Social Isolation and Loneliness in Older Adults

A survey of Canadian health and social service providers

Summary prepared for Guidelines Working Group

CCSMH | CCSMPA

Canadian Coalition for Seniors' Mental Health

Coalition canadienne pour la santé mentale des personnes âgées

CONTEXT

The Canadian Coalition for Seniors' Mental Health (CCSMH) is currently undertaking a project on Social Isolation and Loneliness. This project is intended to lead in the development and promotion of Canadian Guidelines for health and social service providers to identify and address isolation and loneliness among older adults. As part of this work, CCSMH launched a pan-Canadian survey of health and social service providers in January 2023. The focus of this survey was to learn more about the attitudes, experiences, knowledge and ideas of people working directly with older adults, regarding the topic of social isolation and loneliness. This document outlines the methodologies used for survey development, administration, and analysis, as well as a summary of survey results.

METHODS

A mixed methods online survey, consisting of open and close-ended questions, was drafted by the team. Survey questions included a combination of demographic (e.g., professional role, health sector), opinion (e.g., do you agree/disagree with the following statement), and practice-based questions. The draft survey was pilot-tested with a group of health and social service providers who provided feedback regarding terminology, question clarity, usability and technical functionality of the survey. The survey was modified based on received feedback. The finalized survey was translated to the French language (survey was made available in both English and French) and prepared for online administration using Qualtrics Survey Software. The survey and project protocol were approved by the Queen's University Health Sciences Research Ethics Board.

CCSMH distributed an invitation letter via email to their mailing list membership (approx. 1700 contacts) and network of organizational contacts (45 organizations) focused on the health and social care sectors. The survey was also advertised via social media. Contacted organizations and individuals were also encouraged to share with their networks, to facilitate snowball sampling. The survey was a voluntary and open survey, allowing anyone with a link to access the survey.

The invitation letter contained a description of the project and a link to the survey. Prior to completing the survey, participants were asked to view a letter of information and consent form.

This contained information regarding survey length and content, data storage, confidentiality, and study information. Participants who consented were able to complete the online survey, which was anticipated to take approximately 15 minutes to complete.

Participants were not offered any incentives to complete the survey.

The survey consisted of 24 close and 5 open-ended questions, spread across 5 pages (screens). The survey included the use of adaptive questioning but did not include item randomization. Additionally, participants were asked 7 close-ended demographic questions. All questions were optional and participants were not required to provide a response in order to proceed further with the survey. Participants were also not able to review/change answers upon survey completion. Survey data were collected between January 25 2023 and February 28 2023.

Summary statistics were calculated for demographic variables and quantitative data. Sub-group analyses were also conducted, including examining potential differences in responses due to variables such as profession and years in practice. Surveys which were terminated early were included in analyses. Individual item analyses were conducted with all available data for that given item and statistical correction (ex. weighting of items or propensity scores) was not conducted. Qualitative data were analyzed using thematic analysis and content analysis, as appropriate. Results were interpreted through triangulation of quantitative and qualitative data.

RESULTS

Survey Completion

The survey had a completion rate of 56.6%, with the majority of missed questions being the demographic questions located at the end of the survey. Five hundred and seven individuals accessed the survey, with 287 individuals completing the entire survey. The highest number of respondents on a single question was 358.

Participant Characteristics

Table 1 presents a complete summary of survey participant characteristics. Of note, the survey sample included respondents from all of Canada's provinces as well as two out of three territories. Additionally, there were three international respondents. Survey respondents primary practice areas included large urban (33.9%), small urban (27.0%), semi-urban (24.4%), and rural (14.9%) areas. Most respondents did not have a secondary practice area. Approximately 70% of respondents reported working directly with older adults. As outlined in Table 1, a number of professions in the health and social care sectors were represented in the survey sample.

Survey Results

Survey respondents self-reported knowledge of the physical health, mental health, and social issues that contribute to social isolation and loneliness in older adults was high (Table 2). Ninety-five percent of respondents agreed or strongly agreed that they were knowledgeable about the physical health issues. Similarly, 95% and 95% agreed or strongly agreed that they were knowledgeable about the mental health and social issues, respectively. This is in contrast to their self-reported ability to effectively address the physical, mental, and social impacts resulting from social isolation and loneliness, where greater variation in responses was seen (Table 2). Only 45% of respondents felt they were able to effectively address the physical health issues resulting from social isolation and loneliness, and only 55% and 44% felt they were able to effectively address the mental health and social issues, respectively. Statistically significant relationships were found between participants' responses to knowledge/ability questions and their years in practice, with greater years in practice associated with greater self-reported knowledge and ability to effectively address social isolation and loneliness (Table 3).

Most respondents felt it was within the scope of their professional role to address social isolation and loneliness in individuals experiencing it (70%) and preventing it in individuals at risk of developing it (69%) (Table 2). When focusing specifically on what their role includes, an interesting trend was apparent (Figure 1). While most respondents felt that their role included noticing/observing, discussing with the patient, supporting, and referring, marked decreases were seen with respondents indicating that their role included screening/assessing and even more so for intervening/managing. This was consistent across all professional groups.

When asked about barriers impacting their ability to address social isolation and loneliness, the top three barriers identified by respondents were a lack community resources, insufficient system/organizational funding to put appropriate interventions into place, and a lack of organizational/administrative support (Table 4). In a follow-up open-ended question, respondents were asked to select the barrier of most significance to them and to explain how it impacts their ability to address social isolation and loneliness (detailed thematic analysis found in Appendix 1).

