Social Isolation and Loneliness

Learning from the experiences of older adults and health care and social service professionals

CCSMH
Canadian Coalition for Seniors' Mental Health

CCSMPA
Coalition canadienne pour la santé mentale des personnes âgées

Report Authors

Dr. Salinda Horgan, PhD

Dr. Jeanette Prorok, PhD

Project Team

Dr. David Conn, *Chair*

Claire Checkland, *Executive Director*

Bette Watson-Borg

John Saunders

Lisa Tinley

Acknowledgements

The Canadian Coalition for Seniors' Mental Health (CCSMH) is committed to improving the quality of care and support for older adults throughout Canada by working tirelessly to bridge gaps in knowledge and practice, ensuring that mental health receives the attention it deserves within the realm of aging. The Social Isolation and Loneliness in older adults project has been made possible through the generous philanthropic support of an anonymous foundation. The CCSMH is a project of the Canadian Academy of Geriatric Psychiatry.

Contents

Key Messages

Here we highlight the key take-home messages that surfaced out of this work.

In General, We Learned That...

1. Older adults experience social isolation and loneliness both objectively and subjectively which complicates detection, prevention and management.

2. Both older adults and HCSSPs believe that being pro-active, making connections and reaching out can help.

3. HCSSPs working in different care contexts can be impacted by diverse (and sometimes contrasting) barriers that make it difficult to be pro-active, make connections and reach out.

4. Both older adults and HCSSPs have ideas for promising strategies that are currently being carried out in pockets across the health care and social services landscape (but not as standard care).

5. The most promising solutions likely require whole-system innovations to strengthen coordination and collaboration across health care and social service landscape.

Introduction

What Is This Report About?

The CCSMH is working on the development of clinical guidelines to support Health Care and Social Service Professionals (HCSSPs) in their work around social isolation and loneliness in their older patients/clients. We wanted to explore the experiences of older adults and HCSSPs to see what we could learn from their lived experience.

The findings contained in this report are intended to help us better understand the **'on the ground'** nuances and complexities that surface when older adults and HCSSPs face and deal with social isolation and loneliness.

Why Did We Write This Report?

We are still learning the story of social isolation and loneliness for older adults in Canada. This report is intended to start a conversation, informed by the experiences and perspectives of older adults and HCSSPs. We regard perspectives as a value add that create opportunities to hear the voices (and ways of knowing) that are not always reflected in other forms of research. We think exploring the lived experience and perspectives of older adults and HCSSPs can help expand our thinking about what helps, what gets in the way, where the opportunities for change and improvement lie. It is also a good way to surface what more we need to learn and research.

How Do We Envision The Knowledge Being Used?

This report is intended to invite questions, spark ideas and plant seeds to pave the way forward.

We hope the knowledge contained in this report will be a catalyst to help to start conversations about practice, but also education & training, policy, research and community-building as it relates to social isolation and loneliness in older adults in Canada.

Important Background Information

The knowledge contained here is empirically informed. The data were gathered using a systematic approach and methods approved through a certified Research Ethics Board. The information that provided the basis for this report was obtained via specific open-ended questions contained in a larger pan-Canadian Survey that was prepared and distributed by the CCSMH in 2022-2023. Methodological details are described in two companion documents.

For more information on the methods and results of both surveys,
consult our key findings reports on our research web page:

What We Learned

The remainder of the report summarizes what we learned when we asked older adults and HCSSPs to share their perspectives about social isolation and loneliness. Older adults and HCSSPs didn't always share the same perspectives. There were nuanced differences in perspectives amongst and between older adults and HCSSPs. However, we discovered that there were important (and sizable) patterns of agreement across these groups. We did not find any areas of absolute disagreement between or across groups. In presenting this information, we made an effort to capture the interconnections, complexities, and potentialities as they were told to us.

Social Isolation & Loneliness: Same Or Different?

We asked HCSSPs if they thought social isolation and loneliness were distinct concepts. Although most respondents did not perceive these concepts to be one and the same, we learned that they do consider them to be highly interrelated and interconnected.

