Social Isolation And Loneliness In Older Adults:

A Survey of Canadian Older Adults

Summary of Results

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 older adults in Spring 2023, which complemented a previously conducted survey in Winter of 2023. The focus of this survey was to hear and learn from older adults on the topics 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 and opinion questions. The draft survey was pilot-tested with a group of older adults 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. 1800 contacts) and network of organizational contacts 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. Paid and unpaid print and digital media as well as in-person presentations were also used for recruitment and data collection purposes.

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 five to seven minutes to complete. Participants were not offered any incentives to complete the survey.

The survey consisted of seven close- and one open-ended questions, spread across four pages (screens). The survey included the use of adaptive questioning but did not include item randomization. Additionally, participants were asked seven 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. The exception to this was the first survey question which required participants to indicate whether they were an older adult in order to proceed to survey questions. Participants were also not able to review/change answers upon survey completion. Survey data were collected between May 16, 2023 and July 7, 2023.

Summary statistics were calculated for demographic variables and quantitative data. 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. Results were interpreted through triangulation of quantitative and qualitative data.

Result

Survey completion

The survey had a completion rate of 74.2%, with most missed questions being the demographic questions located at the end of the survey. 2277 individuals accessed the survey, with 2086 individuals identifying themselves as older adults eligible to then participate in the survey.

Participant Characteristics

Detailed demographic information is found in Table 1. The survey sample included respondents from every province/territory with the exception of Nunavut, though notably the majority of participants were from Ontario (63%). Respondents were well distributed between large urban (38%), semi-urban (28%), small urban (20%), and rural (13%) settings. The majority of the sample either lived with their spouse/partner (46%) or alone (42%). Nearly half of the sample (48%) was between 70-79 years of age. With regard to gender identity and sexual identity, most participants identified as man/woman and straight/heterosexual, respectively. Seventy-eight percent of respondents had some form of post-secondary education.

Survey Results

Survey questions focused on respondents' knowledge of the impacts of social isolation and loneliness; their preferred methods for addressing social isolation and loneliness in their own lives; and their interactions with health and social care providers as they pertain to social isolation and loneliness.

Overall, respondents indicated that they had high levels of awareness of the negative impacts of social isolation and loneliness on their physical health as well as their mental health (Figure 1). When asked to select actions or activities which help them feel less socially isolated and lonely, the following were the top five identified actions/activities: spending time with family/friends; exercising or taking part in exercise classes; using technology to connect with friends and family; spending time in nature; and participating in hobbies (Figure 2). Interestingly, approximately one in five respondents indicated they feel uncomfortable in approaching their health or social care provider about feeling socially isolated or lonely (Figure 3). The top three reasons for feeling uncomfortable were embarrassment, feeling that their provider does not have enough time, and only being permitted to discuss one concern per appointment (Figure 4). What respondents felt would be helpful was: to receive resources from the provider; to be connected to community programs and supports; and to suggest activities that might help the individual feel less socially isolated or lonely (Figure 5).

The above-reported results from the close-ended questions are consistent with the results of the thematic analysis of the single open-ended question included in the survey. Participants were asked: As you think about health and/or social service providers, what else might they do to support their older patients and clients who may be experiencing social isolation and loneliness? The following themes, listed in order of prevalence, were identified.