In referring to the lack of community resources, respondents shared:

> "There is not enough variety in the types of resources to meet people's unique needs. Not all resources are appropriate for all people so there are limitations as to what to offer folks."
>
> ***– Occupational Therapist***

> "There is a lack of resources available in the community for low income/fixed income older adults experiencing social isolation/ loneliness, including free/low cost, accessible options."
>
> ***– Other Social Service Professional***

Speaking to the insufficient system/organizational funding as well as lack of organizational/ administrative support, two respondents shared:

> "There is only so much we can do. We can refer to a community group, hospital day program etc., but there is no guarantee that the individual or family can afford to take part in that program."
>
> ***– Physician***

> "I have community resources available but need approval and funding from Management to go on Community visits with clients to these programs"
>
> ***– Social Worker***

In addition to barriers to addressing social isolation and loneliness, survey respondents were asked to indicate strategies they have incorporated into their practice to mitigate social isolation and loneliness experienced by older adults. Three strategies were identified as most incorporated. These were: befriending interventions (e.g., older adult peer volunteers, peer groups, neighbourhood helping initiatives); physical activity interventions (e.g., group-based physical activity, physical and social interaction activity); and age-friendly health care (e.g., allot extra time for appointments, flexible appointment modalities [telephone, internet], integrated team approach).

Respondents were also asked to indicate what would better prepare them to address the health and social issues that contribute to and result from the social isolation and loneliness issues experienced by older adults. The top five selected responses were: collaborative partnerships with social organizations/groups (82.1%); collaborative partnerships with health organizations/groups (71.3%); referral pathway navigation tools/resources (67.0%); access to peer support personnel (e.g. trained older adult volunteers) (63.1%); and practice guidelines (56.7%). A follow-up open-ended question asked respondents to select the resource of highest importance to them and to explain why/how the resource they selected could help them optimize their work with older adults experiencing or at risk of social isolation and loneliness (Table 5). Collaborative partnerships with both health and social organizations received nearly a third of the selections, show clearly the significance of partnerships in optimizing care.

Lastly, the final survey question asked participants whether they considered social isolation and loneliness to be two distinct concepts and the reasoning for their response. Seventy-five percent reported that they did consider these to be two distinct concepts, while 14% did not and 11% were unsure. While it is reassuring that the majority of respondents understand that these are distinct concepts, responses do show that there is room for improvement, particularly as some respondents felt these concepts “overlap considerably” and can be “difficult to tease apart.

Interpretation

This survey provided a snapshot of health and social care providers' current attitudes, knowledge, and practices pertaining to social isolation and loneliness in older adults across Canada. Respondents included health and social care providers representing a variety of professions from across Canada. Respondents reported high levels of knowledge regarding the physical, mental, and social issues related to social isolation and loneliness in older adults. However, lower levels of their ability to effectively address the physical, mental, and social impacts of social isolation and loneliness were reported. Years in practice was positively associated with self-reported knowledge and ability. It was encouraging to see that most respondents felt it was within their scope of practice to address social isolation and loneliness in older adults. However, when breaking down their role in greater detail, a deficit in respondents feeling it was within their role to intervene/manage social isolation and loneliness was identified. Survey responses' also identified strategies commonly used by participants to address social isolation and loneliness (befriending interventions, physical activity interventions, and age friendly health care) as well as what would help them to better address social isolation and loneliness. The need for increased collaboration was found to be a central tenet.

The contrast in respondents' self-reported knowledge and their ability to effectively address social isolation and loneliness is indicative that health and social care providers experience barriers in implementing their knowledge in practice. By addressing barriers, it may be possible to facilitate opportunities for health and social care providers to implement their knowledge in practice, thereby improving their ability to address social isolation and loneliness. For example, respondents identified a lack of community resources, insufficient system/organizational funding to put appropriate interventions into place, and a lack of organizational/administrative support as top barriers to effectively addressing social isolation and loneliness. Greater collaboration with health and social groups, which was identified as a need by health and social care providers, may serve to minimize barriers such as a lack of community resources and a lack of organizational/administrative support. Indeed, recent research indicates an urgent need for more collaborative models of care (Lake 2017) and studies focusing on increased collaboration and interprofessional care have demonstrated promising impacts on social isolation and loneliness (Joosten-Hagye 2020; Price 2015).

The barriers identified by respondents may also be a factor affecting what providers feel their role entails with regard to social isolation and loneliness. As the data showed, all provider groups surveyed demonstrated a drop in "intervening/managing" as part of their role. This is particularly as concerning, as if no provider groups feels this is a central part of their role, it may impact older adults seeking care for social isolation and loneliness concerns. Older adults experiencing social isolation and loneliness are not frequently identified within their own community, but often do still interact with the health and/or social care system (Blazer 2020). Therefore, health and social care providers are uniquely positioned to be part of not only screening and assessment but also intervening and managing social isolation and loneliness. Ongoing education and supports for each of these may also be needed.

The development of practice guidelines may serve to enable health and social care providers to feel they are able to effectively address social isolation and loneliness, and consequently recognize the role that they may play in its management. The presence of guidelines coupled with active implementation practices to encourage guideline uptake has also demonstrated improved patient outcomes (Murad 2017). Moreover, 56.7% of survey respondents indicated that practice guidelines would better prepare them to address

the health and social issues that contribute to and result from the social isolation and loneliness issues experienced by older adults. Sixty-one percent of providers surveyed indicated that the absence of practice guidelines somewhat (37%), very much (18%), or extremely (6%) impacts their ability to address social isolation and loneliness in older adults. Therefore, the development of practice guidelines to address social isolation and loneliness is a needed next step.