> *"It's possible to be socially isolated and not be lonely. It is equally possible to be lonely when not socially isolated."*

Many examples were offered that help clarify the ways in which social isolation and loneliness are ***distinct.*** Social isolation was commonly described as a condition that can be observed, outwardly. While loneliness was associated with internal thoughts and feelings.

> ***"Loneliness is an internal lived experience. Social isolation is more of an objective measure."***

At the same time, participant responses also illustrated how social isolation and loneliness can be inextricably linked.

> ***"Social isolation and loneliness are widespread, and people experience these issues on a daily basis. This has a serious impact on older people's physical and mental health, quality of life and their longevity. I do not believe that the two are distinct."***

It also become clear that how these conditions connect and interact are not always linear.

> ***"Social Isolation doesn't always lead to loneliness, some individuals are perfectly fine isolated from others (e.g., extreme introverts). Alternatively, loneliness can happen even when individuals are NOT socially isolated."***

The complexity involved in detecting social isolation or loneliness and determining the impact on a persons' everyday life, appears to involve an intricate dance that consists of investigating both what can be seen objectively and what is perceived subjectively. For instance, loneliness was most often associated with subjective feelings of disconnection. However, many examples were provided to illustrate ways in which older persons can appear connected (objectively speaking) yet still perceived themselves (subjectively) to be alone. In other words, loneliness experiences, can be tied to feelings about social circumstances (e.g., do I have enough social contacts) that may or may not align with what can be seen objectively.

> ***"People who are not at all socially isolated (have friends, family in contact, get out to activities and community events) can still feel very lonely."***

Importantly, an older adult's health and wellbeing may be shaped more predominantly by their subjective impression of the **quality of their social connections,** than the actual **number and or frequency of contacts.**

> ***"Even though someone could not be socially isolated, if they feel alone in their experience, they could still feel loneliness."***

This suggests that how one interprets their experience is likely a defining element in determining the presence and extent of both **loneliness and social isolation experiences.**

> *"They may be isolated (objectively speaking), but they may also receive enough phone / tech interaction with others that they do not feel lonely, or isolated."*

Overall, we heard that when it comes to clinical work, social isolation and loneliness often operate in tandem, which can make it **difficult to delineate where one ends and the other begins.**

> *"Social isolation can contribute to loneliness. And loneliness with other factors may contribute to social isolation."*

We also heard that when it comes to clinical intervention it may be optimal to consider **commonalities over distinctions.**

> *"I feel the two are so closely linked it's hard to differentiate between them. I understand people can be in a social setting and still feel lonely however generally speaking [social isolation and loneliness] have a very similar impact on an individuals' overall health and well-being."*

On the whole, we learned that not only are the situations and circumstances that foster and exacerbate social isolation and loneliness difficult to tease apart, when it comes to **courses of action,** similarities may be more important than differences.

> *"Two distinct concepts but not well differentiated on the ground."*

Based on these learnings and given the aim of this project to inform practice **on the ground** (and recognizing that there is a need for more research in this area), we resolved to refer to social isolation and loneliness **in tandem** throughout this report. We recognise the need for more research in this area.

The Big Picture: 3 Key Themes

When we analyzed across the experiences and perspectives of both groups three prominent themes emerged: being proactive, making connections and reaching out. What follows is an overview of these themes and how and why they help.

Being Proactive

Connecting

Reaching Out

The Big Picture: 3 Key Themes

Being Proactive!

Prevention is Essential

When it comes to detecting and preventing social isolation and loneliness in older adults, participants emphasized the need for **prevention, through pro-action.** Being proactive was seen as a way to detect social isolation and loneliness experiences early and minimize exacerbated health harms.

> ***"Start earlier!!"***
>
> *-older adult*

Connecting!

Connections are Fundamental

Participants spoke about the importance of helping older adults make and maintain **meaningful connections with other people and with their community.** Making connections to people, programs and activities was seen as a way to expand social networks and build coping skills.

