CCSMH
Canadian Coalition for
Seniors' Mental Health

2026

"94 Voices"

Insights on Addressing Social Isolation and Loneliness with Older Adults

A compilation of clinical practice ideas from 94 Health Care and Social Service Professionals from across Canada

Acknowledgements

This project has been made possible through the generous philanthropic support of The Waltons Trust.

The Canadian Coalition for Seniors' Mental Health (CCSMH) gratefully acknowledges the 94 Health Care and Social Service Professionals across Canada who contributed their experiences and insights to this report. Their "on-the-ground" reflections reveal the everyday courage and innovation required to address social isolation and loneliness among older adults and to keep social health at the centre of care. By bringing these voices together, we aim to broaden the movement for social connection and encourage others to work alongside older adults in confronting the profound impacts of social isolation and loneliness in communities across the country.

The CCSMH is a program of the Canadian Academy of Geriatric Psychiatry (CAGP).

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Introduction

In 2024, the Canadian Coalition for Seniors' Mental Health (CCSMH) released the first *Canadian Clinical Guidelines on Social Isolation and Loneliness in Older Adults***, setting out evidence-based recommendations for prevention, assessment and intervention (CCSMH, 2024). This companion report brings those recommendations to life, showing how Health Care and Social Service Professionals (HCSSPs) across Canada are already putting them into practice in everyday care.**

To capture this work, we invited HCSSPs from across the country to share how they are addressing social isolation and loneliness with the older adults they support, so that others could learn from and be inspired by their experiences. The contributions that follow weave together practice stories and insights, all grounded in a shared belief in the ripple effect: the idea that every action, however small, can build toward broader change in how we address social isolation and loneliness among older adults.

This report recognizes the meaningful work HCSSPs are already doing, often quietly and without formal acknowledgement, and gives voice to the everyday practices, relationships, and small acts of connection that frequently go unseen. By bringing these contributions forward, we hope to create space for shared reflection, mutual learning, and continued progress in how HCSSPs support older adults at risk of, or experiencing, social isolation and loneliness.

Social isolation and loneliness are closely related but distinct concepts, with both recognized as critical social determinants of health (Hawkley & Cacioppo, 2010; Wu, 2020). Loneliness is a distressing, subjective "feeling that accompanies the perception that one's social needs are not being met by the quantity or especially the quality of one's social relationships" (Hawkley & Cacioppo, 2010, p. 1). Understood this way, loneliness is fundamentally an emotional experience: a perceived deficiency in the amount and/or quality of someone's existing relationships, rather than a description of the relationships themselves. This experience can take several forms, including emotional loneliness (the absence of meaningful relationships), social loneliness (a perceived deficit in the quality and quantity of social connections), and existential loneliness (a feeling of fundamental separateness from others and the wider world).

Social isolation, in contrast, is an objective, measurable state defined as "having few social relationships or infrequent social contact with others" (Wu, 2020, p. 2). It captures the level and frequency of a person's social interactions and can be assessed through indicators such as the size of a person's social network and how often they engage with it. Loneliness is often, but not always, associated with isolation, and the two are not interchangeable. An older adult may be socially isolated without feeling lonely, sometimes by choice, in a way that feels acceptable or even preferred. Another may feel profoundly lonely despite being surrounded by others in settings where they appear socially connected. Recognizing this distinction is essential for HCSSPs, because it shapes both what to assess and how to respond.

Social isolation and loneliness have profound and wide-ranging impacts on health, particularly in later life. They are associated with increased risks of cardiovascular disease, stroke, dementia, depression, anxiety, and premature mortality, with some studies suggesting effects comparable in magnitude to other established risk factors such as smoking, obesity, and physical inactivity (Hawkley & Cacioppo, 2010; Holt-Lunstad & Perissinotto, 2023; National Academies of Sciences, Engineering, and Medicine, 2020).

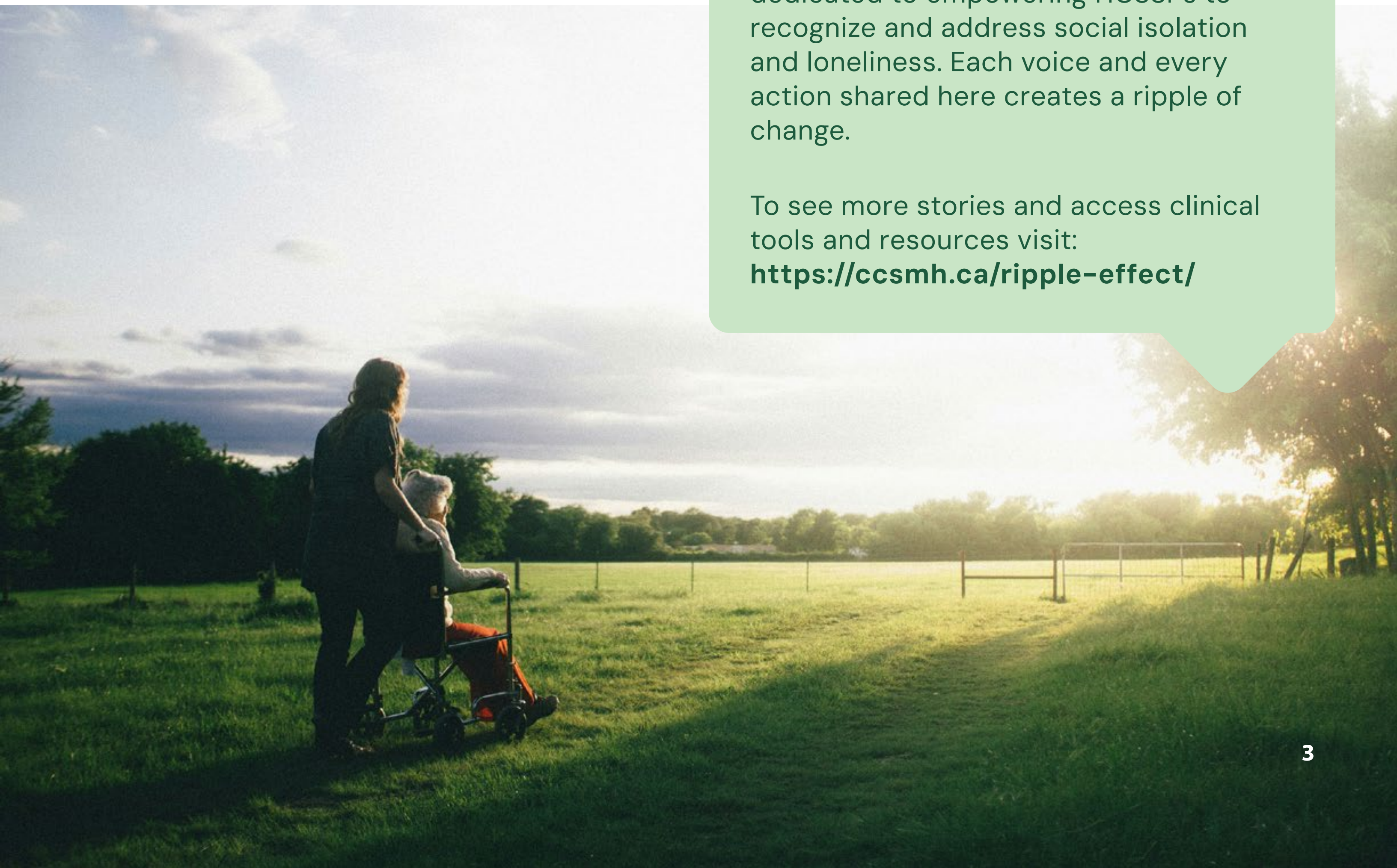
Loneliness has been linked to heightened physiological stress responses, poorer sleep quality, and impaired immune function, which can further exacerbate chronic conditions and reduce overall resilience (Hawkley & Cacioppo, 2010). Social isolation, as an objective lack of social contact, can limit access to practical and emotional support, reduce opportunities for health-promoting behaviours, and increase the likelihood that new or worsening health problems go unnoticed or untreated (National Academies of Sciences, Engineering, and Medicine, 2020).

