increasingly at risk of becoming detached from participating in social activities as well as from important everyday tasks.

One example of an important consequence of the increasing reliance on society of technology creating the conditions for preventing participation can be seen in the decline of local newspapers and television. With the rise of search engines and a highly fragmented online media space, traditional print local news media have been forced to shutter their operations because they are no longer as profitable. As a result, more and more local newspapers (and even local TV affiliates in Canada) have either moved to online only formats or have ceased operating altogether. These communication channels provide essential information to communities – especially suburban and rural communities about local events, volunteering opportunities and developments in and around the communities in which older adults may live.

The issue of declining local media also creates a challenge to social participation for those older adults who then are forced to use technology they may never have used before in order to access this information as well as to be a participant in the changes taking place around them. While cost barriers to accessing this technology as well as the internet connection that accompanies it are certainly real, there are also barriers with regards to user friendliness as well as internal challenges, such as attitudes towards having to learn a new skill or being able to read that can prevent older adults from fully participating in their communities.

# How can Risk Factors be Mitigated/Addressed?

There are both a number of challenges and opportunities that lay ahead of those seeking to mitigate the risk factors for social isolation in older adults. Approaches to addressing social isolation in older adults thus far have attempted to:

* Reduce loneliness and/or depression
* Increase social network size
* Improve quality of supports and
* Improve frequency of social contacts

Several reviews in both the academic and grey literature point to a wide variety of interventions that have been used to address social isolation (Gardiner et al, 2016; Cattan et al, 2005) albeit with varying levels of success.

Given the sheer number and diversity of different programs, systematic comparisons have been difficult. Nonetheless several comparisons of large groups of interventions have made it possible to identify components of an activity that tend to improve outcomes for older adults at risk for or suffering from social isolation or loneliness.

Three frameworks for understanding intervention types are presented below. The first two models, by Gardiner (2016) and Cattan (2005) take a more traditional categorical approach to classification of services. The third is perhaps the most integrative and stems from the United Kingdom as part of the Campaign to End Loneliness (Jopling, 2015). This latter approach is worthy of consideration at the systems level as it incorporates multiple levels at which interventions and the impact that they may have on various determinants of well-being.

According to a review of social isolation interventions by Gardiner (2016), six categories capture the most common intervention types for social isolation among older adults based on purpose, mechanisms of action and intended outcomes:

1. Social facilitation interventions
2. Psychological therapies
3. Health and social care provision
4. Animal interventions
5. Befriending interventions
6. Leisure/skill development interventions

Another popular method of organizing intervention types was distinguishing between group interventions or one-on-one interventions (Cattan et al, 2005; Elder et al, 2012; Cohen-Mansfield et al, 2015). These interventions could be further categorized into the features provided by the intervention (e.g. educational interventions for groups in community settings, shared activities).

Cattan et al (2005) conducted a systematic breakdown of 30 quantitative intervention studies into the following categories:

1. Group
2. One-to-one
3. Service provision
4. Community development

Of this pool, there were 10 interventions that were considered effective and of those, nine were group-based activities. Despite the diversity of interventions, effective interventions shared the following characteristics:

* Group interventions with focused educational input or targeted support activities
* Interventions targeted specific groups (e.g. women, caregivers, widowed etc)
* Enabled some level of participant control or consulted with intervention group prior to developing intervention
* Evaluated an existing service or activity
* Effective services also contained some form of process evaluation

Interestingly, according to Cattan’s review (2005) the common feature to interventions that were deemed to be ineffective for reducing social isolation were those that were one-on-one conducted in people’s own homes.

A subsequent review by Gardiner (2016) further identified three factors associated with successful intervention programs for social isolation in older adults:

* Adaptability
* Taking a community development approach
* Productive engagement

In terms of adaptability, programs or interventions that can be tailored to meet the needs of local populations were typically more effective than those that could not. Often it is at the local level implementation of a broader strategy that the particular issues of a population need to be addressed. Thus, a befriending program, for example, might require additional consideration for cultural norms between men and women or might entail having to coordinate transportation resources to help older adults get out of their own homes and to a community centre-based program in order for the older adult population being served to benefit from this choice of intervention.

The community development approach relies on the targeted population of service users to be instrumental in the development or design and implementation of interventions.

Lastly, programs with a focus on productive engagement, i.e. activities that require individuals to “do things” tend to have better outcomes than those that are more passive. For example, programs that facilitate individuals being able participate in an activity and socialise were more effective than those that had passive activities, such as watching television.