> ***"Help them connect with others. Suggest keeping active, going out in nature, joining a senior's group, or getting a pet."***
>
> *-older adult*

Reaching Out!

Reaching Out is Vital

Participants stressed the importance of reaching out. Reaching out was positioned **as an additional layer of support.** This additional layer (which can be provided formally or informally) was seen as being particularly necessary for older adults who experience more significant health and situational complexities (e.g., persons who experience low-income, mobility limitations, and/or transportation challenges). Reaching out is as a next step, a way to stay in touch and provide a guiding hand.

> ***"It's all very well to suggest resources, but there needs to be a follow-up or an action to further direct support."***
>
> *-older adult*

What Helps And What Gets In The Way

We asked older adults and HCSSPs to tell us about strategies and approaches they thought could help prevent and/or mitigate social isolation and loneliness in older adults. Next, we asked older adults and HCSSPs to discuss the things that get in the way; the challenges that make it difficult to action strategies that can help. What follows is an exploration of what helps and the challenges, including how and why they get in the way.

Be Proactive

Strategies We Heard About

Screen for Social Isolation and Loneliness

Routine screening can identify older adults who are experiencing or at risk of social isolation and loneliness, ensuring they receive connections and interventions early on. Screening was seen as a way of triggering referrals to appropriate health and social supports. Screening levels for instance, could function as eligibility criteria to activate preventative services including social prescriptions, home and volunteer supports. However, the need to go beyond screening to offer solutions and interventions was emphasized.

> *"Conversations about social isolation and loneliness should be part of the annual checkup process."*
>
> *- older adult*

Incorporate Social Isolation and Loneliness into the Care Plan

Participants recommended that **social isolation and loneliness be included as part of formal care planning.** This means recording screening results in care plans as a baseline measure. This also means that suggestions for lifestyle changes and community connections are written down as part of the care plan. Many HCSSPs proposed including short and long-term goals in care plans to monitor progress over the long term. The benefits of including family members in formal care planning around social isolation and loneliness were also stressed.

> *"Discuss what their goals are towards social reconnection, smart goal setting and deciding together what they might actually find helpful, and doing the referrals (if needed), and then being able to follow up after the fact."*
>
> *- social worker*

Offer Flexible Service Delivery Options

Many older adults live with challenging health and situational complexities. HCSSPs can help break down the barriers that exacerbate social isolation and loneliness for these older adults by offering **multiple (and flexible) ways to access programs and services** (e.g., face-to-face, phone, webinar, groups). For example, caregivers who are unable to leave a loved one at home unattended may be more likely to engage in services/supports that offer respite care, or that can be accessed online.

"It's a conundrum. As my wife's caregiver, I feel that I am fulfilling an essential role. There are not many activities that I can participate in while fulfilling this role."

– older adult

Build Resilience

Participants suggested **strengthening the capacity of older adults to be resilient** in response to social isolation and loneliness experiences. Resilience refers to the capacity to adapt to and cope with challenging life circumstances. Interventions (i.e., therapeutic programs, groups) that focus on coping, resilience, communication, health and digital literacy can all build skills that protect older adults from the harms of social isolation and loneliness.

"Give me tools to cope with loneliness such as CBT or some other method."

– older adult

Coping Skills

Coping skills can help older adults self-manage early-stage social isolation and loneliness experiences and improve help-seeking. These types of psychosocial interventions also align with the expressed desire of many older adults to receive non-pharmaceutical treatments that help them cope with mood, and everyday stressors.

"Build capacity in skill sets to improve mood, physical health, mental health, reduce stress & improve quality of life."

– nurse

Being Proactive

What Gets In The Way

Time

Participants highlighted **time as a factor that can hinder prevention and early intervention.** Older adults discussed feeling as though there is insufficient time in appointments to have meaningful conversations about social isolation and loneliness with HCSSPs.

HCSSPs also noted their struggle to find the time to properly assess and address social isolation and loneliness concerns in conjunction with other medical issues (i.e., primary reason for referral). Time-restrictions can hinder the ability learn about applicable interventions and resources.