The burden of social isolation and loneliness also reflects intersecting systems of oppression; racialized and Indigenous older adults, 2SLGBTQ+ seniors, and others who experience ageism, racism, sexism, ableism, homophobia, or transphobia are more likely to be isolated because these structural forces shape access to housing, income, community spaces, and culturally safe services (National Academies of Sciences, Engineering, and Medicine, 2020; Government of Canada, 2018). Together, these pathways help explain why social isolation and loneliness are now recognized as critical social determinants of health for older adults and a growing priority for health policy and health system change (Holt-Lunstad & Perissinotto, 2023; U.S. Surgeon General's Office, 2023).

Insights from the Field

This report highlights practice ideas and insights from **#TheRippleEffect,** a National Spotlight Campaign for Social Isolation and Loneliness in Older Adults dedicated to empowering HCSSPs to recognize and address social isolation and loneliness. Each voice and every action shared here creates a ripple of change.

To see more stories and access clinical tools and resources visit: **https://ccsmh.ca/ripple-effect/**



National Representation: A Pan-Canadian Effort

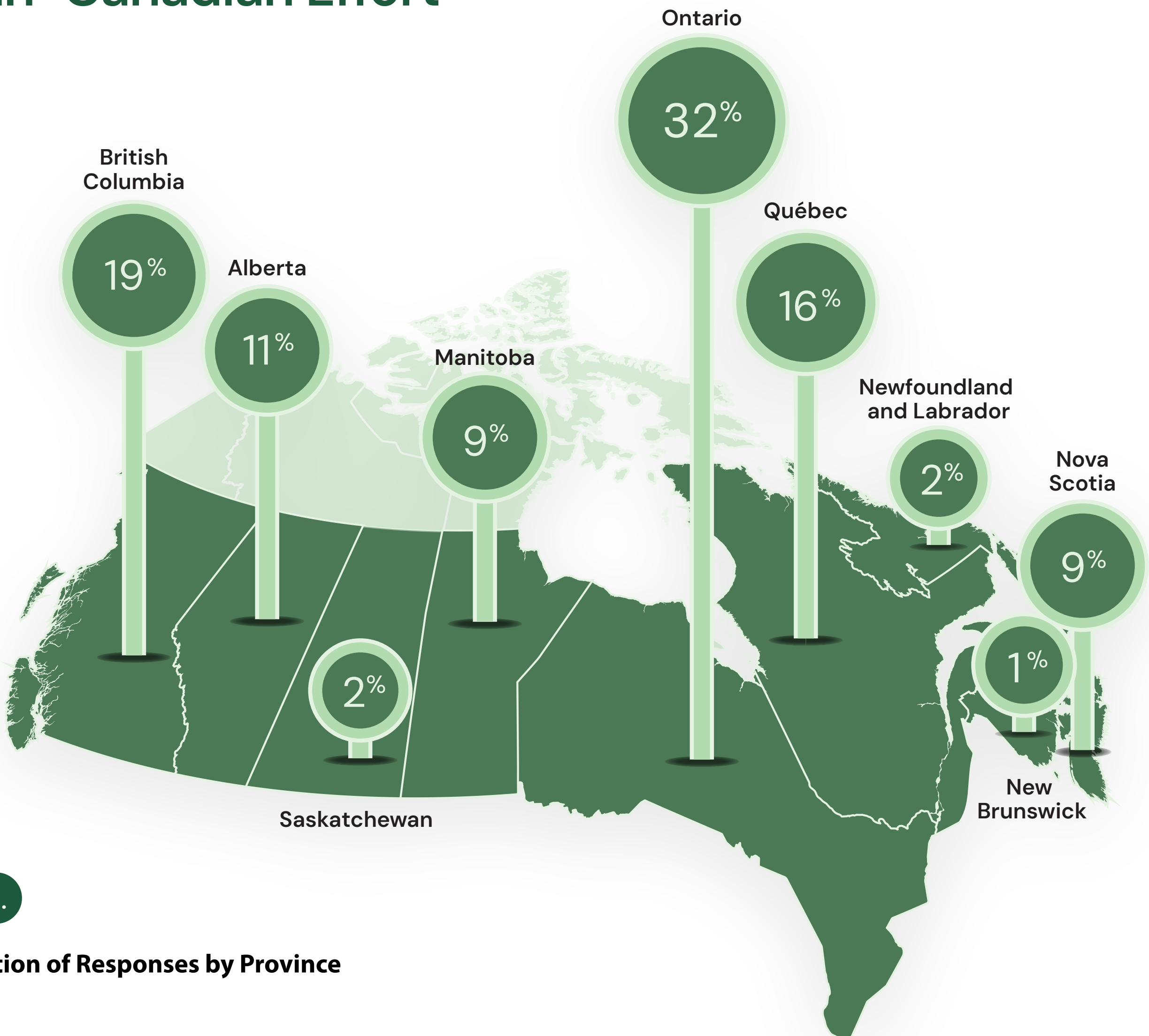


Figure 1.

Distribution of Responses by Province

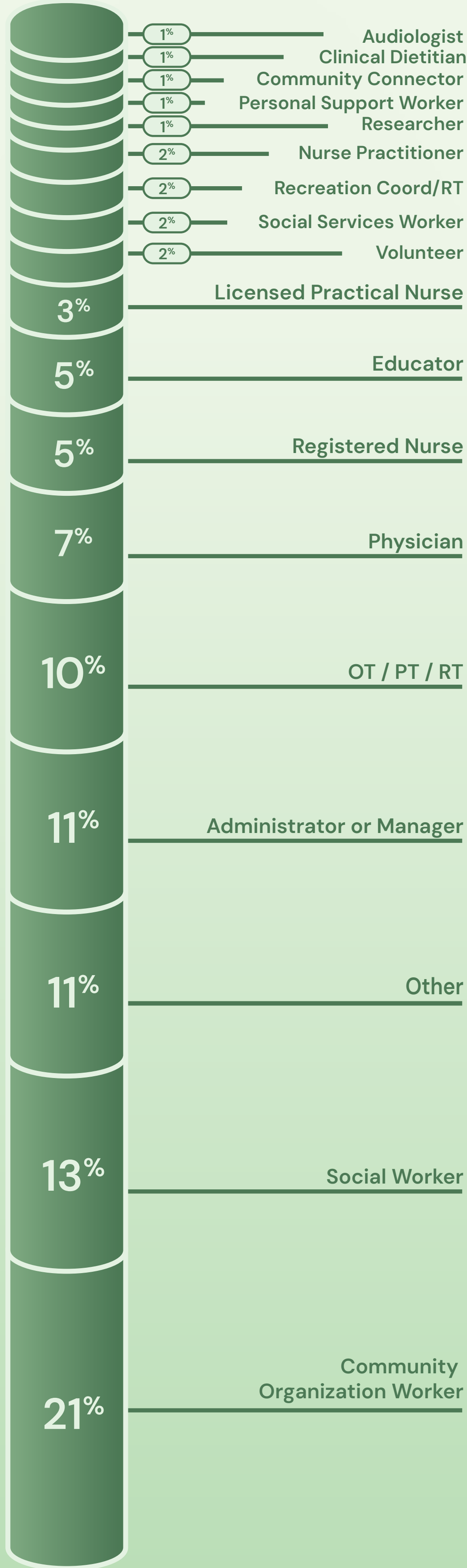
The contributors to this report reflect the vast and varied landscape of the Canadian health care and social service sectors. From bustling urban centres to more remote communities, social isolation and loneliness do not adhere to borders, and neither does the commitment of the HCSSPs who address them.