THEME	
Time	• Longer appointment times for older adults to address more than one issue • Ask about social isolation and loneliness during regular appointments (initiate the discussion) • Spend time talking to person and family members • Genuinely listen to concerns
Screen for Social Isolation & Loneliness	• Regular screening for social isolation and loneliness as standard care • Make social isolation and loneliness part of the care plan (screen, address, follow-up)
Regular and Frequent Check-ins	• Provide regular check-ins (monthly/weekly/daily depending on needs) • Could take the form of phone calls, Zoom, in-home visits • Check-in on issues that go beyond medical health – check-in on mental and social health
Navigation Support	• Be knowledgeable about what resources are available locally - beyond formal healthcare services. E.g., mental health resources/community programs/community events • Provide accurate, up-to-date lists with contact information and eligibility criteria • Make information broadly available through multiple communication channels (e.g., family doctors, various community locations, media, newspaper, web-sites)
Outreach	• Provide (or make connections to services that offer) drop-in visits that include time to chat, go on outings • Hands on accompaniment to community programs/social events if needed at first (could be provided by professionals or peer volunteers) • Goes beyond providing information about what resources exist in the community
Social Prescribing	• Encourage active lifestyles • Have options for addressing social isolation and loneliness other than pharmaceuticals • Actively facilitate connections to community programs/events (not just health and social care services) • Offer creative options (non-stereotypical - that assume older adults are active, intelligent, and motivated) • Connect people to a wide variety of physical, intellectual, leisure interests (e.g., movies, walking, sports, research participant opportunities, lectures, academic courses) • Identify/provide/advocate for low-cost or free resources in the community • Make formal referrals to community programs (beyond just making suggestions to 'get active')
Older Person-Centred Care/ Approach	• Be aware of what constitutes ageist behaviours (language, assumptions) • Zero tolerance of ageist behaviours • Screen for and address mental health issues (do not assume that depression & anxiety are a natural part of ageing) • Advocate for an older-person centred approach in health and social care but also in the community • Don't minimize/dismiss the concerns of older adults (particularly those related to mental health and social concerns) • Don't treat SI&L as a concern that only affects older adults (normalize) • Offer flexible options to access services (e.g., face-to-face, phone, Zoom, groups)

Transportation	• Provide low-cost/ free transportation to medical appointments, social events, and community programs • Advocate for accessible transportation in the community
Technology	• Provide appointments/services via Zoom technology (don't assume all older adults are tech illiterate/avoidant) • Provide information about community resources on web-sites • Provide non-technology options for those that are not comfortable with Zoom technology • Provide/make connections to services that offer digital literacy training
'Treat' Social Health Issues	• Go beyond social prescribing • Offer (or connect to) counselling and coping skills groups • Facilitate groups/social events/outings that bring people together • Connect with the family (make them aware) • Connect the family with supports so they can help their loved ones
Peer-to-peer supports	• Make connections (or offer) peer supports (e.g., buddy initiatives) • Peer supports can accompany older adults to community programs/social events/help with transportation • Match (interests/experience/background) • Organize initiatives that facilitate 'natural' peer connections (e.g., registry of people interested in connecting, neighbourhood visiting initiatives)
Volunteers	• Link with volunteers who can provide additional support/extend the reach of existing services • Volunteer supports can be peer-oriented or intergenerational • Promote volunteering as a way for older adults to get connected
Tailored programming	• Tailor formal healthcare services and community programs to the needs of older adults • Diversity (tailor programs/services in consideration of mobility, cultural issues, income level) • More government funding to tailor services/programs to the needs of diverse groups of older adults
Access to Diverse Workforce	• Are family doctors the only or optimal professionals for identifying/addressing social isolation and loneliness? (spread too thin/not enough time in appointments) • Provide access to an extended array of professionals (e.g., social workers, grief counsellors, mental health professionals, peer supports, volunteers) who have more time to devote services that address social isolation and loneliness directly
Proactive approach	• Be knowledgeable about the precipitating factors (e.g., addictions, grief, mental health issues, low-income) of social isolation and loneliness and how to address them proactively • Better understand and actively respond to barriers that exacerbate social isolation and loneliness (e.g., low-income, mobility issues, transportation issues) • Apply a life course approach (screen and address barriers in younger adults as well)
Stories of Recovery	• Share stories of people who have 'recovered' – and what worked for them • Share these stories with other professionals and with older adults/families

Interpretation

This survey provided a mechanism by which to hear and learn from older adults in Canada regarding social isolation and loneliness. Respondents included individuals from across Canada, ranging in age from 65 years of age to 90+ years of age. Respondents identified themselves as aware of the negative impacts of social isolation and loneliness on their physical and mental health, with respondents being slightly more aware of the mental health impacts compared to physical health impacts. Additionally, although most felt comfortable approaching their health or social care provider regarding social isolation and loneliness concerns, a considerable proportion of respondents felt some level of discomfort. The most common reason for feeling uncomfortable was embarrassment. Two of the top three actions/activities for combatting loneliness included ways to connect with family and friends, which underscores the importance of these relationships in mitigating social isolation and loneliness.