> *"As it is now, patients are restricted to 10-minute blocks of time and can only discuss one health issue at each appointment."*
>
> *- older adult*

> *"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*

Help-Seeking

Social isolation and loneliness can be a difficult topic for older adults to discuss. HCSSPs highlighted their concern that many older adults who experience and are at-risk of social isolation and loneliness, remain invisible. This complicates efforts to detect and provide early supports. Older adults discussed their hesitancy to initiate conversations about social isolation and loneliness with family doctors.

> ***"Recognize that loneliness is linked to negative health outcomes and many seniors might not be comfortable talking about it."***
>
> *- older adult*

The reasons included but went beyond the issue of time. Some worried that their concerns may be considered a non-medical issue. Others noted that social isolation and loneliness is often accompanied by low motivation and self-assurance, characteristics that can impeded help-seeking. Several older adults spoke about times when they were unaware of the extent to which social isolation and loneliness was negatively impacting their overall health and wellbeing.

> ***"We can become more isolated and unaware of our own needs."***
>
> *- older adult*

Relationships

HCSSPs stressed the need to build trusting relationships with older adults to surface and address issues of social isolation and loneliness. Both groups accentuated the need for **zero tolerance of ageist behaviours** in clinical settings. Ageism is reflected in language, attitudes and behaviours that belittle the goals, values and capacities of older adults. Many older adults indicated that ageist encounters negatively impact their view of the therapeutic relationship and halt conversations about sensitive topics such as social isolation and loneliness.

> ***"As an active 70-year-old woman with a doctorate in education I sometimes feel frustrated when some health or social service providers assume I am frail and not too bright."***
>
> *- older adult*

Scope of Practice

HCSSPs noted that **social isolation and loneliness does not fit squarely within the scope of any particular discipline, profession or sector.** Most HCSSPs, depending on their professional role and organizational context, identified aspects of social isolation and loneliness they believed they could be of help with. However, most also highlighted the need for contributions from other professions/organizations/sectors to fully address and resolve issues of social 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.

- community service organization

For instance, some HCSSPs indicated that they were well positioned to screen for and detect social isolation and loneliness. Yet, they did not feel well equipped (in terms of training and/or setting) to provide active intervention or follow-up.

"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."

- health promoter

Eligibility Criteria

Participants from both groups highlighted that **social isolation and loneliness is not considered a formal medical condition.** Its' positioning as a non-medical health issue means that social isolation and loneliness can only be addressed in conjunction with other (eligible medical) conditions. Similarly, many older adults questioned whether social isolation and loneliness would be considered (on its own) a valid reason to book an appointment with a family doctor. HCSSPs indicated that in many settings/contexts, appointments for social isolation and loneliness are not billable. Along these same lines, social isolation and loneliness often does not constitute a legitimate reason for referral to another health care or social service agencey.

"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

For instance, an older adult who could benefit from home companionship (to help with social isolation and loneliness) may not meet eligibility criteria (i.e., diagnosed functional or medical condition) for a referral to homecare services. Some HCSSPs discussed the ways in which they must be creative to address issues of social isolation and loneliness (e.g., screening for social isolation and loneliness as part of an assessment for depression).

> ***"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. It could be considered within my scope but 3rd party payers may not endorse this service as it falls outside the reason for referral."***
>
> *- community service organizations*

Being Proactive: Summary

Strategies

- Screen for Social Isolation and Loneliness
- Incorporate Social Isolation and Loneliness into the Care Plan
- Offer Flexible Service Delivery Options
- Build Resilience
- Coping Skills

Challenges

- Time
- Help-Seeking
- Relationships
- Scope of Practice
- Eligibility Criteria

Connecting

Strategies We Heard About

Offer Social Prescriptions

Social prescriptions aim to **connect older adults to local, non-clinical programs and supports.** Social prescribing was described by several participants as a 'warm hand-off' to community programs that can benefit an older adult's overall health and wellbeing.