The geographic distribution of responses reflects the vast reach of this movement (Figure 1). We are proud to feature perspectives from Ontario (32%), British Columbia (19%), Québec (16%), Alberta (11%), Nova Scotia (9%) and Manitoba (9%), alongside important contributions from Saskatchewan (2%), Newfoundland and Labrador (2%), and New Brunswick (1%).

This pan-Canadian representation ensures the report reflects a wide range of practice environments, from major urban centres to rural and more remote communities. These voices share a diversity of ideas, from navigating winter transportation barriers in the Prairies, to addressing linguistic and caregiver isolation in rural Québec, to using libraries and community programs as connection points in the Maritimes. Together, these contributors demonstrate that while local contexts may differ, advancing social health is a shared priority for HCSSPs across Canada.

Figure 2.

Distribution of Responses by Role



The contributors to this report represent a wide range of professionals working with older adults (Figure 2). Community Organization Workers (21%) led the response, followed by Social Workers (13%), Administrators and Managers (11%), and Therapeutic Professionals such as OTs, PTs, and RTs (10%). Nurses (10% combined), Physicians (7%), and Educators (5%) added clinical and teaching perspectives, while researchers, volunteers, audiologists, clinical dietitians, and others added further depth. Each role brings a different lens to social isolation and loneliness, and taken together, their insights help ensure that the practice ideas in this report are relevant across the entire continuum of care.

Section 1

Insights and Tips from the Field

Turning the Tide on Loneliness through Meaningful Action

Across the 94 stories submitted to this report, a clear and consistent message emerged: addressing social isolation and loneliness rarely begins with a formal program, a new referral pathway, or a large-scale intervention. More often, it begins with a small moment of attention. Noticing a change in behaviour. Asking a better question. Adjusting the environment. Offering a personal invitation. Helping someone take one manageable step toward connection.

Meaningful action, the stories show, is both practical and relational. HCSSPs described listening closely, learning what matters to the person, removing barriers that others may not see, and using everyday encounters as opportunities to restore dignity, confidence, and belonging. As one contributor reflected, *"The loneliness didn't 'disappear' in one big moment; it faded as he felt known, respected, and in control again."* This is the heart of the work: not trying to solve loneliness all at once, but creating repeated signals that say, *"You matter. You are seen. You belong here."*

The insights that follow are drawn from across the full set of stories. They are not a prescriptive checklist. They are a synthesis of what HCSSPs across Canada described as working in their settings, alongside the older adults they support, and within the realities of busy clinical and community practice. Taken together, they offer practical starting points that any HCSSP can adapt, regardless of role, sector, or scale.

Insights

Shift from *"How are you?"* to *"What matters to you?"*.

HCSSPs emphasized the importance of moving beyond routine or closed-ended questions toward conversations that reveal personhood. Asking about sleep, preferred name, routines, food, faith, hobbies, work history, family, or what matters today can transform an encounter from an assessment into a moment of connection. One contributor described using the *"What Matters to You?"* framework, a clinical approach that asks people about their values and priorities rather than only their symptoms (Barry & Edgman-Levitan, 2012). The shift is small but powerful: it reframes the encounter as a relationship and creates space for the person, not the assessment, to lead. She noted that the patient *"felt seen and heard"* and *"knew this was a visit for her and not an assessment."* Another advised: *"Know the person… ask personhood questions and share with team."*

Start small and go at the older adult's pace.

Many stories showed that connection often begins with one manageable step, not a major commitment. A personal invitation, a brief conversation, an offer to accompany someone the first time, or a low-pressure activity can feel more possible than asking someone to *"join a community."* One HCSSP put it simply: *"Don't start with programs, start with a conversation."* Another advised: *"Listen and start small. Sometimes what makes the biggest difference begins with a simple conversation and truly listening to what a senior needs or wishes for. Small steps can lead to major changes in confidence and independence."*

Identify and remove "invisible" barriers.

Withdrawal is not always a sign that someone does not want to connect. HCSSPs repeatedly described practical, sensory, cognitive, emotional, and environmental barriers that can make participation difficult. A person may appear withdrawn when the real issue is something else entirely: unaddressed pain, sensory loss, continence concerns, confusing routines, anxiety, or fear of being a burden. Asking what is getting in the way often opens the door. One contributor captured this clearly:

"A person may seem 'withdrawn' when it's actually mobility, vision, pain, continence, or confusing routines. Fix what you can: safe mobility aids, clear signage, flexible meal times, simpler medication routines. Small adjustments can unlock social life."

Connect people to community supports, but do not simply hand them off.

HCSSPs described the importance of knowing local resources and actively building bridges to them. Community centres, libraries, churches and faith communities, older adult centres, volunteer groups, transportation programs, social prescribing navigators, and grassroots organizations can all become part of the support network. The stories also showed that referrals are most effective when they feel personal and supported. As one contributor noted, *"Partnering with local organizations can open doors to resources you might not have known were available. Collaboration makes solutions possible."* Where possible, personally introducing someone, helping arrange transportation, or inviting them by name can make the difference between a referral that is offered and a connection that is actually made.

Use every touchpoint as an opportunity for connection.

HCSSPs stressed that social connection does not need to be treated as an *"extra"* task. It can be woven into medication rounds, safety checks, meals, home visits, assessments, hallway conversations, care planning, and discharge conversations. One contributor wrote: "We make social connection part of our routine, not an 'extra.'" Another described how *"connection moments"* happen during *"care, meals, cleaning, repairs and hallway conversations."*

Even five minutes can matter:

> *"If I have 6 clients in a day, allowing a five-minute conversation during the task calls equals 30 minutes of time in the day to learn what my clients are going through on a personal level."*

Taken together, these insights point to a shared way of working. Turning the tide on loneliness asks HCSSPs to notice what is changing, listen for what is not being said, adapt care to the person in front of them, and create small openings for connection within the realities of busy clinical and community settings. It is work that depends less on new programs than on intentional practice: the steady, often quiet decisions that signal to an older adult that they are known, valued, and not alone.

These insights take on their full meaning when read against the conditions in which HCSSPs are working. The next section turns to those real-world realities: the barriers, constraints, and competing demands that shape what is possible, and that help explain why small, relational actions matter so much.