This work has been undertaken as part of a project to develop national practice guidelines on social isolation and loneliness in older adults for health and social service providers. It is therefore important to note, that of the 18 options provided for actions/activities that respondents feel would help them feel less socially isolated or lonely, talking to their family doctor or nurse practitioner was ranked 4th lowest. This is consistent with other survey responses, where over 20% of respondents said they were uncomfortable approaching their health or social care provider and 6.5% said they did not have a provider with whom to speak about social isolation or loneliness concerns. Respondents said they were uncomfortable because they were embarrassed, they felt their provider did not have the time, they were limited to one concern per appointment, and they felt that it wasn't their providers' role. These data provided important considerations for guideline implementation. They indicate that older adults may not be as forward in presenting social isolation and loneliness concerns to providers and providers may need to be proactive in guideline implementation. These data highlight the work that still needs to be done in reframing how older adults see health and social care providers roles, particularly with regard to social isolation and loneliness, as well as highlight the persistent stigma around social isolation and loneliness.

Survey data also indicate that respondents want to be provided resources, suggested activities, and connected with programs. Qualitative data provided deeper insight into these responses. Respondents want more than just passive provision of information. They would like to be actively connected with programs, services, and supports. They wish for more detailed and tailored recommendations, beyond simple directives such as "be more active." Additionally, respondents stressed the need for a wide range of health and social care providers to be equipped to manage social isolation and loneliness concerns. Respondents felt this could address the time constraint challenges they feel when seeking to bring up social isolation and loneliness concerns with primary care providers. Ensuring the national practice guidelines can be utilized by a broad range of health and social care providers will be an important step in facilitating older adult access to care regarding their social isolation and loneliness concerns.

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 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 this survey of older adults as well as a survey of health and social providers 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, the team attempted to mitigate this through administering paper versions of the survey to increase the representativeness of the sample. Based on analysis of available demographic information, the sample was of limited diversity with regard to gender identity and sexual orientation. This limits the generalizability of the results to these populations. Additionally, with regard to geographic representation, the sample was heavily represented by respondents from Ontario.

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. This survey has identified that although older adults are well-aware of the negative impacts of social isolation and loneliness on their physical and mental health, there are still several barriers that persist in older adults reaching out to providers to address concerns. Guidelines development can draw on these survey results to ensure that guidelines address the challenges and concerns experienced by older adults and provide health and social care providers with guidance in line with the needs and experiences of their patient populations.

Tables and Figures

Table 1: Participant Characteristics

Province of Residence	Number of Respondents
Ontario	1,162
Quebec	216
Manitoba	172
British Columbia	114
Alberta	75
Nova Scotia	63
Saskatchewan	17
New Brunswick	9
Prince Edward Island	6
Newfoundland and Labrador	5
Yukon	2
Northwest Territories	1
Nunavut	0
Residence Area Size	
Large Urban (population over 500 000)	692
Semi-urban (population between 10 000 - 100 000)	507
Small urban (population between 100 000 - 499 999)	362
Rural (population of less than 10 000	249
Prefer not to answer	25

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Age	
65-70	516
71-79	888
80-89	390
90+	45
Prefer not to answer	8
Current Living Situation	
Live with spouse/partner	858
Live alone	770
Live with family member (e.g. siblings, children)	110
Other	42
Live with friend or roommate	34
Live in an assisted living residential facility or long-term care facility	25
Prefer not to answer	9
Gender Identity	
Woman	1,413
Man	414
Prefer not to answer	22
Another	11
Questioning or unsure	8
Two-Spirit	8
Nonbinary	7
Genderfluid or genderqueer	5