Connections to Community Programs

Connections to community programs (e.g., physical fitness groups, leisure interest groups) events (e.g., cultural celebrations) either in person or online provide opportunities for older adults to make friends, explore interests and potentially alleviate social isolation and loneliness experiences. Common examples of social prescribing included prescriptions for nature therapy, physical activity, yoga, and educational interest groups.

> *"Give names of social activities, clubs or organizations or perhaps the name of a certain person in the organization or club to call."*
>
> – older adult

Offer Group Programming

Therapeutic groups (offered as part of health care and social services) can help older adults who live with health and situational complexities that make it difficult to access and participate in community programs. For instance, support groups for health-related issues (e.g., depression, anxiety, diabetes) present an opportunity to provide disease specific support (e.g., education, coping skills) while also facilitating valuable social connections for participants. Some participants suggested that groups could be formed for the explicit purpose of bringing together older adults who are struggling with social isolation and loneliness.

> *"Providers could form a group of clients experiencing social isolation and loneliness who could join together for discussions or social get-togethers."*
>
> – social worker

Help Make Peer Connections

Older adults expressed a desire to **make connections with other older adults for social connection and mutual support.** Many older adults expressed a desire to meet peers who shared similar interests to expand their social worlds. While others wished to make connections with peers experiencing similar struggles; to share strategies for recovery. Some ways to facilitate peer-to-peer connections included offering peer support groups, hosting registries of older adults looking to connect, or making referrals to companion programs.

"Have visiting persons who are not necessarily health care professionals but just caring individuals with a compassionate ear."

– older adult

"Post the names of others who are looking to connect."

– older adult

Offer Older Person-Centred Care

Participants underscored the importance of a **person-centred approach** that takes into consideration the goals, values and capacities of older adults. Participants described an older-person centred approach as including key elements such as giving more time in medical appointments, allowing more than one issue to be discussed in a medical appointment, and taking all concerns seriously. Older adults suggested that the using a person-centred approach and an openness to exploring solutions beyond pharmaceutical interventions could foster an environment that was more comfortable for discussing difficult issues like social isolation and loneliness.

"You need extra time for the elderly: we are physically and mentally slower to explain [things to] and process. Our health needs are more; generally speaking, then the young and our health needs are significantly different and progressively chronic. This requires a different set of skills needed by the professionals in health and social services."

– older adult

Connecting

What Gets In The Way

Information

A lack of information about available and appropriate health care and social services **or community programs** can make it difficult to link older adults to helpful resources. To make effective connections a good deal of information is required. For instance, HCSSPs want to make connections to programs that are low-cost and easily accessible via public transportation. To do so requires detailed information about program location, cost, hours of operation and nearby bus stops. It is also useful to know about hours of operation, eligibility criteria and waitlist status. This level of information is often not easily accessible for most HCSSPs. Several HCSSPs indicated their reluctance to 'prescribe' programs for which they did not have this level of information.

> ***"Have visiting persons who are not necessarily health care professionals but just caring individuals with a compassionate ear."***
> *– nurse practitioner*

> ***"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."***
> *– primary care physician*

Range & Diversity of Options

Participants discussed the lack of **social and recreational programs tailored to the broad range of interests and capacities of older adults.** For instance, programs (e.g., running groups, fitness classes) are commonly offered at a pace and intensity level that is beyond the capability of many older adults. The older adult population is characterised by a great deal of diversity in terms of what they can and wish to do. Participants noted that much of what is available in the community does not fully align with their wide range of interests and abilities. Moreover, many programs are not tailored to the interests, and cultural characteristics (e.g., language, values) of older adults who belong to equity-deserving groups.

> ***"Programs and places that a senior can participate at their own level of involvement... meaning they can join in at their comfort level. "***
> *– older adult*

Transportation

A **reliance (either partially or exclusively) on public transportation** is a factor that negatively impacts the ability and motivation of older adults when it comes to accessing programs and services to mitigate social isolation and loneliness. Transportation can be difficult for all older adults but can be more problematic for those who live with health and situational complexities. Participants highlighted difficulties in coordinating accessible transit, affording bus passes, and managing extended walks between stops and destinations.