> *Making a difference doesn't always look dramatic: it can be as simple as a smile, a nod, or a shared silence."*
>
> – Licensed Practical Nurse, British Columbia

The Real-World Context for Action

The 94 stories did not describe ideal settings with unlimited time, resources, transportation, staffing, or access to services. They described HCSSPs working within complex everyday realities: mobility challenges, rural and remote service gaps, language and cultural barriers, cognitive changes, environmental constraints, staffing pressures, and limited formal training. These barriers do not diminish the impact of the examples that follow. Rather, they help explain why small, relational, and context-sensitive actions matter so much.

Across the stories, HCSSPs repeatedly emphasized that social isolation and loneliness are not simply the result of an older adult "not wanting" to participate. In many cases, withdrawal was linked to barriers that were practical, systemic, sensory, emotional, or environmental. A person may appear disengaged when they cannot hear well, cannot safely leave their room, do not have access to transportation, feel embarrassed about asking for help, cannot afford a program, are grieving, are navigating dementia or cognitive change, or do not see themselves reflected in the available services. Recognizing these realities is an essential part of responding well.

Physical, geographic, and financial barriers:

Mobility challenges, transportation gaps, program costs, and the absence of nearby services were common obstacles. HCSSPs described older adults who wanted to connect but could not safely leave their homes, could not afford transportation or program fees, or lived in communities where appropriate services were limited or far away. These barriers were especially visible in rural, remote, and low-income contexts, where even a strong referral may not be enough if there is no accessible, affordable way for the person to participate.

The hidden nature of isolation:

Several stories showed that isolation is often least visible for those who are most affected by it. Older adults living with dementia, grief, sensory loss, language barriers, stigma, or a lack of culturally safe and inclusive spaces may be less likely to seek help, accept invitations, or be identified through routine care. Caregivers, particularly those supporting someone with dementia or complex needs, were also described as isolated and struggling to navigate systems on their own. This underscores the importance of proactive noticing, gentle inquiry, and making referral pathways as simple and welcoming as possible.

Environmental and sensory obstacles:

The setting itself can either support or hinder connection. In hospitals, long-term care, clinics, community programs, and home care, HCSSPs described how lighting, noise, room setup, bed height, access to a phone, availability of a chair for visitors, hearing loss, vision loss, confusing routines, and lack of private or welcoming spaces can all affect whether meaningful connection is possible. Small changes, such as adjusting the environment, using a pocket talker, creating clearer routines, offering personal invitations, or making space for someone to sit and talk, can open the door to social connection.

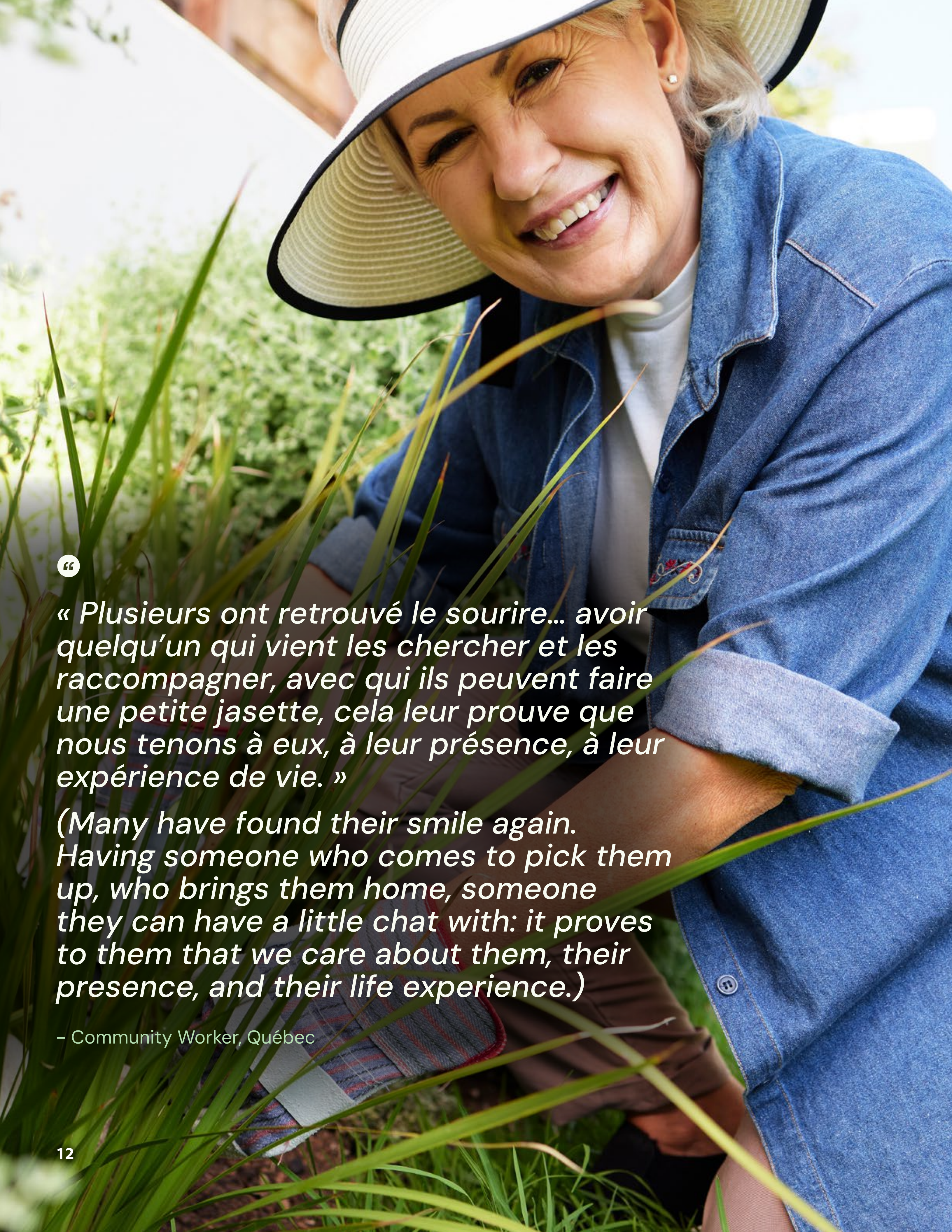
Systemic resource, staffing, and training gaps:

Many HCSSPs are doing this work in the context of long waitlists, limited staffing, heavy workloads, and little protected time for outreach or relationship-building. Some described coming in early, skipping breaks, working around their schedules, or taking it upon themselves to learn about community services because this work was not always formally built into their role. These efforts reflect deep commitment, but they also point to the need for organizational support, education, staffing models, and policy change so that addressing social isolation does not depend solely on individual HCSSPs stretching beyond sustainable limits.

The need for local adaptation and cross-sector connection:

The stories also show that effective responses are rarely one-size-fits-all. What works in a large urban centre may not fit a small rural community, and what works for one older adult may not feel safe, relevant, or meaningful to another. HCSSPs frequently relied on partnerships with community organizations, older adult centres, libraries, faith communities, volunteer programs, social prescribing navigators, family members, and local service providers. These connections helped transform individual effort into a broader network of support.

The vignettes that follow should therefore be read not as simple solutions to complex systemic issues, but as examples of practical action within constraint. In 2025, the World Health Organization called for social connection to be recognized as a core determinant of health and a public-health priority, and the CCSMH's recent policy and practice guide echoes that call while reminding us that real movement begins when we start where we are, reach beyond our immediate sphere, and find others to work with at any level (CCSMH et al., 2026). The stories that follow show exactly that: HCSSPs starting where they are, working within their scope, and building the connections that systems are only beginning to formalize.