Future directions

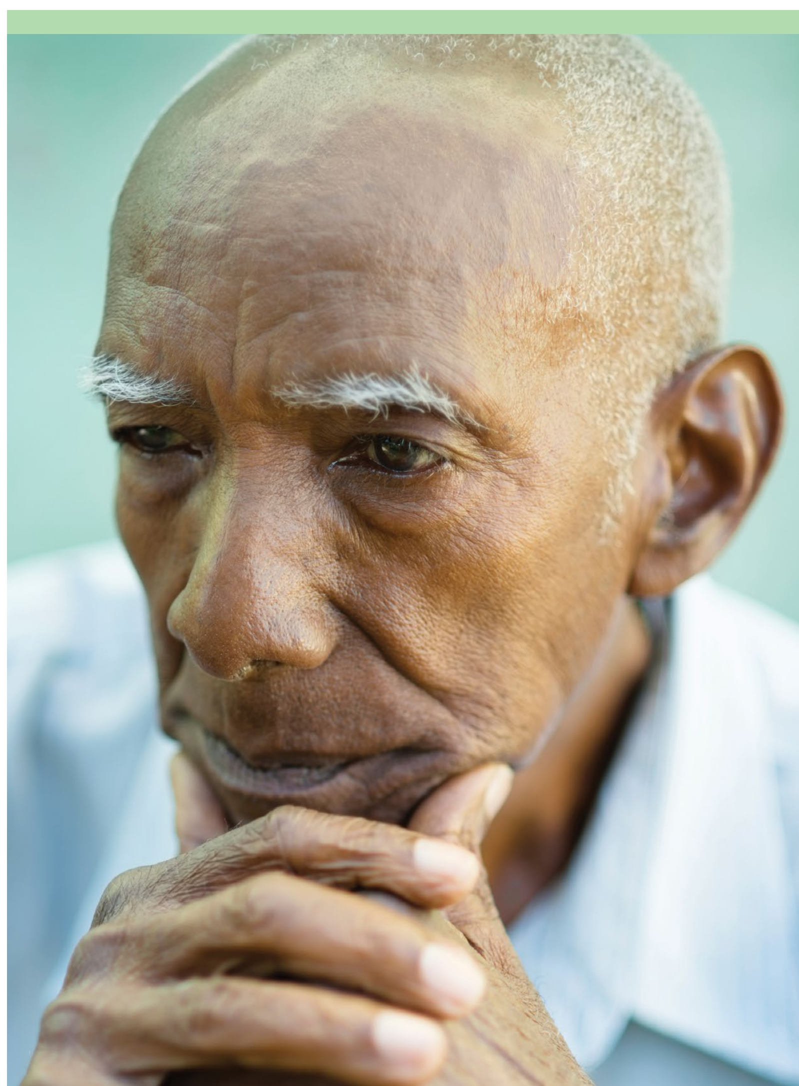
The findings from this study will be used to support the development and promotion of national practice guidelines on social isolation and loneliness in older adults for health and social service providers. A complementary survey of older adults across Canada is currently being conducted to also inform guideline development. Additionally, a guidelines working group consisting of subject matter experts has been convened. The guidelines working group will examine evidence from a review of the literature on social isolation and loneliness in older adults. The working group will use best evidence to draft the national practice guidelines. Learnings from the health and social provider survey as well as older adult survey will be used to inform knowledge translation initiatives and to improve uptake of guidelines among health and social service providers.

Limitations

Online surveys such as the one reported here are subject to self-selection for participation. Another common limitation of online surveys is the 'non-representative nature' of individuals who are capable of using computers and the internet. However, given the target population for this survey, this was unlikely to be of concern as these individuals would be comfortable with computer/internet use as part of their daily work. Survey length did prove to be a challenge as nearly half of participants did not complete the survey. Most of the missed questions were demographic questions. Responses to these questions would have allowed us to know more about the representativeness and generalizability of our sample.

Conclusion

While social isolation and loneliness have long been an area of concern for older adults, the COVID-19 pandemic served to draw significant attention to this topic. Older adults as well as their family, friends, and care partners, may increasingly look to health and social care providers for guidance. Health and social care providers must be prepared with best available evidence and knowledge of strategies and resources. Additionally, barriers to effective care must be identified and addressed. This study has contributed by providing an understanding of the current attitudes, knowledge and practices of health and social service providers regarding social isolation and loneliness in older adults. Future work on practice guideline development will build on findings to date and provide much needed guidance for health and social service providers.



Tables & Figures

Table 1: Participant Characteristics

Primary Province of Practice	Number of Respondents
Ontario	109
Nova Scotia	36
Manitoba	35
British Columbia	27
Northwest Territories	24
Newfoundland and Labrador	19
Quebec	12
Alberta	10
New Brunswick	9
Nunavut	4
Saskatchewan	4
Other	3
Prince Edward Island	2
Yukon	0
Practice Area Size	
Large Urban (population over 500 000)	98
Small urban (population between 100 000 – 499 999)	78
Semi-urban (population between 10 000 – 100 000)	70
Rural (population of less than 10 000)	43

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Secondary Practice Area	
No	174
Yes	115
Years in Practice	
20+ years	108
11-20 years	65
5-10 years	56
1-4 years	47
less than 1 year	13
Practice Focus Area	
Directly in contact and working with older adults	189
Other (e.g. occasional contact with older adults)	31
Supervision/oversight of others who are in direct contact with older adults	28
Administration/ oversight of teams or systems supporting older adults	24
Profession	
Nurse- RN	40
Social Worker	40
Community Service Organization	29
Pharmacist	17
Other Social Service Professional	16
Psychiatrist	25
Other Health Care Professional	15
Family Practice Physician	12
Occupational Therapist	12

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Geriatrician	11
Public Health Professional	10
Nurse- LPN	9
Nurse-NP	8
Other Specialist Physician	7
Personal Care Worker	7
Dentist	6
Nurse - RPN	6
Health Promoter	5
Counsellor	4
Physiotherapist	4
Psychologist	2
Nutritionist/Dietician	2

Table 2: Participant self-reported knowledge and attitudes

Please indicate your level of agreement with the following statements:	Strongly Disagree (%)	Disagree (%)	Neither Agree nor Disagree (%)	Agree (%)	Strongly Agree (%)
I am knowledgeable about the ***physical health issues*** (e.g., limited mobility) that contribute to social isolation and loneliness in older adults.	1	2	2	46	49
I am knowledgeable about the ***mental health issues*** (e.g., depression) that contribute to social isolation and loneliness in older adults.	0	2	3	44	51
I am knowledgeable about the ***social issues*** (e.g., loss of a partner) that contribute to social isolation and loneliness in older adults.	1	1	2	44	52
I am able to effectively address the ***physical health issues*** that result from social isolation and loneliness in older adults.	4	21	30	33	12
I am able to effectively address the ***mental health issues that result from*** social isolation and loneliness in older adults.	3	17	25	43	12
I am able to effectively address the ***social issues that result from*** social isolation and loneliness in older adults.	5	18	33	33	11
It is within the scope of my professional role to address the social isolation and loneliness issues of older adults ***who are experiencing*** social isolation and loneliness.	6	9	14	43	28
It is within the scope of my professional role to try to prevent social isolation and loneliness issues in older adults ***who are at risk of*** social isolation and loneliness.	6	8	17	44	25