> ***"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."***
>
> *- occupatuional therapist*

Cost

Older adults living on low incomes may face barriers that make it difficult for HCSSPs to link them to appropriate community supports. Many noted their reluctance to suggest community programs that were not either free or low-cost. Unfortunately, few community options seem to meet this criteria, particularly in urban settings.

> ***"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 get there or take part in that program."***
>
> *- primary care physician*

A social prescription to join a community fitness centre for instance, hinges on the ability to purchase a membership (or day pass) and cover transportation costs (bus, taxi). For older adults who experience low income and/or who live in rural settings, the costs to access such programs can be highly prohibitive.

> ***"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."***
>
> *- social service professional*

Digital Literacy

Digital literacy refers to the skills and resources that older adults need to live, learn, and work in a society where communication and access to information is increasingly exchanged via digital technologies. Many HCSSPs expressed concern that older adults have **limited capacity to access and make optimal use of** the information and resources available through **digital technologies.**

"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 professional

Online resources offer an advantage for accessing therapeutic, recreational and social resources that are of no (or low) cost and do not require transportation. However, concerns over digital literacy deficits impact the extent to which HCSSPs believe these resources can be effective for older adults.

"Keeping up with the technological change is confusing, frustrating and expensive."

– older adult

Motivation & Self-Assurance

Low motivation and self-assurance are characteristics that frequently accompany experiences of social isolation and loneliness. These characteristics can dissuade older adults from reaching out and joining community programs (even if they are 'prescribed').

"It's hard to take that first step when you're feeling low."

– older adult

Many older adults described the anxiety and lack of confidence that can arise when they attempt to initiate connections to settings and environments that are unfamiliar. Likewise, HCSSPs indicated that decreased motivation and self-assurance is likely an underlying reason why older adults may avoid accessing the services and supports they recommend.

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

Connecting: Summary

Strategies

- Offer Social Prescriptions
- Offer Group Programming
- Help Make Peer Connections
- Offer Older Person Centred Care

Challenges

- Information
- Range & Diversity of Options
- Transportation
- Cost
- Digital Literacy
- Motivation & Self-Assurance

Reaching Out

Strategies We Heard About

Check-in Regularly

Participants recommended that HCSSPs **check in with older adults who are struggling.** For example, active check-ins (either by phone, webinar or in-person) were seen as a way to extend support to older adults who have difficulty attending health care appointments. Older adults in particular, recommended that check-ins be done on a regular basis (e.g., weekly, bi-weekly or monthly as necessary) and over the long-term.

> *"Phone them and encourage them to go. Keep in touch and encourage them as they take small steps. Follow up on patient's progress or if more help is needed."*
> *– social worker*

Offer Supports in Home Environments

Supports that **bring interventions** (e.g., CBT, midfullness training, physical activity, peer connections) **to older adults in their home environments** can be a way to ensure equitable access for those who have difficulties accessing health care and social services (e.g., mobility limitations, low motivation, transportation challenges). These supports can be provided by community progams, peer volunteers or HCSSPs (or a combination).

> *"Set them up with trained/skilled volunteers who can come into their home and engage with them in meaningful activities."*
> *– nurse*

Connect Them to a Buddy

Many older adults indicated they would feel more comfortable attending community programs if they could **go with a friend.** Several HCSSPs described the benefits of "buddy initiatives". Buddy initiatives were characterised as paired peer/volunteers that accompany older adults to community programs (at least for the first few sessions), offer motivation support, and potentially help with transportation. Making the connection to existing buddy initiatives or embedding these resources into exisiting health care and social services are both options.

> ***"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*

Actively Follow-up

Active follow-up involves encouraging older adults to set goals and continue to engage with social isolation and loneliness supports. This includes **establishing goals, tracking progress, problem-solving, and acknowledging achievement.** It can also include contacting programs and services as asking them to initiate the connection.