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« Plusieurs ont retrouvé le sourire… avoir quelqu’un qui vient les chercher et les raccompagner, avec qui ils peuvent faire une petite jasette, cela leur prouve que nous tenons à eux, à leur présence, à leur expérience de vie. »

(Many have found their smile again. Having someone who comes to pick them up, who brings them home, someone they can have a little chat with: it proves to them that we care about them, their presence, and their life experience.)

– Community Worker, Québec

Section 2

Practice Vignettes

Voices of Impact

The following vignettes bring the 94 voices to life through concrete examples of action in practice. Each story shows how HCSSPs across roles, regions, and settings are recognizing social isolation and loneliness, responding with creativity and care, and adapting evidence-informed approaches to the realities of the people they serve. These are not presented as perfect or one-size-fits-all solutions. Rather, they illustrate how meaningful change often begins with noticing what others may miss, asking a more personal question, removing a practical barrier, or creating a supported pathway back to connection.

Together, the vignettes show that addressing social isolation and loneliness is both deeply human and highly practical. A social worker helps a new resident rebuild identity through life story work. An audiologist looks beyond "withdrawal" and identifies a sensory barrier that had quietly cut an older adult off from those around her. Across the stories that follow, the common thread is intentionality: HCSSPs start with the person, listen for what matters, and build from there.

Each vignette is paired with relevant recommendations from the clinical guidelines to show how the stories align with evidence-informed practice. In this way, the section connects the wisdom of HCSSPs in the field with the broader guidance on screening, assessment, social prescribing, social activity, leisure, physical activity, psychological approaches, technology, reassessment, and other interventions. The result is a set of practical, adaptable examples that demonstrate what it can look like to turn evidence into action within everyday care.

Contributor
Social Worker, Ontario

Solving the Mystery of "Self"

The Story

A newly hired social worker in a long-term care home was introduced to a woman in her 70s who had been struggling with identity, loneliness, isolation, and anxiety for three years following an accident that left her experiencing amnesia. The resident could not recall her family members, her past roles, or her own identity, and much of her frustration appeared to stem from this loss. To support her, the social worker helped her "investigate herself and her past" using Google, Ancestry.ca, LinkedIn, and Facebook, gathering information about her personhood, family, and history.

The Impact

Together they compiled an Identity Book containing family obituaries, photos of family members, images of her old home, stories about her pets, and other pieces of her past. The resident became, in the contributor's words, "content, happy, and proud of the book and of herself for feeling a sense of identity." She is more peaceful in her living situation, rarely expresses frustration, and can be easily redirected back to her Identity Book during difficult moments. She has reconnected with family members and made plans to connect with relatives who live far away over the internet.

Evidence in Action

Recommendation #7

Assessment

The social worker moved beyond presenting symptoms (anxiety, isolation) to a biopsychosocial understanding of the resident's life history, cognitive changes, and what was driving her frustration.

Recommendation #8

Intervention: an overall approach

Care was individualized around what mattered most to the resident (identity, family, personal history) rather than defaulting to generic social programming.

Recommendation #12

Psychological therapies

The Identity Book functions as a reminiscence and life-review intervention, using personal history to support meaning, identity, and self-acceptance.

Recommendation #14

Leisure skill development and leisure activities

The collaborative research process itself became a meaningful, structured activity that the resident now returns to for grounding.

Contributor
Administrator or Manager, Saskatchewan

Coordinated Welcome to a New Home

The Story

A long-term care home administrator/manager and interprofessional team supported an older adult who arrived feeling lonely and disconnected after an unhappy experience in a previous residence. Staff began by listening: they took time to learn what mattered most to him, including independence, being able to use his scooter, familiar food, his faith, and small comforts "like a beer at Happy Hour." From there, the care team used a coordinated, relationship-based approach: simplifying his diabetes management in partnership with the physician and pharmacy, removing barriers so he could move freely with his scooter, and ensuring recreation, nursing, and spiritual care staff personally invited him to meals, chapel, and programs by name.

The Impact

In his first days, he mostly stayed in his room, ate little, and had a flat affect. As the plan was implemented, he began coming out independently with his scooter to meals, chapel, and programs without prompting. He started attending Happy Hour, chatting with staff and peers, and joking with the team.

His appetite and sleep improved, his diabetes management became smoother with fewer crises, and he and his family both reported that he felt "at home" and "kept busy in a good way."

Evidence in Action

Recommendation #7

Assessment

Staff conducted a thorough social, functional, and medical assessment, identifying preferences, barriers, and supports rather than focusing on deficits.

Recommendation #8

Intervention: an overall approach

Care was coordinated across nursing, recreation, spiritual care, physician, and pharmacy, with shared decision-making centred on individual values and preferred routines.

Recommendation #10

Social activity

Staff offered "frequent, low-pressure invitations to connect," allowing him to engage at his optimal level (meals, chapel, Happy Hour) without pressure.

Recommendation #17

Reassessment

The team monitored his response to each adjustment, observing changes in affect, appetite, and engagement and adapting accordingly.

Contributor
Administrator or Manager, Alberta

Tea and Conversation: A 48-Year-Old Welcome Program

The Story

A community centre administrator in Calgary has run a program called Tea and Conversation for 48 years. The administrator described it as "often one of the first programs I recommend to someone who has lost a loved one, has been alone for a long time and is very nervous about coming to a new program." New members are introduced to a table of existing participants who are asked to welcome them, and staff monitor whether the placement is a good fit, adjusting as needed. The administrator described a recent participant, a shy widow new to the city with no friends, whose son accompanied her to her first few events.

The Impact

Over time, the new member made friends, began joining in line dancing, and "started to thrive." She has since joined the centre's Board of Directors, and never misses Tea and Conversation unless she's away visiting family.

Evidence in Action

Recommendation #8

Intervention: an overall approach

The program's intake process is individualized where staff ask about likes and dislikes to find a good fit, and adjust placement based on observation.

Recommendation #9

Social prescribing

The program functions as a community-based resource that HCSSPs and family can refer newly bereaved or homebound older adults into.

Recommendation #10

Social activity

A structured, recurring group activity provides ongoing opportunities for sustained social participation, with built-in scaffolding for newcomers.

Contributor
Community Organization Worker, British Columbia

Climbing Out of "the Downward Spiral of Despair"

The Story

A community organization worker met a recently bereaved man who had been married for 67 years; his wife had died just six months after a cancer diagnosis. The couple had retired locally and had few friends, with children living in other provinces. He joined the organization's seniors walking group after seeing a flyer, and by chance another man — also widowed the previous year — attended the same day. The community organization worker accompanied the group for coffee afterwards, and the two men began comparing the very different paths their wives' illnesses had taken to the same end. Both described being in "the downward spiral of despair" and recognized they had to climb back out and find life again.

The Impact

He was listened to in a non-judgmental setting, among people who gave him space to express his emotions. For the first time in six months, he had more than one person to talk to — and he was deeply grateful for having seen the flyer. He was able to ask the other widower questions and learn about additional services and activities in the area. The community organization worker described watching "someone come out of the shell that had formed around him and him smile and laugh with others."

> *"This is not something that individuals alone can tackle. It's like smoking: we need a society-wide response."*
>
> – Physician, Ontario

Evidence in Action

Recommendation #9

Social prescribing

A flyer-based referral pathway connected a bereaved older adult to a community walking group that opened up further peer connections.