Figure 1 :

Participants' responses to survey question: "What do you see as your professional role with respect to mitigating social isolation and loneliness for older adults? [select all that apply]"

Role by Profession

40
35
30
25
20
15
10
5
0

Noticing/observing
Discussing with patient
Screening/ Assessing
Supporting
Intervening/ Managing
Referring
Advocating
Not my role

Community Service Organization
Counsellor
Dentist
Family Practice Physician
Geriatric Physician/Geriatrician
Health Promoter
Nurse-LPN
Nurse-RN
Nurse-RPN
Nurse-NP
Nutritionist/Dietician
Occupational Therapist
Other Healthcare Professional
Other Social Service Professional
Other Specialist Physician
Personal Care Worker
Pharmacist
Physiotherapist
Psychiatrist

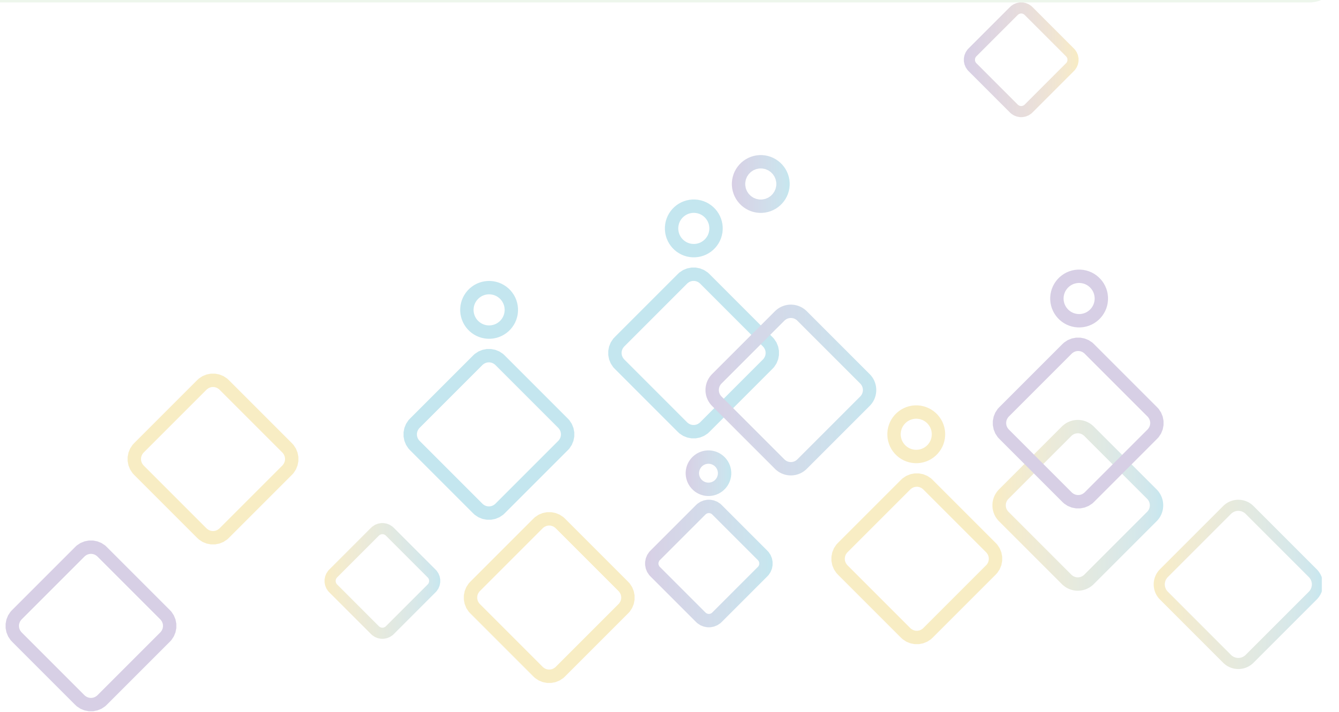


Table 3 :

Relationship between participants' self-reported knowledge and attitudes with years in practice.

Question	Statistical Significance
I am knowledgeable about the ***physical health issues*** (e.g., limited mobility) that contribute to social isolation and loneliness in older adults.	Statistically significant relationship p=0.0000917; Effect size: 0.204
I am knowledgeable about the ***social issues*** (e.g., loss of a partner) that contribute to social isolation and loneliness in older adults.	Statistically significant relationship p=0.000510; Effect size: 0.193
I am knowledgeable about the ***mental health issues*** (e.g., depression) that contribute to social isolation and loneliness in older adults.	Statistically significant relationship p=0.00948; Effect size: 0.170
I am able to effectively address the ***physical health issues*** that result from social isolation and loneliness in older adults.	Statistically significant relationship p=0.0127; Effect size: 0.168
I am able to effectively address the ***social issues that result from*** social isolation and loneliness in older adults.	Statistically significant relationship p=0.0363; Effect size: 0.157
I am able to effectively address the ***mental health issues that result from*** social isolation and loneliness in older adults.	Not significant (p=0.252)
It is within the scope of my professional role to address the social isolation and loneliness issues of older adults ***who are experiencing*** social isolation and loneliness.	Not significant (p=0.555)
It is within the scope of my professional role to try to prevent social isolation and loneliness issues in older adults ***who are at risk of*** social isolation and loneliness.	Not significant (p=0.798)

Table 4 :

Impact of barriers on participants' ability to address social isolation and loneliness issues experienced by older adults.