> ***"For many patients, they don't "want to bother" anyone; for these patients, making a referral to the supports for the supports to reach out and contact the patients and invite them to join a group would be wonderful. The older patient populations want to be invited to come and feel they will add something and not just take from a group or situation."***
>
> *– counsellor*

Provide Online Support & Promote Digital Literacy

Many HCSSPs emphasized the need for digital literacy programs **to build the capacity of older adults benefit from the ever-expanding potpourri of online resources.** Digital services/supports were thought to have a high degree of potential for relieving social isolation and loneliness in older adults, particularly those who live with complex health and situational complexities. Although many HCSSPs expressed concerns over digital literacy deficits in the older adult population, several older adults discussed their comfort with and preference for online supports. Many adults just entering their older adult years have sufficient digital literacy skills to access health and social supports online.

> ***"Zoom meetings are a great way to connect older adults. It can give a sense of community."***
>
> *– older adult*

Reaching Out

What Gets In The Way

Resources

Most HCSSPs have **limited access to resources that help them 'reach out'** where social isolation and loneliness is concerned. To start, the resources necessary to compile and keep updated rosters of community programs and supports do not exist currently within HCSSP organizations. Nor does funding allow for the additional time and resources required to put extended peer and home-based 'reach out' strategies in place (e.g., check-ins, buddy initiatives, follow-up).

Volunteers can be a valuable resource to facilitate outreach to older adults who are in need of additional support. However, many communities lack a robust supply of volunteers that HCSSPs can be tapped into to initiate and augment existing 'reach out' strategies.

> *"We need helpers to assist people when they need support to find connection – get out the door, and through the door."*
>
> *– primary care physician*

> *"Lack of resources – not sure how to get best information brought forth to me to understand the interventions that exist and how I go about implementing and streamlining outreach for the patients that I see."*
>
> *– primary care physician*

Coordination

A **lack of coordination between and across health care and social serviceorganizations and community programs** make it difficult to put effective 'reaching out' strategies in place. For instance, centralized resources information can help older adults identify and connect with appropriate programs and services.

> *"Provide addresses, e-mail addresses, phone numbers for all activities geared for seniors."*
>
> *– older adult*

Many HCSSPs noted the need to coordinate efforts across multiple professions and settings to sufficiently address social isolation and loneliness. Several HCSSPs noted imitations with respect to determining whether a client had accessed the supports prescribed and the duration of participation. A centralized way of recording social prescriptions (for example, through an EMR system), and following program participation, could provide a way to track connection and participation.

> *"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*

Training

The extent of **training related to social isolation and loneliness can impact confidence and know-how.** For instance, a lack of knowledge about the most appropriate tools for screening (and how to interpret results) can foster a hesitancy to screen for social isolation and loneliness.

> *"Insufficient or inadequate training opportunities – I feel the lack of training combined with lack of support staff is a real problem."*
>
> *– nurse*

Similarly, older adults who are experiencing elevated difficulties may benefit from more intensive interventions (e.g., mindfulness training, befriending programs, group therapy). However, a lack of knowledge about effective strategies (and how to implement them within specific settings/contexts) can diminish confidence for putting these interventions in place.

> ***"A personal lack of awareness of best practice for intervention / management how to assess / screen for social isolation."***
>
> *- primary care physician*

Reaching Out: Summary

Strategies

- Check in Regularly
- Offer Supports in Home Environments
- Connect Them to a Buddy
- Activity Follow-Up
- Provide Online Support & Promote Digital Literacy

Challenges

- Resources
- Lack of Volunteers
- Coordination
- Training

Where Do Opportunities Lie?

We mined the experiences and perspectives of older adults and HCSSPs to better understand where opportunities for change and innovation might lie. We learned that many older adults and HCSSPs believe there is a need to put in place new and novel infrastructure that better connects health care, social service and community supports for social isolation and loneliness.

This is because social isolation and loneliness is impacted by interconnected physical, mental, social and environmental factors. Several innovative initiatives were highlighted that hold potential for forging integrated (whole-system) pathways to enable a seamless and comprehensive approach to social isolation and loneliness.