Table continues on next page

Sexual Orientation	
Straight/Heterosexual	1 653
Prefer not to answer	75
Bisexual	33
Another	26
Lesbian	19
Do not know	17
Gay	17
Highest Level of Education Completed	
Graduate Degree	811
Post-secondary (College degree, Vocational training)	630
High school diploma	319
Other	49
Prefer not to answer	23
No formal education	16

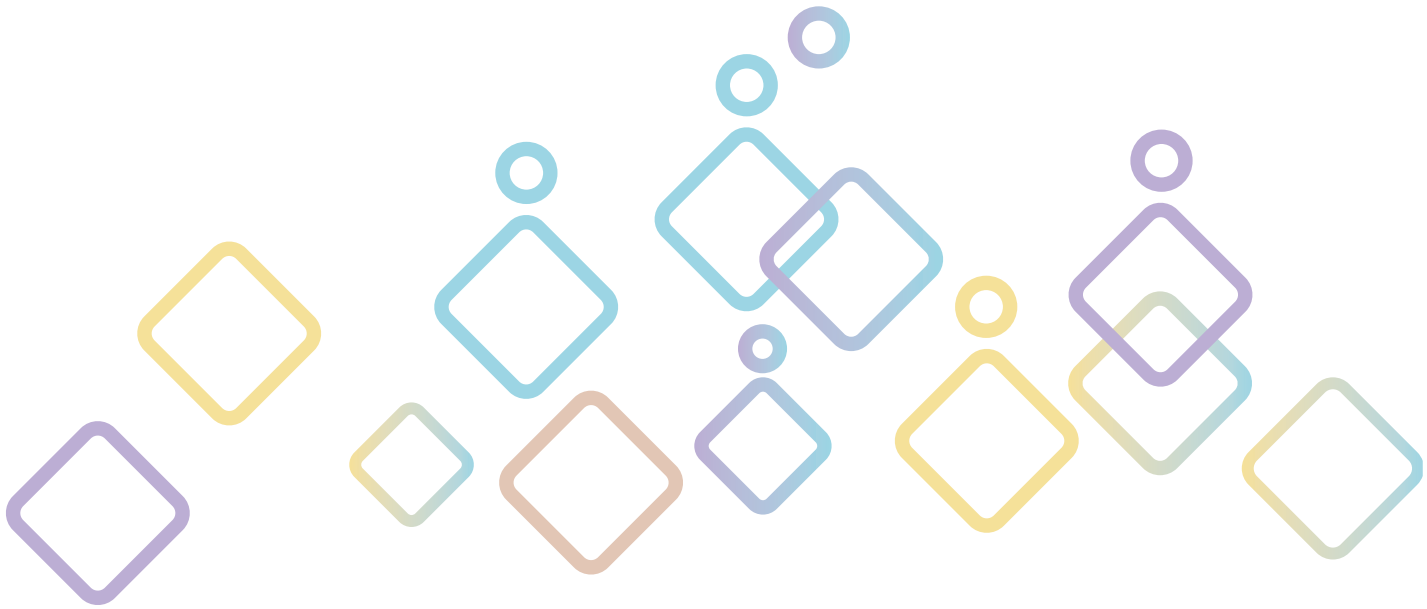


Figure 1: Awareness of impact of social isolation and loneliness on physical and mental health