	It does not all impact my ability (%)	It impacts my ability a little (%)	It somewhat impacts my ability (%)	It very much impacts my ability (%)	It extremely impacts my ability (%)
Absence of practice guidelines	18	21	37	18	6
Personal lack of knowledge regarding how to help older adults facing loneliness and isolation	25	31	25	16	3
Personal lack of awareness of appropriate interventions for addressing social isolation and loneliness in older adults	28	27	27	14	4
Lack of available community resources	2	9	14	32	43
Personal lack of knowledge about the community resources that may be available	16	27	25	22	10
Insufficient system/ organizational funding to put appropriate interventions in place	1	6	13	34	46
Lack of organizational/ administrative support	1	15	22	26	26
Not in job description	53	18	15	7	7
Insufficient or inadequate training opportunities	21	21	26	21	11
Personal lack of time to attend training opportunities	24	19	27	18	12
Personal lack of time to implement appropriate interventions	21	18	27	23	11

Table 5 :

Respondents' selection of resources of highest importance which could optimize their work with older adults who experience or are at risk of social isolation and loneliness.

Resource of highest importance	Percentage of respondents selecting resource
Collaborative partnership (with health and social organizations)	31%
Resources to guide best-practices (practice guidelines/ role specific/ equity-deserving groups)	12%
Referral pathway navigation (with case management coordination)	11%
Volunteer sector/peer support	10%
Training/Education (tailored to professions)	10%
Proper infrastructure (priority area - training, sustained funding, subsidies, policies, coordination, seamless, affordable/accessible community supports e.g., transportation	7%
Innovative (tailored) community programming	5%
Tools / Risk (screening/clinical decision-making algorithms)	5%
Awareness of what is available	3%
Hearing about lived experiences / voice & input of older adults	3%
Person-centred approach/explore & build capacity	3%

Appendix 1: Thematic Analysis of Barriers

b) From the list above, please indicate the barrier that is of most significance for you. Please explain how this barrier impacts your ability to help older adults who experience or who are at risk of social isolation and loneliness (Optional/2-3 sentences)

RESPONSE SUMMARY

From the perspective of HSSPs, the following barriers impact their ability to prevent and mitigate SI&L in older adults:

Lack of:

- Outreach resources that can help identify older adults at-risk, help them navigate the system of supports available to them and /or accompany them to programs/events of interest.
- Community-based options that are free or of low-cost
- Transportation options that are free or of low-cost to help older adults access community and health-care based programs and events (both formal and informal).
- Digital literacy skills on the part of older adults (to make use of technologically innovative interventions)
- Understanding regarding how one's professional role can play a role in preventing and/or mitigating SI&L
- Organizational infrastructure/resources to promote and support practices known to prevent and/or mitigate SI&L
- Knowledge regarding appropriate supports available (both in the community and within the health and social service systems) to prevent and mitigate SI&L / and how to access them

Personal Barriers

Personal barriers are precipitated by the personal characteristics (e.g., psychological, attitudinal, socio-demographic) and/or capacities (e.g., knowledge, skills, abilities) of older adults. Personal barriers can impact the ability of HSSPs to make viable linkages and promote optimal use of supports to prevent and mitigate SI&L in older adults.

Motivation & Self-assurance

Older adults who experience SI&L may lack motivation and self-assurance which can precipitate a reluctance to seek help. As such, it can be difficult for HSSPs to locate and reach out to these older adults. Instead, many remain invisible, complicating the efforts of HSSPs to provide support to this population.

"People being too shy and/or self-conscious and not wanting to access the resources/ programs/ services."

- Social Worker

Similarly, a lack of motivation and self-assurance can be an underlying reason why older adults may avoid accessing the services and supports recommend by HSSPs.

"Clients would be more successful and confident attending one of these community resources if they have someone to go there with them."

-Other Social Service Professional

Financial Capacity

Many older adults being on a fixed income is a noted barrier which impacts the extent to which HSSPs can connect older adults with supports to help mitigate SI&L. For instance, if a taxi is required to access a particular service, this implies a direct out of pocket expense to the patient/ client and may be a reason to avoid making a linkage to said resource. Moreover, for older adults who live in rural settings, the transportation costs to access community resources in nearby cities can be particularly prohibitive.

"There is only so much we can do. We can refer to a community group, hospital day program etc., but there is no guarantee that the individual or family can afford to take part in that program."

-Physician

Access to Transportation

The ability to drive one's own vehicle versus a reliance on public transportation or accessible public transit vehicles can impact whether or not an individual makes use of a particular service/support. Many older adults rely on public transportation. Transportation to and from healthcare and community resources can be difficult to coordinate, particularly on the part of older adults who may experience low motivation. When HSSPs refer a client to a suggested resource, the likelihood that the individual can and will be able to access the resource is often unknown. Furthermore, there are personal costs associated with the use of accessible public transit vehicles for purposes other than medical appointments.

"It is very challenging to connect seniors to resources if they are not independently mobile and if they have limited funds."

-Social Worker

Digital Literacy

Digital literacy involves the skills and resources to live, learn, and work in a society where communication and access to information is increasingly obtained through digital technologies. Online resources offer an advantage for accessing therapeutic, recreational and social resources that are of no (or low) cost and that do not require transportation. However, the deficits in digital literacy exhibited by many older adults impacts the extent to which HSSPs can make linkages to online resources to aid older adults in self-managing SI&L issues. This barrier was noted to be particularly problematic during the height of the Covid-19 pandemic.

"Many senior clients do not prefer communicating through technology (e.g. Zoom).In addition, access to (and ability to use) technology is also a major barrier."

-Other Health Care Professional

Professional Barriers

Professional barriers are precipitated by professional characteristics (e.g., scope of practice, professional training) and/or the individual capacities (e.g., knowledge, skills, abilities) of HSSPs. Professional barriers can impede the extent to which HSSPs can effectively identify, manage, and/or follow-up on issues involving SI&L with their patients/clients.

Scope of Practice

Depending on their professional role and the organizational setting in which they work, SI&L may or may not fall within the direct care responsibilities of HSSPs. In other words, HSSPs who are well positioned to screen and detect SI&L may not feel well positioned to provide active interventions and /or engage in follow-up activities. For instance, professionals who work in acute care settings have a primary responsibility to intervene in acute health issues (e.g., cardiovascular disease). While the social and psychological issues experienced by their patients/clients (such as SI&L) may constitute a secondary responsibility. In situations where SI&L is suspected, it is important that these HSSPs are able to access and make connections to supports that can directly assist with SI&L. Knowing which professionals/organizations provide direct interventions to address SI&L and how to refer to them, is integral to ensuring a seamless and comprehensive approach to SI&L across the continuum of care.