A meta-analysis performed by Masi (2011) found that randomized group comparison studies had a modest but measureable impact on reducing loneliness. Specifically, they found that the mean effect size for interventions which addressed maladaptive social cognition was larger than that for interventions which attempted to improve social skills, enhance social support, or increasing opportunities for social interaction. Thus, targeting the maladaptive perceptions or thoughts and behaviours that may contribute to social isolation or loneliness would appear to be more likely to be effective than interventions geared towards other aspects of loneliness.

In addition to the findings listed above, there has also been innovative work being done out of the UK as a result of their national Campaign to End Loneliness initiative. Specifically, a review of effective interventions for loneliness (Jopling, 2015) proposed a novel and more holistic framework (see Fig. 3) through which to view services and programs for isolated or lonely older adults. In particular, services and activities are clustered into four key categories:

* Foundation services
* Direct interventions
  + Services to support and maintain existing relationships
  + Services to foster and enable new connections
  + Services to help people change their thinking about social connections
* Gateway services
* Structural enablers

An important insight from the AGE UK work was in relation to the kinds of activities and interventions that experts felt would have the greatest promise. Specifically, “The approaches in which most experts saw promise were not the lunch clubs, social groups, and befriending schemes that have most commonly been evaluated in previous studies. Instead experts focused on two other types of approach, including services that worked with individuals at the stage before they started to access lunch clubs, book groups, etc; and approaches that were less centered on the individual and more about the way in which a community responds to the challenge of loneliness” (Jopling, 2015).

The framework of service delivery within the UK helps to better define the intervention type and strategy. For example, foundation services are considered those that seek to identify individuals who may need services; these services use a combination of linked data to identify individuals who may be at risk of isolation and loneliness and pair that with outreach workers who directly engage members of the community. A second approach uses the ‘eyes on the ground’ or community partners to help identify and refer individuals who may be at risk of or experiencing isolation or loneliness.

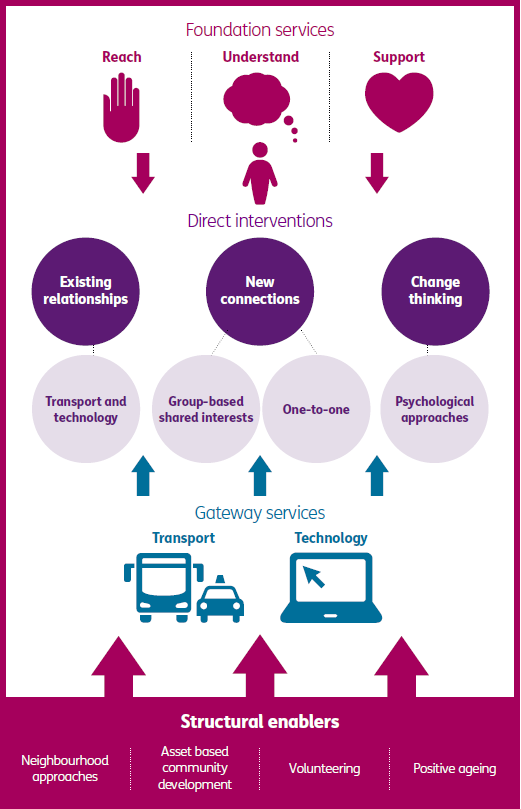


Figure 3: Framework for integrated service response to address loneliness in older adults - Source: Jopling, 2015

| Table 5: Summary of Service Category Framework Tiers and Associated Programs | | | |
| --- | --- | --- | --- |
| **Service Category** | **Category Description** | **Strategy/Impact** | **Example Programs** |
| Foundation Services | Focussed on the individual and are the first steps taken as part of the work to reduce an individual’s loneliness. | * Using data, eyes on the ground and links to healthcare services to reach lonely individuals * One to one conversation to understand individual needs * Facilitate interaction with supported access | Springboard – Cheshire (using data to identify areas at risk)  Leeds Senior Network (similar to seniors reach outreach program)  Community Wellbeing Practices\* |
| Direct Interventions | Services and groups that have more traditionally been thought of as loneliness interventions. | * Support individuals to reconnect with and/or maintain existing relationships * Foster and enable new connections * Modify how individuals think about social connections | Touchstones – Yorkshire (bereaved older adult support)  Male Carers Support Group – Brighton and Hove Carers  Psychological Support Services - Warwickshire |
| Gateway Services | Play a critical role in directly enabling existing relationships and a vital supporting role  in those interventions designed to support new social connection. | * Technology can help connect to individuals while they’re at home. * Transportation to facilitate attendance and build friendships | Call in Time – National telephone befriending service  Contact the Elderly Tea Parties |
| Structural Enablers | Approaches that support the development of new structures within communities. | * Neighbourhood approaches * Volunteering * Asset Based Community Development * Positive Ageing – Age Friendly Cities, Dementia Friendly Communities | * Neighbourhood Networks – Leeds * LinkAge – Bristol * Culture champions - Manchester |