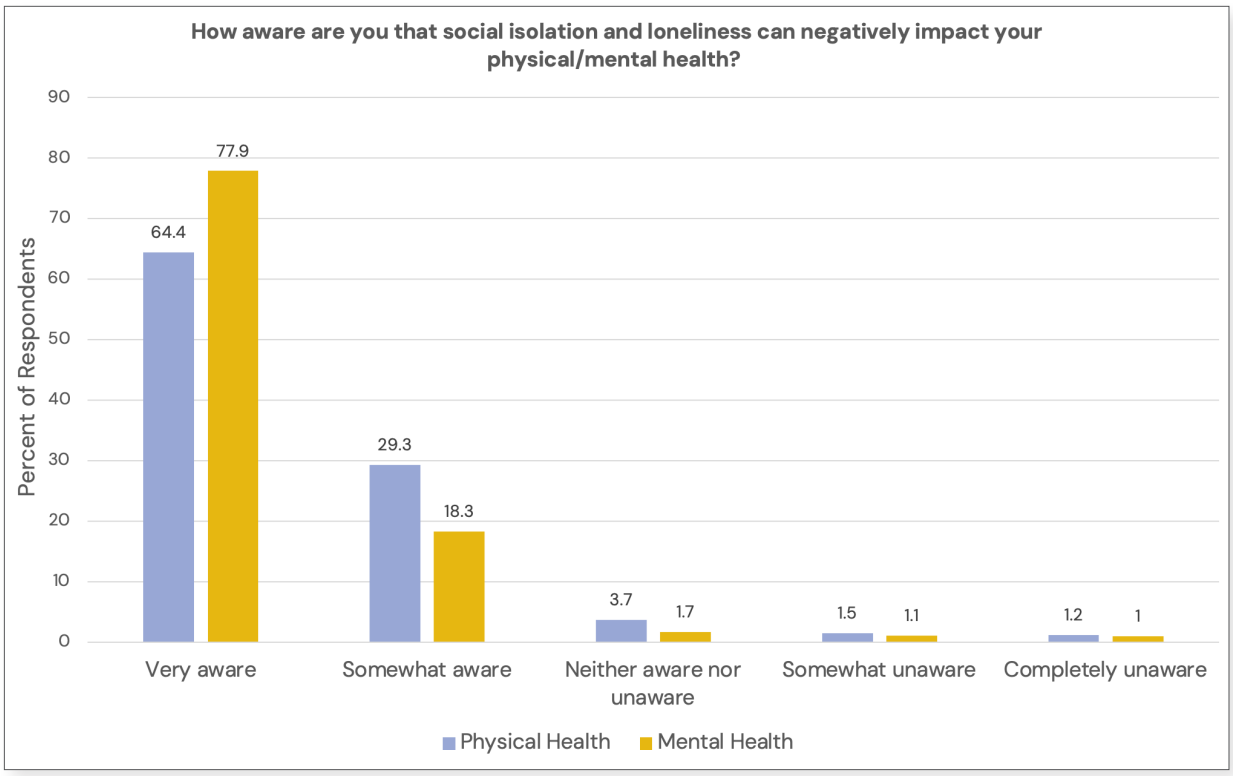


Figure 2: Activities/actions selected by participants to help with social isolation or loneliness