> "Social Isolation is evident, and I believe it impacts other areas of health. However, it is not the reason that I am seeing the individual, could be considered within my scope but 3rd party payers may not endorse this service as it falls outside the reason for referral, and I do not have time outside of work hours to address this issue with my clients."
>
> ***-Community Service Organization***

Time

The amount of time that HSSPs have to assess SI&L in older persons, attend training, and become familiar with resources and interventions can vary across professions and settings. When SI&L falls outside the scope of practice, HSSPs may have more limited time to devote to this issue. Some HSSPs struggle to find the additional time required to properly assess and address SI&L issues in conjunction with other medical issues (i.e., reason for referral).

> "Time, I can have all the resources and support, but if I do not have the time to sit with older adults, or spend the extra 10 min on the phone to gain trust. Or hear the older adult, meet them where they are at, and so on, I can't do it well."
>
> ***- Not Identified***

Finding the additional time to source knowledge and resources related to SI&L (if not already known) can also be a challenge. For example, it is not unusual for organization not to compile and keep up-to-date information regarding the eligibility and referral criteria of external health, social and community services/supports. As a result, individual HSSPs, are left to gather this information and make these connections on their own time.

> "Workload is so heavy it is hard to take the time to read emails to learn about what is out there if I am not already aware of it."
> ***-Other Specialist Physician***

Knowledge of Available Supports

A lack of knowledge and information regarding available resources and supports (within and across healthcare, social service and community settings) can hinder the ability of HSSPs to link (via referrals, social prescriptions and/or suggestions) older adults to helpful resources. The granularity of the knowledge required by HSSPs (e.g., location, cost, eligibility criteria, accessibility via public transportation, hours of operation, wait lists) to make reliable and effective linkages and suggestions is often not present in an easily accessible, consolidated and up-to-date manner within their organizations.

> "Lack of knowledge or central stream of information to get it. Always hearing from different people of different resources no central resource sheet."
> ***-Occupational Therapist***

Consequently, HSSPs often possess limited and not always reliable knowledge of available resources and supports. For instance, knowing whether a resource is located within easy walking distance of a bus stop is of high importance and the lack of this information can be a detractor in making certain referrals.

> "A lot of my knowledge comes from making random ad-hoc phone calls with various individuals to see what is available."
> ***-Physician***

Access to Training & Resources

The extent of training related to SI&L plays a role in how HSSPs work with older adults who may be experiencing SI&L. For instance, linking older adults to resources within healthcare, social service or community settings is a common approach to mitigate SI&L. However, a lack of training in how to screen for SI&L and knowledge of appropriate tools can underlie a hesitancy to screen for SI&L.

> "Insufficient or inadequate training opportunities - I feel the lack of training Combined with lack of support staff is a real problem."
> ***-Nurse (LPN)***

Similarly, a lack of knowledge regarding effective strategies and how to implement them within relevant settings/contexts can dissuade HSSPs from implementing SI&L interventions.

> "Personal lack of awareness - not sure how this get best information brought forth to me to help understand the interventions that exist and how I go about implementing and streamlining this for the patients that I see."
> ***-Pharmacist***

Organizational Barriers

Organizational barriers are precipitated by the rules, regulations, resources and procedures that exist within and across organizations. Barriers exist both within and across organizations that hinder HSSPs in their capacity to mitigate, manage and follow-up on issues of SI&L with their patients/clients.

Multi-disciplinary Teams

The configuration of professionals that HSSPs can easily access within their own organizations can impact the timeliness with which SI&L issues are detected and intervened upon. It can also foster appropriate referrals and connections to external services/supports. As an example, if an HSSP is part of a broader multidisciplinary team they may be able to make connections to appropriate internal resources in a timelier fashion than were they to refer to an external source. Disciplinary backgrounds that were seen as being highly relevant for advising on and actively addressing issues related to SI&L were social work, occupational therapy, and recreational therapy, and psychology.

> My opinion is that it is not the role of a Geriatric Psychiatrist to be managing social issues such as loneliness. This is the job of a social worker. Social workers are an integral part of a Geriatric Psychiatry team."
>
> ***-Psychiatrist***

Collaboration Across Health & Social Organizations

The extent to which HSSPs can easily access others outside of their own organizations/sectors can influence their ability to ensure effective connections across transition points. For example, established linkages between health and social service organizations can foster pathways for HSSPs to integrated knowledge and resources to collaboratively support and assist clients/patients. For instance, HSSPs working in primary and acute care settings may establish greater connections to specialized outreach and home care teams who can reach out to directly support and assist clients/patients in the community.

> "We can address the recognition (validation) of isolation and loneliness. We can offer support and discuss interventions with the client. We can make referrals to additional programs or services to specifically address social isolation / loneliness. But it is not within our mandate to put appropriate interventions in place."
>
> ***-Nurse (RN)***

Administrative Support

In many cases the implementation of SI&L interventions requires administrative support to access additional resources (e.g., staff, volunteers, training). For instance, an initiative to embed pet therapy into a LTC home would (at a minimum) require resources to engage a pet therapist, resources (robo or live pet) and release time to train LTC staff. Thus, restricted access to resources specific to SI&L can hinder HSSPs in efforts to implement interventions such as befriending programs, mindfulness training groups, or physical fitness/social connection groups.

> “I have community resources available but need approval and funding from Management to go on Community visits with clients to these programs.”
> ***-Social Worker***

Extended Outreach

Not all HSSPs are well positioned to directly assist older adults to actively initiate and maintain participation in social, recreational and therapeutic endeavours. For these HSSPs an inability to easily connect patients/clients with outreach resources (e.g., volunteers, peer supports and/or outreach personnel) can be a significant obstacle. Without access to resources that can provide assistance ‘on the ground’, HSSPs can lack the confidence that their referrals and suggestions will be effective and garner desired results.