Recommendation #10

Social activity

The combination of structured walking and informal coffee afterwards created multiple low-pressure entry points for connection.

Recommendation #11

Physical activity

Group walking provided gentle physical activity alongside the social opportunity, consistent with the Guidelines' emphasis on combining movement with connection.

Contributor
Recreation Therapist, Saskatchewan

From Hospital Bed Back to Community

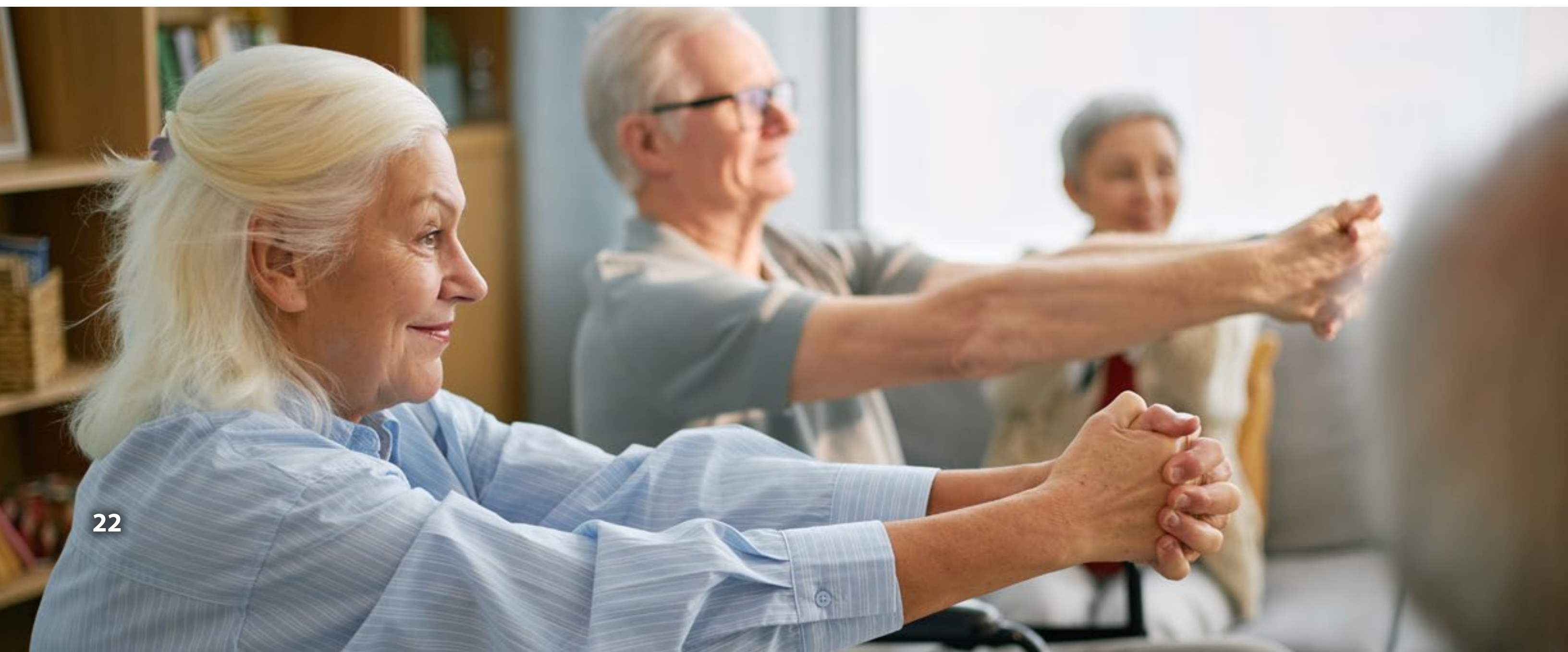
The Story

In early 2024, an older adult was hospitalized with severe shortness of breath and transferred to the Convalescent Unit at Saskatoon City Hospital to recover. She worked closely with the therapies team to regain mobility, strength, and endurance, with the goal of returning to live independently in her own apartment. During her stay, she saw a Recreation Therapist, who assessed her recreation and leisure strengths, challenges, and needs. Together they set meaningful goals focused on social connections during her hospital stay and ways to re-engage with her community after discharge.

The Impact

The older adult made a smooth transition home and began attending the Saskatchewan Health Authority-facilitated "Forever…in motion" program, an adaptive physical activity class for individuals with chronic health conditions, held at Market Mall. She attended with the support of a friend from her building, as planned during her hospital stay.

"Before long, the older adult had transformed one friend into five, strengthening her friendships and creating a supportive community in her apartment building. The group became regular attendees, often adding a shopping trip, groceries, and a shared meal to their weekly outings."



Evidence in Action

Recommendation #7

Assessment

The Recreation Therapist conducted a focused recreation and leisure assessment in hospital, identifying strengths and goals beyond medical recovery.

Recommendation #8

Intervention: an overall approach

Discharge planning was coordinated across the therapies team, the patient, and a community partner, with shared decision-making around what mattered to the older adult.

Recommendation #10

Social activity

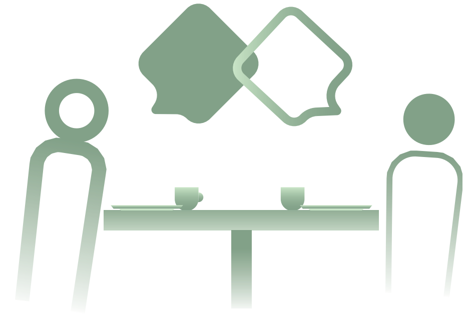
A community-based group activity became the vehicle for sustained peer connection after discharge.

Recommendation #11

Physical activity

An adaptive physical activity class served as both a health-promoting practice and a gateway to deeper social connection.

Contributor
Community Connector / Program Coordinator, British Columbia



A Date With a Senior

The Story

To build rapport and trust with older adults who were isolated, this community connector started an activity called "A Date With A Senior." Because older adults often did not open up during a formal interview or intake, she invited them out to a coffee shop or restaurant of their choice as a point of entry. Over coffee, older adults would begin to share what was going on for them and what they were finding difficult. The conversations then helped the community connector identify their needs and refer them to appropriate resources.

The Impact

One older adult the community connector went out with was leaving her home for the first time since the pandemic. After that initial outing, they continued to meet every two weeks. The older adult began going out again on her own, regained confidence, and was no longer afraid of leaving her comfort zone.

*"She wasn't done.
She just needed a doorway back in."*

– Owner/Programmer, Ontario

Evidence in Action

Recommendation #7

Assessment

Rapport-building through informal, social-setting conversations made it possible to assess needs that would not surface in a standard intake.

Recommendation #8

Intervention: an overall approach

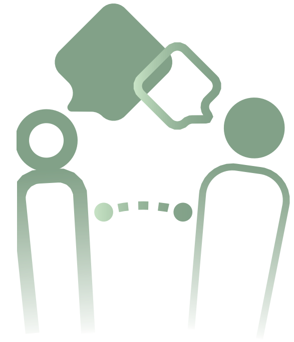
The intervention was shaped around the older adult's comfort, choice of setting, and pace.

Recommendation #10

Social activity

The "date" itself functioned as a structured, recurring social activity that gradually rebuilt the senior's confidence to engage with the broader community.