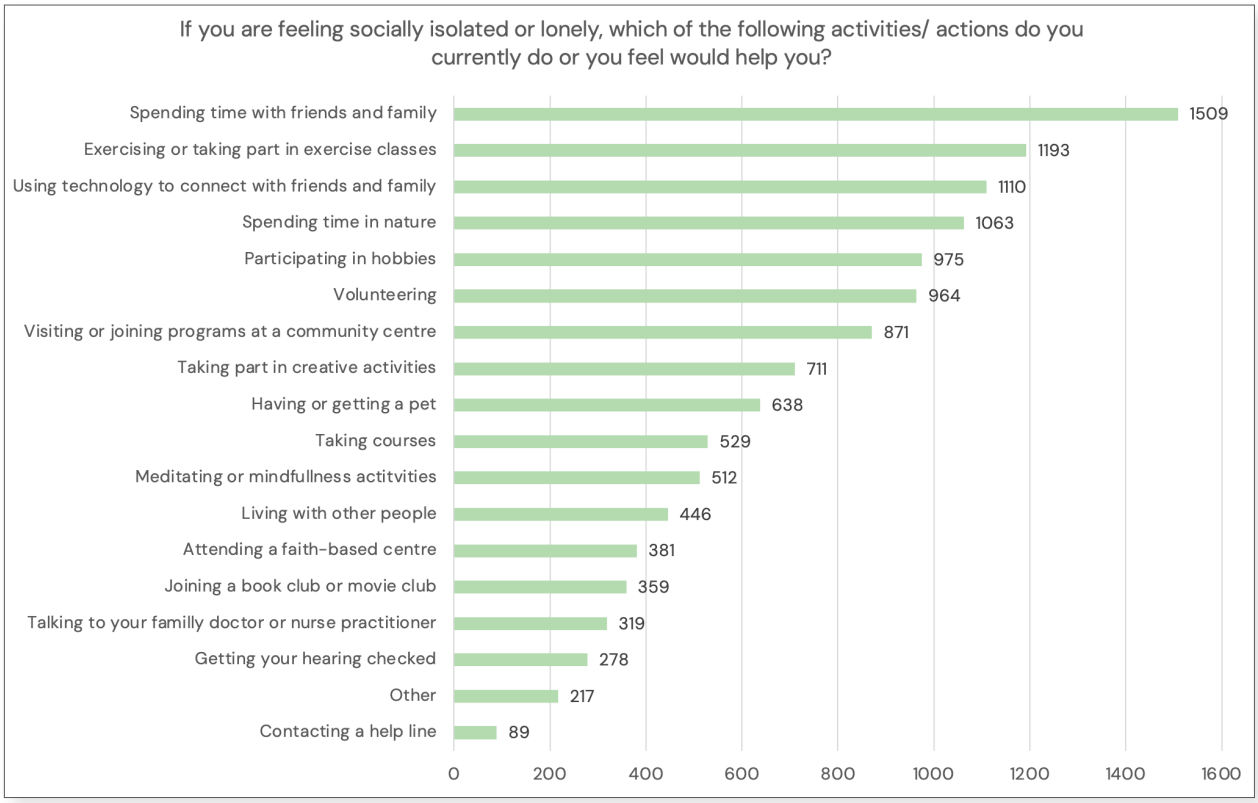


Figure 3: Comfort level discussing social isolation or loneliness with health or social service provider