> “We need helpers to assist people when they need support to find Connection - get out the door, and through the door.”
> ***-Other Health Care Professional***

The flexibility to offer outreach resources within home environments would afford greater reach of SI&L interventions.

> “Socially isolated older adults face barriers, making it sometimes impossible to leave their home. We need more in home, affordable support that focuses on recreation and leisure, not just personal care.”
> ***- Social Worker***

A number of barriers within the community can hamper the capacity of HSSPs to prevent and mitigate SI&L for older adults. A lack of informal community programs and supports that are free (or low cost), easily accessible via public transportation, and aligned with the capacities and interests of older adults can prevent HSSPs from making meaningful community connections for older adults.

Transportation

Many older adults rely either partially or exclusively on public transportation. Consequently, HSSPs are conscious of the need to ensure that older adults can easily access these resources via public transportation. For instance, a social prescription to join a community fitness centre hinges on the ability of the individual to purchase a membership (or day pass) and cover transportation costs. Not wanting to add additional burden, HSPPS may shy away from making connections to programs that are not either free or of low-cost.

> “They may be interested, but they may not have transportation to attend. e.g. $18 roundtrip to take para transit for a one hour exercise class is not affordable or justifiable for them.”
>
> ***-Occupational Therapist***

Range in Types of Services/Supports Available.

Not all communities have resources tailored to the capacities and interests of older adults. This restricts HSSPs in their ability to make viable referrals and suggestions to suit the wide variety of interests, capacities and situations of older adults who experience or who may be at risk of experiencing SI&L. In particular, HSSPs are constricted in their ability to make connections for older adults who belong to equity-deserving groups (e.g., ethnic and linguistic minority groups, individuals who are homeless, those who experience chronic mental health conditions, mobility impairment, cognitive impairment, caregivers).

> “There is not enough variety in the types of resources to meet people’s unique needs. Not all resources are appropriate for all people so there are limitations as to what to offer folks.”
>
> ***-Occupational Therapist***

As well, HSSPs can be reluctant to suggest community-based social and recreational programs that are not either free or low-cost. Unfortunately, few community options meet this criteria, particularly in urban settings.

> “There is a lack of resources available in the community for low income/fixed income older adults experiencing social isolation/loneliness, including free/low cost, accessible options.”
>
> ***-Other Social Service Professional***

Centralized Coordination

The lack of a centralized community-based coordination resource can detract from referrals to community services and supports. Such a resource could enhance coordination across community-based services and supports could help both HSSPs and older adults better navigate the available options and eligibility criteria of services and supports located in the community.

For instance, a community-based intake/coordination centre could potentially retain and disseminate up-to-date information regarding community-based options, provide on-the-ground outreach services, assume responsibility for linking older adults with appropriate community services and supports (& when appropriate linking to healthcare and social service resources), and identify older adults in the community who are experiencing or at risk of SI&L but who are not currently in connection with HSSPs.

> “While I have familiarity of my community I practice in, I am not aware of any seamless network of social supports. Rather, it is quite patchwork and ever changing. The challenge is keeping up with the system, the patchwork programs, and the underfunding.”
>
> ***- Psychiatrist***

Systems Barriers

Systems barriers are precipitated by broader government-level infrastructures (e.g., policies, accountability frameworks, funding envelopes, practice standards) that define and shape healthcare, social care and community systems.

Navigation Pathways

The constraints that HSSPs face are largely shaped by broader infrastructural between and across healthcare, social care and community systems that make it difficult to carve out and navigate effective pathways to address SI&L.

> “I think the biggest issue is the lack of connection between community/non-profit/ government groups to collectively support these people as best we can. In addition to some being over capacity, with call back or waitlist times that are months or years long.”
>
> ***- Health Promoter***

Eligibility criteria for most health and social care organizations is tied to medical (as opposed to social) criteria. Hence, the lack of widespread systems acceptance that SI&L is a medical issue can be a barrier for HSSPs who work in these settings to provide services that address SI&L directly. HSSPs may need to be creative to address SI&L issues within the context of other medical (& billable) health issues. For instance, an HSSP may screen for SI&L as part of an assessment for depression. Or they may link a patient/client who is isolated to a mental health outreach program so that they can receive in-home support and companionship.

> “There are not clear pathways for management of patients who are identified as socially isolated or lonely.”
>
> ***-Physician***

Moreover, the very specific and narrow eligibility criteria for many health and social service programs can exclude older adults who experience SI&L but who do not meet the eligibility criteria for formal service/ supports. For instance, if a family doctor wished to connect a patient/client with a day program but the individual did not meet the age criteria for that program they would not be able to access this resource. Similarly, a person who could benefit from home companionship may not be eligible to receive formal home services (on the basis of a medical or functional impairment).

> “As a physician in a walk-in clinic, I see patients suffering from isolation. I can refer them to mental health, but they are overloaded with patients suffering from depression, which is a different condition. There is very little I can do.” ***-Physician***

Community-based programs that are mandated and funded to directly support SI&L are often underfunded or have unstable funding. This can mean that HSSPs working in community environments are limited in the number of patients/clients they can take on. They may also be limited in the number of new programs they are able to develop and offer.