Contributor
Educator, Ontario



Closing the Digital Access Gap

The Story

Following a joint research study with higher education institutions and the City of Toronto on digital access needs, this educator identified five urgent barriers facing older adults: lack of reliable, affordable high-speed internet; preference for tablets or laptops over small phone screens; need for device setup; need for safe-internet training and social media skills; and additional supports for those with sensory, functional, or cognitive impairments. She developed the Seneca Digital Access Training Team, where students in placement help isolated, low-income seniors obtain devices, connect to free or low-cost internet, and learn to navigate the internet safely.

The Impact

The program has been running for four years in partnership with local libraries and non-profits across the GTA. Older adults have used the access and skills to "link with family, friends, join virtual groups for exercise, social gatherings, topic-related discussions and use online services especially during the winter months." The educator described the result as "lower feelings of isolation" and noted that for some older adults, the access has been "a literal life-saver."

Evidence in Action

Recommendation #9

Social prescribing

The team links isolated, low-income older adults with concrete community resources (devices, internet, training, libraries, NPOs).

Recommendation #10

Social activity

Digital access becomes the gateway to virtual exercise groups, social gatherings, and topic-based discussions.

Recommendation #15

Technology

The intervention directly addresses access, digital literacy, and adaptive supports for sensory and cognitive needs — three areas highlighted in the Guidelines as essential for technology-based approaches.

Contributor
Program Owner / Online Movement Instructor, Ontario

Low-Barrier Entry With Built-In Belonging

The Story

Early in the pandemic, this online movement instructor connected with a woman who had been living alone in a seniors' building and had lost her husband after over 50 years of marriage. She joined one of the morning Gentle Moves Dance sessions on Zoom but kept her camera off for the first few weeks. The online movement instructor described her approach as "low-barrier entry points with built-in belonging" — rather than asking someone to commit to becoming part of a community (which can feel daunting when you're lonely), inviting them into a specific activity where connection happens organically.

The Impact

She started with one class. Within a month she was attending five sessions a week and had her camera on, waving to familiar faces. The online movement instructor watched several key shifts: physical changes (regained strength and balance, with confidence she could continue living independently), social connection (from camera-off observer to active participant who looked forward to specific people in class), and emotional stability (daily routine gave her life structure).

Evidence in Action

Recommendation #10

Social activity

A recurring group activity offered at low barrier and high frequency allowed her to titrate her own engagement.

Recommendation #11

Physical activity

Gentle, group-based movement was the vehicle for both physical and social re-engagement.

Recommendation #15

Technology

Zoom-based delivery removed transportation and mobility barriers and allowed gradual social exposure (camera off → camera on) at the participant's pace.

Contributor
Community Organization Worker, Saskatchewan

Men's Shed: Building Community Side-by-Side

The Story

In a rural community, this community organization worker helped establish a Men's Shed for older adults living in a 55+ rental apartment building. Working with a housing developer, they set up an incentive system that encouraged senior residents to join the Shed and take part in hands-on projects and shared activities. The Shed became a practical, side-by-side space where men could work on tools and projects together while informally getting to know one another.

The Impact

Residents who had previously kept to themselves began coming out regularly for Shed activities, getting to know neighbours and feeling more connected to the building community. The community organization worker observed that the Shed broadened seniors' perspectives, strengthened informal support networks, and created a stronger sense of belonging in the apartment complex.

> *"What they needed most was not a program, but a relationship."*
>
> Administrator/Manager, Alberta
> on the need for relationships

Evidence in Action

Recommendation #10

Social activity

The Men's Shed offers a structured, recurring opportunity for older men to gather, work on projects, and socialize in a way that feels comfortable and familiar, directly supporting engagement in social activity. The "side-by-side" format lowers social pressure while still creating space for conversation, which can be particularly important for individuals who may be reluctant to join traditional or more conversational programs.

Recommendation #14

Leisure skill development and leisure activities

The Shed centres on meaningful, practical leisure activities (woodworking and other tool-based projects) that build skills and a sense of productivity. Using a valued hobby as the entry point for connection reflects the guideline emphasis on leveraging enjoyable, interest-based activities to foster social participation, confidence, and a sense of being useful and valued.

Contributor
Recreation Therapist, Nova Scotia

A Library as a Doorway Back

The Story

This recreation therapist frequently uses the local library as a resource and meeting place with clients. She described it as "usually considered a 'safe' space," quiet, and one that helps people get out into the community while finding out about other library programs, signing out books, and using accessible computers. With one client, the two of them sought out books on whittling — a topic the client was interested in. They ordered some that suited his needs, and when notification came that the books had arrived, the client went back to the library and picked them up on his own. Through the library connection, he also signed up for an e-book app to use on his daily walks. As it turned out, the librarian had been a classmate of the client in their youth.

The Impact

"They started to go to other libraries to source information. This, socially isolated person, eventually extended their connections and after working with me for about 6 months, applied and got a part time job and was making meals a few times a week. Huge win, as before they were always going to their elderly mothers' home for meals, and visits, and not 'hanging' out with peers/others."

Evidence in Action

Recommendation #8

Intervention: an overall approach

The plan was built around the client's specific interest (whittling) and a setting where he felt safe.

Recommendation #9

Social prescribing

The library was used as a community-based resource, with the recreation therapist warmly handing off to a trusted setting and on to further library branches.

Recommendation #14

Leisure skill development and leisure activities

A genuine leisure interest (whittling, reading) anchored the intervention and led to broader community participation and eventually paid work.

Narrative Synthesis

Practice wisdom from the Field

The practice vignettes show social health in action. This synthesis draws the stories together, highlighting the shared mindsets, strategies, and lessons that appeared across the 94 responses. Together, these themes offer a practical roadmap for integrating social connection into clinical and community practice. They show that addressing social isolation and loneliness is not only about creating new programs; it is also about strengthening the everyday practices, relationships, and small moments that already shape connection in clinical and community settings.

Across settings, HCSSPs described social health as a core part of quality care. They recognized that loneliness can affect mood, cognition, motivation, physical health, care engagement, and sense of identity. They also showed that meaningful action often begins with small, intentional acts: a better question, a personal invitation, a practical adjustment, a supported referral, or a moment of genuine presence. These actions may appear simple, but the stories demonstrate that they can profoundly change how an older adult experiences their day, their care, and their place in the world.

Practical entry points for social connection

HCSSPs rarely began with a formal "loneliness intervention". Instead, they often used practical, everyday needs as gentle entry points into deeper connection. Addressing a hearing aid, a ride to the grocery store, a scooter loan, a meal, or a technology question created the opening, and the connection followed. These functional moments built trust, revealed hidden barriers, and created opportunities for older adults to re-engage at a pace that felt manageable.

→ **Functional needs as doorways:** Addressing immediate needs, such as transportation, technology, grocery access, medication routines, hearing aids, mobility equipment, or meal support, often became a doorway into broader social connection. One contributor described how a Food Access Bus designed to address transportation and grocery barriers became a place where participants exchanged phone numbers and started attending other programs together. Another described how treating hearing loss often does more for social participation than any social program, because withdrawal often follows the moment people stop being able to follow a conversation. These tasks gave HCSSPs a natural opportunity to learn what mattered to the person, who was in their support network, and what barriers were limiting their participation.