## Examples of Programs with Demonstrated Effectiveness in Reducing Isolation & Loneliness

**Senior Reach**

The Senior Reach program was originally deployed in Denver, Colorado in 2006 as an adaptation to the Spokane Gatekeeper program. The mission of Seniors Reach program was to “support the well-being and independence of seniors by educating the community on how to identify and refer isolated, at-risk older adults who may benefit from a model of care management support well-being and independence of seniors.” (Bartsch et al, 2009)

The program contains two essential components. The first is a referral source, either traditional (e.g. primary health care or allied health care professionals) or non-traditional (known as community partners). These community partners could include:

* Restaurant/retail staff
* Bus drivers
* Senior center staff
* Members of civic organizations

The second essential component of the program is a toll-free number to which community partners can call and report the individuals in need. Call center representatives can then follow up with the at-risk older adult directly to determine what needs they may have.

Impressively, in three years there were over 5,000 individuals trained as Community Partners, with 91% (n=436) of seniors offered services accepting them through this program.

Interestingly non-traditional clients lived alone at twice the rate of traditional clients – suggesting that pathways to support services can be associated with individuals who have different profiles. Those that are at greater risk (i.e. those who live alone) may not interact with traditional intake points, such as healthcare settings, more so than other community touchpoints. This supports the case for alternative touchpoints that can recognize isolation and steer care services towards those in need.

Results from this intervention suggest that individuals identified for support via community partners and traditional pathways benefit significantly from being connected with support services. Specifically, there were statistically significant reductions in markers of social isolation, emotional disturbance, cognitive impairment and economic disadvantage.

That said, evidence suggests that different pathways taken to use services have different outcomes – namely that the community partners were effective in identifying individuals who benefitted more in terms of emotional disturbance, cognitive impairment and social isolation than those in traditional referral pathways.

**Group-based Exercise Program**

Although the exact mechanism for group-based exercise programs’ effectiveness is unclear, there is evidence suggesting that physical activity programs can reduce loneliness over time, regardless of the program design (Pels et al, 2016). One possible suggestion is that the underlying mechanism for the positive impact may be attributed to perceived social support (Savikko et al, 2009 as cited in Cohen-Mansfield et al, 2015).

One peer reviewed evaluation of a group-based exercise program (Ollonqvista et al, 2008; cited in Centre for Policy on Ageing 2014) showed promising reductions in markers of loneliness and improvements of risk-factors for isolation, such as self-reported health.

Group activities primarily focused on physical activation including exercises while in a sitting position, pool exercises or resistance training in the gym. Program participants also attended group discussions and lectures given by members of the rehabilitation team. The content focused on the realities of older adulthood, including possible problems, promotion of self-care, psychological counselling, medical-themed discussions, information on social services and recreational activities. Individual counselling was provided in some cases for up to three sessions.

While it was difficult to discern whether the group aspect of the intervention or the exercise alone had the beneficial impact, there was only a modest decrease in the amount that individuals felt lonely. Though this decrease was encouraging it was not a statistically significant reduction suggesting this intervention is promising.

**Friendship Enrichment Program**

The Friendship Enrichment Program is a 12-week long group based intervention which was deployed in the Netherlands that is “designed to empower older women in the process of meeting personal goals in friendship” (Stevens et al, 2006).

The objectives of the program included helping participants to:

1. Clarify their needs, desires and expectations in friendship
2. Analyze their current relationship networks in order to identify actual and potential friends
3. Formulate goas that involve the improvement of existing friendships or the development of new friendships
4. Develop strategies to achieve these goals

This program sought to acquire participants through various methods of advertising (newspapers etc) and as such, likely appealed to individuals who, though lonely or isolated, nevertheless had a sufficient desire to participate in a social activity.

There is data from the CCMHS (Gilmour, 2012) that indicates that a certain percentage (21%) of the Canadian older adult population would want to participate further in more social activities. Based on the data collected, and the possibility for selection bias towards individuals who would be more likely to voluntarily participate in social activities, this figure should be interpreted cautiously.

Interestingly, the impact of this program on reduction of loneliness in older adult women was significant only when participants improved existing relationships and made new friendships as opposed to relying on either strategy exclusively. In addition to reduction in loneliness, the intervention did help participants form new friendships as well as improve existing friendships with encouraging results up to one year after participating in the program.