We Heard There Is A Need For:

Whole-System Innovations That Make It Easier For Older Adults to:

1. Find out about programs and events happening in their community.
2. Tap into supports that can help them access appropriate supports across the health care and social services landscape.
3. Inform community, health care and social services programming so it better aligns with their values, goals and capacities (across diverse sub-groups).
4. Receive therapies specifically designed to address social isolation and loneliness.

Whole-System Innovations That Make It Easier For HCSSPs to:

1. Provide information about programs and events happening in their communities.
2. Connect older adults to programs and events happening in their communities.
3. Learn about and implement interventions specifically designed to address social isolation and loneliness in older adults.
4. Offer active outreach supports to address social isolation and loneliness.

Whole-System Strategies That Have the Potential to Move Us Forward

Navigation/Connection Hubs

Participants suggested that **community-based navigation/connection hubs** could provide a place (physical and/or virtual) for older adults, family members and HCSSPs to find information, access resources and seek help for social isolation and loneliness.

These centres could offer opportunities for connection and operate as a central source of information about services, supports and other resources helpful for preventing and managing social isolation and loneliness. Moreover, navigation centers were seen as potential hubs through which to connect older adults with trained volunteers, senior-friendly transportation, and outreach services.

> *"Easy, centralized referral to a robust social services/ outreach/social program with effective case management."*
>
> *– primary care physician*

> *"Something that older adults can be referred to that is a point of care service to connect them to a resource that matches their unique reason for loneliness/ social isolation."*
>
> *– health promoter*

Integrated (or Shared) Care

Older adults expressed a desire to discuss social isolation and loneliness experiences and seek help from **a range of HCSSPs and other (non-professional) sources of support across a variety of community and health care and social service settings.** Because the determinants of social isolation and loneliness cut across physical, mental, social and environmental factors, an inter-professional/inter-organizational/inter-sectoral approach is likely needed to sufficiently address social isolation and loneliness.

The idea of offering multiple doorways for older adults to access social isolation and loneliness supports aligns with a proactive and comprehensive strategy. A variety of strategies can help to open multiple doorways including inter-professional education & training, and centralized referral that goes across healthcare, social service and community organizations.

> *"It is my understanding that many family practices now have social workers as part of the team … they could be most helpful with these activities."*
>
> *– older adult*

Community Building

Participants noted that **age-friendly communities** can help older adults better access services and supports that help them deal with and overcome social isolation and loneliness experiences. For instance, senior-friendly transportation services, tailored & low-cost programs, centralized navigation/coordination supports, and trained community volunteers can together create a community web that is responsive to the prevention and management of social isolation and loneliness in older adults. For instance, trained volunteers can be a potential source of companionship, rides, and accompaniment to community programs. Community volunteers can also be tapped into by HCSSPs to 'reach out' to older adults to connect them with people, programs and interventions. Community awareness was seen as an important by-product of community-building.

> ***"Utilize an asset-based community development (ABCD) lens to work with community partners and build connections to reduce social isolation."***
>
> *– social worker*

Integrated Technologies

Participants discussed ways that technology can be better used to support whole-system initiatives across the health care and social services landscape to improve the prevention and management of social isolation and loneliness in older adults. For instance, several HCSSPs noted that recording progress on social isolation and loneliness in health record systems (with whole-system access) could enable valuable information sharing and communication across organizations. This was seen as a potential way to engage multiple agencies, providers and family members in carrying out care plans and fostering a robust (and informed and up-to-date) support network. Other examples included online community directories of appropriate community and HCSS resources that could be easily accessed by older adults, family members and HCSSPs alike.

> ***"Provide a portal to services and programs offered in the senior community."***
>
> *– older adult*

Canadian Coalition for Seniors' Mental Health (CCSMH)

info@ccsmh.ca

1-888-214-7080 extension 102

www.ccsmh.ca

CCSMH | CCSMPA

Canadian Coalition for Seniors' Mental Health | Coalition canadienne pour la santé mentale des personnes âgées