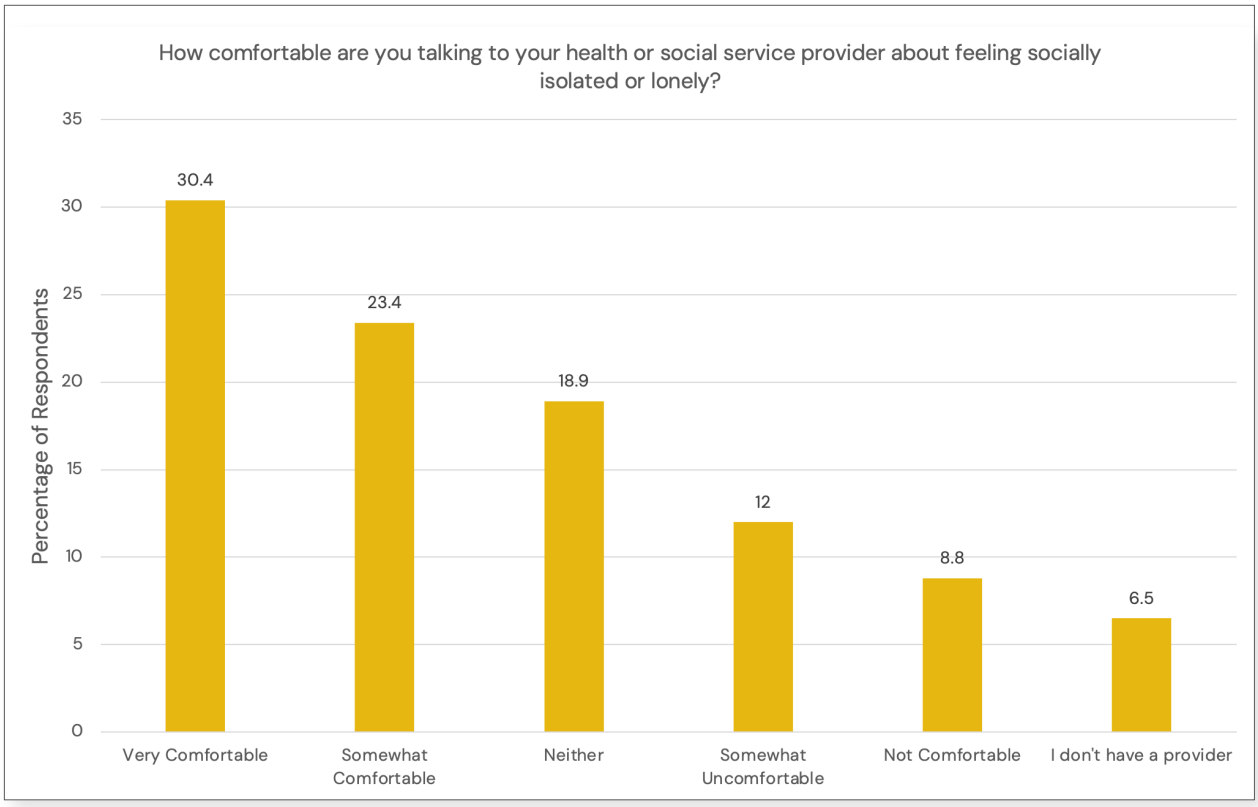


Figure 4: Reasons for feeling uncomfortable discussing social isolation or loneliness with health or social service provider