## Promising Programs Identified by the Campaign to End Loneliness (UK)

The Campaign to End Loneliness launched in the UK in 2011. Since that time, a considerable body of literature has been generated to understand the scope and impact of loneliness in older adults in the UK as well as the interventions and programs that can help address it. As a result of the extensive work done in the UK, there is also a small but important body of evaluation data from the programs deployed that can offer some measure of insight into effectiveness. While many of the programs described below do not have exhaustive evaluation literature that replicates or substantiates the performance achieved from local deployments, the results in addressing loneliness and isolation are nonetheless promising. As such these programs are intended to create a dialogue around potential deployment or fit within the Canadian context, in particular within BC.

***Program:*****Community Wellbeing Practices (Halton)**

***Description:*** Older adults are provided with one-on-one sessions with Community Wellbeing Officers who guide and conduct a ‘Wellbeing Review’. These reviews help to uncover social issues that may be causing or exacerbating physical health problems. Review plans then form the basis for an action plan that helps to identify personal strengths and additional sources of support in the community.

***Outcomes:*** Approximately 4,000 interventions are delivered each year through Community Wellbeing Practices (CWP). Outcomes data from the CWP initiative have shown that:

* 64 per cent of participants improved their subjective wellbeing levels after an intervention;
* 55 per cent of participants reported a reduction in depression symptoms after an intervention.

***More information:***[www.wellbeingenterprises.org.uk](http://www.wellbeingenterprises.org.uk)

***Program*:** **Social Prescribing (Rotherham Social Prescribing Scheme)**

***Description*:** An integrated approach is taken at the primary care physician level whereby older adults who are considered at-risk for unplanned hospital admissions are identified and subsequently assessed by community sector advisers. These advisers help to connect individuals to appropriate services intended to help improve health and well-being. Services are time-limited with a focus on facilitating independence and eventually patients assuming control of health and well-being enhancing behaviours.

***Outcomes*:** During the pilot phase of the project, it was found that:

* 83% of patients experienced positive change in at least one social outcome
* 27% of patients made progress in family and friends outcomes
* Inpatient admissions were reduced by 21%
* Emergency room visits declined by 20%
* Outpatient appointments declined by 21%

***More information:*** [www.varotherham.org.uk](http://www.varotherham.org.uk)

***Program:* Living Well (Cornwall)**

***Description:*** The Living Well program is designed to improve individual self-confidence and self-reliance through the provision of practical support, navigation and coordination of those deemed to be “at risk” of increased dependency or hospitalization. The program involves a ‘guided conversation’ between individual and coordinator trained in motivational interviewing to determine goals and a establish a management plan to achieve them.

The core elements of Living Well include:

* Understanding the population – using risk stratification, case finding and local knowledge to identify people at high risk of hospitalization; recognizing social isolation and loneliness as factors that contribute towards a crisis
* Guided conversation – an unscripted engagement to identify individual needs
* Community involvement and mapping – through conversation with local leaders to identify existing resources and find the ‘community makers’
* Information sharing – sharing data across all sectors, using common protocols and
* Management plans

***Outcomes:*** An evaluation of a pilot program upon which the Living Well program was based showed the following:

* A 23% improvement on wellbeing scores (20% improvements were seen in the early months of the Living Well program)
* A minimum of a 29% reduction in cost of hospital admissions; estimated return on investment was 4:1.

***More information:*** <https://www.cornwall.gov.uk/media/6162062/Newquay-pathfinder-Evaluation-proof3.pdf>

<https://www.cornwall.gov.uk/health-and-social-care/health-and-wellbeing-board/living-well-pioneer-for-cornwall-and-the-isles-of-scilly/>

***Program:* Village & Community Agents (Gloucestershire)**

***Description:*** Launched in 2006, this program has grown to 39 centres across the Gloucestershire region. Individuals within the community act as ‘agents’ by providing information and support to community dwelling older adults. This is an early intervention/prevention service.

Community-based agents engage with older adults and determine where or if referrals to services may be appropriate. An emphasis is made to link to community-based solutions wherever possible.

***Outcomes:*** Data from an early evaluation point to savings for health & social care, increased income for vulnerable community members, maintained independence of individuals in the community and improved access to socially isolated individuals.