> "Community approaches not institutional ones would be more effective but get little to no resources to support community groups to take on the commitment."
> ***-Other Health Care Professional***

A lack of funding can also limit the number of volunteers they are able to train and support. Whereas, in the healthcare sector the dwindling number of outreach programs can mean long wait lists, a detractor to timely intervention and prevention. **Connections**

> "Lack of finding for positions in health organizations, which results in part-time positions, rather than full-time hours. As such there is limited time to dedicate to the [SI&L] needs of client."
> ***-Not Identified***

c) If the above was not a barrier, what do you envision you could do differently in your practice to help older adults who experience or who are at risk of social isolation and loneliness? [Optional/2-3 sentences]

Connections

- Warm hand off
- Link person to appropriate resources upon discharge
- Connect to central navigation/outreach and programming
- Connect equity-deserving older adults (cognitive impairment, low-income etc.) with appropriate community programming (without barriers)
- Be able to screen/assess for SI&L and then have actual solutions/suggestions to offer in terms of available programs/supports
- Provide information on what is available – and how to connect them
- Engage families to visit
- Link older adults to resources of interest
- Make referrals to online community programming / virtual care

Options

- More diversity in available options
- More in-person services in rural areas
- Get individuals out and about in the community
- Providing more intergenerational programming

Collaboration

- Opportunity to link with other professions/ organizations to co-manage
- Work with community partners and build connections to create a coordinated network at a community level that can be accessed by older adults in different settings & situations
- Consult with appropriate professionals
- Collaborate with other allied health workers
- Make more informed suggestions

Coordination

- More coordinated/supported opportunities in the community
- Centralized referral to a robust array of diverse and coordinated options
- More appropriate referrals
- Referral to a point of care service
- Refer to appropriate resources (e.g., SW, OT, RT) – either in the community or within health/social service settings

Access

- More in-home supports
- Connect with supports more quickly
- Make suggestions that are cost free and easily accessible via low-cost, accessible, convenient transportation to social outings (not just medical appointments)* (*not everyone qualifies for parabus, handitransit)
- Provide free transportation / home pick-up / accompany to social programming
- Get more older adults into existing programs
- In-person therapeutic & social recreation in people's homes
- Supportive team home visits
- Develop free groups for older adults with multiple barriers
- Rapidly connect older adults to services/ supports to help mitigate their SI&L
- Plan services in the home

Capacity

- Build capacity – of older adults
- Get to know what is available locally (on the part of HSSPs)
- Help older adults see that they are SI&L
- Work to improve communication/ socialization skills in older adults
- Education for other disciplines
- Use guidelines to provide evidence-based supports

Personalization

- Help them make that first contact & then follow-up
- More personalized suggestions for programming / referrals (versus blanket roster)
- Set up with companion individuals* to explore community options (human resource issue)
- Refer to groups/agencies that facilitate connections between older adults and community programming aligned with their interests/needs
- Help older adults choose between options
- Connect to social/emotional supports (with awareness of how to approach/intervene with older adults with and without complex needs)
- Provide assessment of needs and functional ability
- Develop a plan with the individual and implement it
- Engage older adults in motivational discussions

Relationships

- Take the time to build trusting relationships

Action

- Provide more interventions
- Provide opportunities for people to get out of their homes with other seniors and members of the care team on a regular basis
- Develop, implement and evaluate programs to address and prevent SI&L
- Provide assistance and run groups more frequently

Sustainability

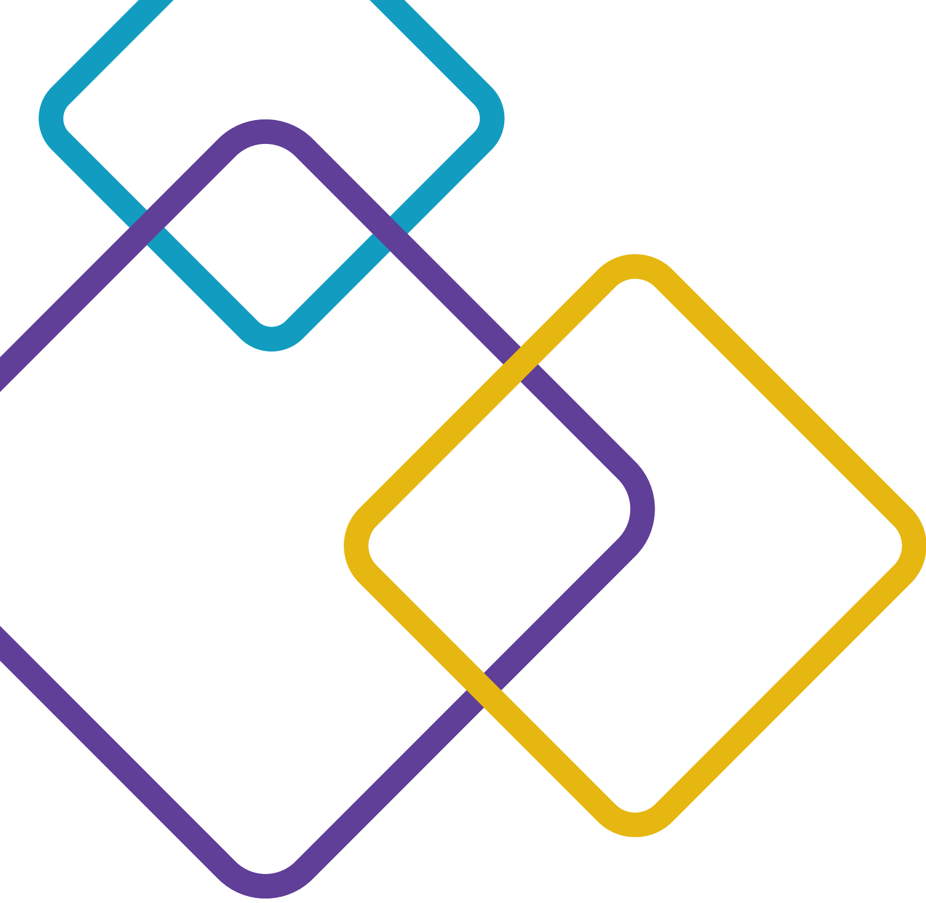
- Long-term programming
- Set and monitor for long-term goals
- Provide stable programming
- Put regular visits in place

Infrastructure

- Systems-level priority – would mean SI&L prevention / management would be built in to aspects of community design, community programming, health/social service support
- Bring clients to a central (community) location for social activities.
- Programs in the community geared toward inclusion of the elderly
- Offer hub/spoke model clinics (pharmacy, multi-disc care) in their communities.

Reach

- Authorize services for those at-risk
- Use SI&L as eligibility criteria for assessing home support to mitigate risk
- Bring awareness – i.e., radio programming, social media
- Expand scope – to reach a higher volume of older adults



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Canadian Coalition for Seniors' Mental Health