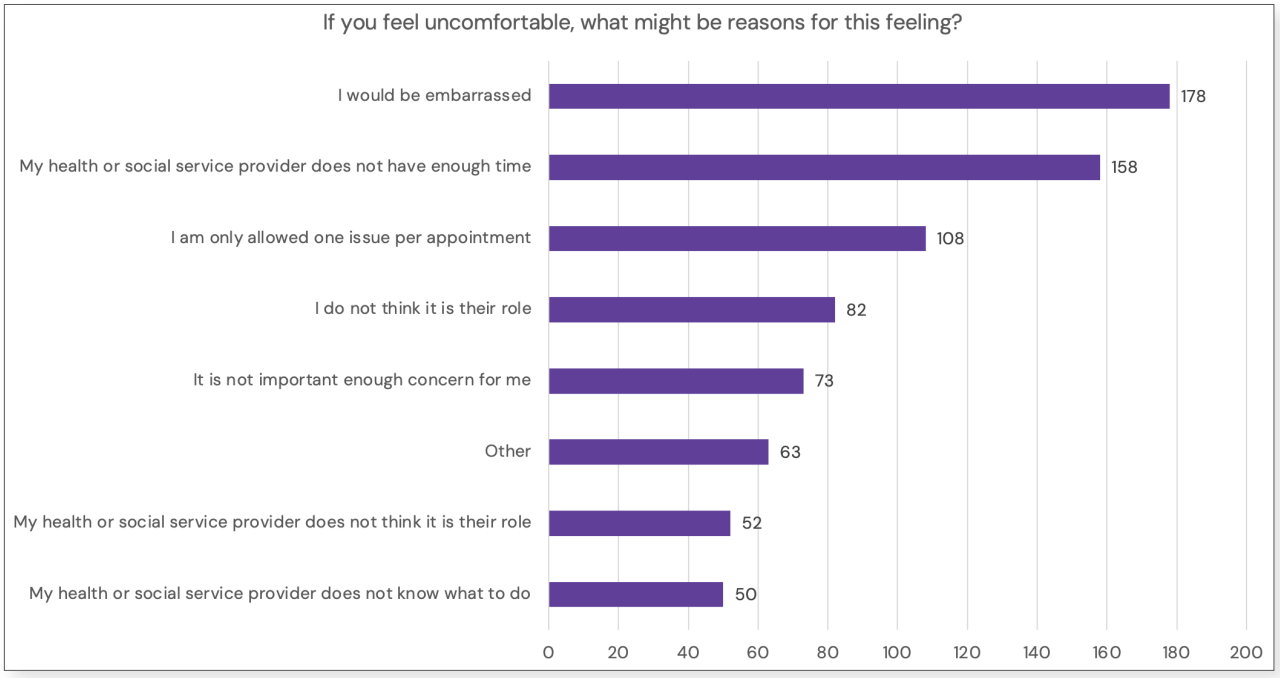
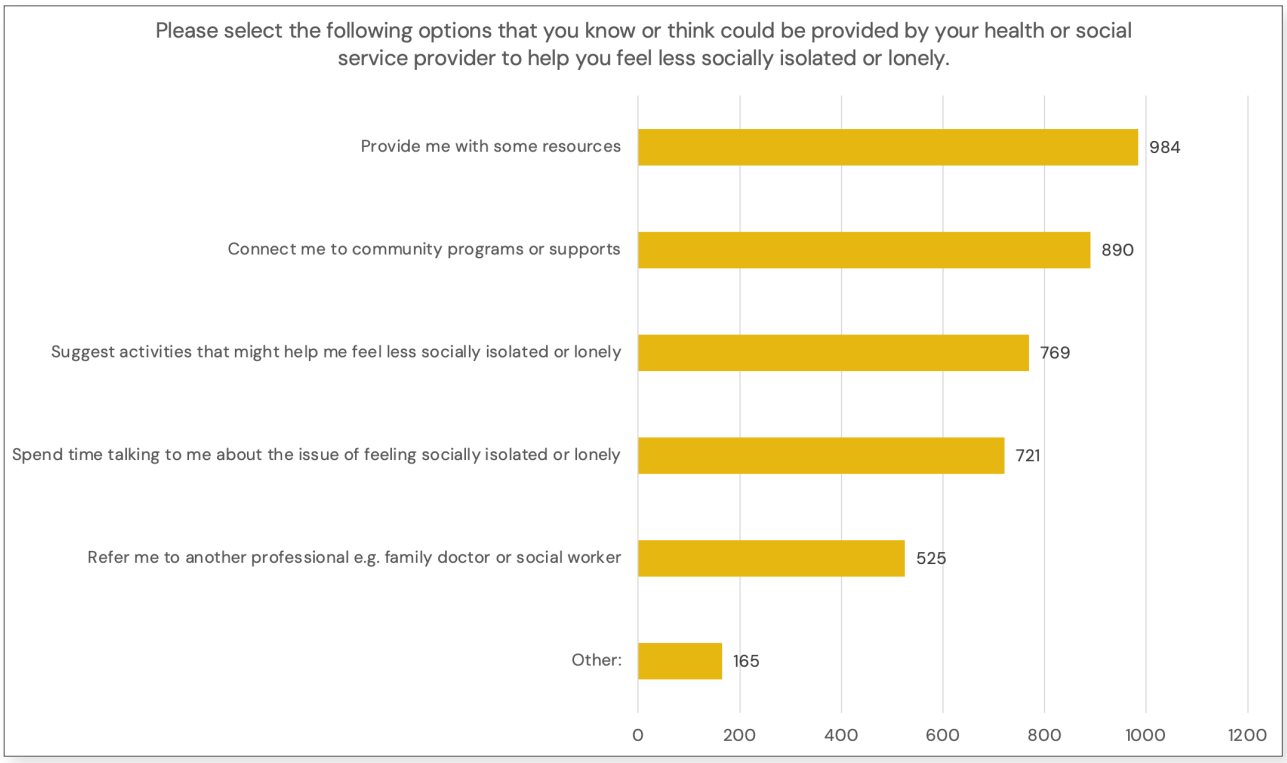


Figure 5: Options that could be provided by health or social service provider



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