***More information:*** [www.villageagents.org.uk](http://www.villageagents.org.uk)

***Program:* Time for Life (Devon)**

***Description:*** This intervention aims to help older adults re-engage in activities that are meaningful and enjoyable; re-engage with the community and develop confidence and skills to self-direct their own involvement in social activities. Unlike befriending interventions, this program uses ‘coaches’ or ‘enablers’ to assist individuals experiencing isolation following life changing events such as bereavement, illness or disability. These ‘enablers’ are typically time-limited and very focused on assisting individuals reach particular objectives or milestones.

***Outcomes:*** Program participants report significant improvements against multiple measures of well-being (e.g. health, economic well being, experiencing personal dignity and more) upon completion of the program and six months afterwards.

***More information***: <http://www.timeforlife.org.uk/>

***Program:* Male Carers Support Group (Brighton and Hove)**

***Description:*** This support group brings together male older adult caregivers in a relaxed and social setting. It was put together as a response to poor attendance by male older adults to other kinds of social programming. Programs typically run twice per month and are scheduled to run in the evenings or on weekends as this enables greater flexibility for attendance. Length of the programs is kept to a few hours which reflects awareness that individuals have to return to caregiving duties. Typical social activities include monthly coffee mornings in a café, bowling, pool, mini-golf and more. Efforts are made to assist individuals within the program to participate and attend (e.g. covering transportation costs) for certain members.

***Outcomes:*** Based on an evaluation questionnaire sent to participants, on a scale of 1 to 5 (where one represents a low rating and five a high rating) the average scores ranged from 3.75 to 5 in terms of usefulness in managing stress, depression, feelings of isolation and ability to cope with the caring role.

***More information:*** [*http://www.thecarerscentre.org/*](http://www.thecarerscentre.org/)

***Program:* Fit for the Future (Age UK)**

***Description:*** This is a holistic well-being focused program that takes a person-centred approach to intervention engagement. The goal of the program is to improve participants’ quality of life and enhance the ability of individuals to effectively live independently for longer and also delay the requirement for intensive and costly health or social care treatments. Trained staff members or volunteers meet one-on-one with older adults to tailor a plan suited to the individual’s health and well-being needs. Intake to the program comes from a variety of sources including GPs and healthcare professionals as well as from friends, relatives or other voluntary sector service partners.

***Outcomes:***Significant positive impacts were observed on participants’ measures of well-being, life satisfaction and social isolation measures. Broader improvements were also noted including increased dietary intake of fruits and vegetables, improved participation in physical activity.

***More information:*** [www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle/fit-for-the-future](http://www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle/fit-for-the-future)

<http://www.ageuk.org.uk/Documents/EN-GB/fit%20as%20a%20fiddle/fit%20for%20the%20future%20project%20-%20Final%20Evaluation%20Report%20(July%202015).pdf?dtrk=true>

***Program:* Silver Line Helpline (UK)**

***Description***: 24-hour helpline offering friendship and advice to older people. There is an additional component to this service which includes matching individuals to one another either by telephone or through letters as part of a befriending program. This is a large and well-coordinated program that offers older adult volunteers the opportunity to participate meaningfully in the improvement of wellbeing for others as well as themselves.

***Outcomes:*** Data from an evaluation study indicated reductions in loneliness were achieved for 30% of individuals engaged with the program.

***More information:*** [www.thesilverline.org.uk/](http://www.thesilverline.org.uk/)

<https://www.thesilverline.org.uk/wp-content/uploads/2016/07/The-Silver-Line-Annual-Report-2016.pdf>

***Program:* Call in Time (UK)**

***Description:***This is a national telephone-based befriending program used to reach out to older adults in areas where befriending programs may not exist. By partnering with businesses and organizations, the corporate volunteer base enables individuals to volunteer their time while at work to perform simple “good day” check-in phone calls.

***Outcomes:***Perceived wellbeing and mood were indicated to have improved according to pilot evaluation data.

**More information:** [www.ageuk.org.uk/health-wellbeing/relationships-and-family/telephone-befriending/](http://www.ageuk.org.uk/health-wellbeing/relationships-and-family/telephone-befriending/)

***Program:* Active Online**

***Description:*** Internet training activity that was offered to older adults in their own homes on a one-to-one basis. The service involved trainers providing instruction to individuals on how to use the internet on tablet devices. Trainers included young adults or youths who provided the majority of sessions and, when required, specialists were brought in who could assist those individuals with additional needs such as visual impairments, learning disabilities or dementia.

***Outcomes:*** Evaluations from the pilot studies found that the vast majority of individuals found tablets easy to use, felt that they were more in touch with the world around them and valued the new skills they had learned.

***More information:*** <http://www.campaigntoendloneliness.org/wp-content/uploads/Viridian-Housing-Case-Study.pdf>

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