→ **Low-barrier participation:** HCSSPs described offering options that felt safe, flexible, and non-intimidating: joining a telephone program, attending a coffee group, walking indoors, being personally invited to a meal, observing before participating, or joining a group built around a shared activity. These approaches reduce pressure and allow older adults to take one step at a time. As one contributor advised, "Make invitations personal, gentle, and persistent."

→ **Personal, not just informational, referrals:** Several contributors were candid about the limits of referrals that consist only of a brochure or a phone number. Information alone rarely leads to follow-through, especially for those most isolated. The stories of successful connection almost always involved a warm introduction, a first-time companion, a follow-up phone call, or a partnering organization that made the next step easier.

→ **Restoring purpose and agency:** The stories repeatedly showed that social connection is not only about being included; it is also about feeling useful, valued, and able to contribute. HCSSPs opened space for older adults to share stories, teach skills, contribute to small tasks, welcome others, participate in decision-making, or reconnect with roles that mattered to them. These moments can shift a person's identity from "patient," "resident," or "client" to "helper," "teacher," "friend," "host," or "knowledge keeper."

Recognize that not all loneliness looks the same

The stories make clear that culture, language, identity, and life circumstance shape what isolation feels like and what kinds of connection feel safe. A one-size-fits-all approach to social health risks missing the older adults who are most marginalized and most in need of connection.

- **Cultural safety and identity:** Contributors described the deep value of identity-affirming, culturally grounded spaces for Two-Spirit Indigenous LGBTQQIA+ older adults. These approaches start with relationships, centre cultural connection, and welcome people exactly as they are, opening the door to belonging, trust, and meaningful community.
- **Language and linguistic minorities:** Other contributors highlighted the experience of Francophone seniors in primarily Anglophone settings, Anglophone seniors in primarily Francophone regions, and seniors whose first language is neither English nor French. Offering care, exercise, and social programs in a person's preferred language is not a logistical detail; it is often the difference between participating and staying home.
- **Family caregivers as a hidden isolated population:** Several contributors described family caregivers, especially those supporting a loved one with dementia, as deeply isolated themselves. Including caregivers in the social health conversation, whether through respite, support groups, or simply asking how the caregiver is doing, was described as essential. As one contributor put it, "caregivers are the backbone of our health care system, and their well-being is part of the care plan".
- **Rural, remote, and resource-limited settings:** Contributors in smaller and rural communities described real constraints: limited transportation, fewer programs, longer distances, and stretched staffing. They also described adapting strategies to fit their community rather than importing urban models, and using whatever resources existed (libraries, churches, walking groups, telephone programs) as anchors for connection.

“

Do not simply assume, take the time to understand the cause of social isolation.”

– Community Organization Worker, Manitoba

From individual action to shared responsibility

The stories celebrate the creativity and commitment of individual HCSSPs, but they also make clear that addressing social isolation and loneliness cannot rest on individual effort alone. Many contributors described working within time pressures, staffing constraints, transportation gaps, limited resources, and uneven access to community programs. In this context, social health needs to be supported as a shared responsibility across teams, organizations, communities, and systems.

- **Team-based noticing:** Several stories showed the value of sharing observations across roles. Care staff, nurses, recreation therapists, social workers, physicians, volunteers, housekeeping, spiritual care, and food services may each notice different signs of withdrawal, distress, or re-engagement. When these observations are shared through huddles, care conferences, notes, or informal communication, the whole team becomes better able to respond.
- **Cross-sector connection:** HCSSPs frequently relied on partnerships with community organizations, social prescribing navigators, seniors' centres, libraries, faith communities, schools, volunteers, transportation services, and local programs. These partnerships extended a single point of contact into a broader web of support. The stories suggest that strong community knowledge and warm handoffs are essential, especially for older adults who may feel anxious, uncertain, or overwhelmed.
- **Organizational support:** Contributors also pointed to the need for protected time, training, leadership recognition, staffing support, and sustainable referral pathways. While many HCSSPs found ways to create connection within existing workflows, some described stretching themselves beyond what is sustainable. The challenge moving forward is to ensure that social health is not dependent on individual goodwill alone, but is built into systems of care.

The reciprocal impact: meaning for HCSSPs

Prioritizing social health benefits older adults, but the stories also show that it has a powerful impact on HCSSPs themselves. Many contributors described these moments of connection as deeply meaningful, professionally renewing, and personally affirming. Walking alongside an older adult who smiles again, speaks up in a group, attends a meal, reconnects with family, or regains confidence reminded HCSSPs why they entered this work.

- **Renewed sense of purpose:** Witnessing change in an older adult, especially someone who had been withdrawn, fearful, or disconnected, often reaffirmed the value of the HCSSP's role. These moments allowed contributors to see the tangible impact of relational care.
- **Connection as a source of professional renewal:** Several HCSSPs described social connection as sustaining for them as well as for the older adult. One contributor reflected that being present for someone to share what was on their mind was "relieving" and "good for my own nervous system." These stories suggest that meaningful human connection can counterbalance the emotional strain of busy and complex care environments.
- **Personal connection to the work:** Many contributors brought personal experiences of aging, caregiving, grief, loneliness, family connection, or community service to this work. This made the meaning of these stories feel deeply human, not only professional. Their reflections remind us that social isolation and loneliness are not abstract clinical issues; they are experiences that touch families, communities, care providers, and systems alike.

Taken together, these themes show that social health is both a practice and a culture. It is reflected in how HCSSPs ask questions, notice change, adapt environments, build trust, collaborate with others, and make space for older adults to feel known and needed. The stories offer a hopeful but realistic message: while loneliness is complex, meaningful action is possible. Small, consistent, person-centred actions can create openings for connection, and when those actions are supported by teams, organizations, communities, and systems, they can become part of a broader shift toward care that treats connection as essential, not optional, and that recognizes social health as inseparable from physical and mental health in aging well.

“It’s meaningful for us, too”

Across submissions, HCSSPs described how this work gives back to them as much as it gives to the older adults they serve.

“I am an older adult living alone, and find that volunteering and making a positive difference for others gives me a sense of both purpose and accomplishment, and makes me personally feel less loneliness and isolation.”

– Volunteer at museum, Ontario

“I can be strength for the individual and that makes my heart happy. I am the person helping them find their voice so they can advocate for themselves.”

– Licensed practical nurse, British Columbia

“This work gives me ‘warm fuzzies’ when I know I have made a difference!”

– Educator, British Columbia

“Made me feel like I made a difference. It is one less person in the health care system who is not falling through the cracks.”

– Recreation Therapist, Alberta

“This experience made me feel deeply fulfilled and reminded me why I chose to work in this field.”

– RN Nursing Student, Ontario

“To know that simply allowing someone an ‘outlet’ which can regulate their nervous system, is relieving, and also good for my own nervous system.”

– Community organization worker, British Columbia

“HELP Volunteers describe their work as deeply meaningful because they can see and feel the impact they have on reducing isolation and loneliness in older adults. Many say it’s the reason they stay in the program year after year.”

– Elder Life Specialist, Ontario

Closing Reflection

This project has made it clear that HCSSPs across settings are already doing deep, skilled work to notice, respond to, and advocate around social isolation and loneliness in older adults. Their stories highlight both the creativity and commitment they bring to everyday encounters, and the very real constraints of time, staffing, geography, housing, and system design that shape what is possible in practice. The reflections and tools in this report are not meant to add another layer of expectation, but to name and honour what is already happening, offer language for what often goes unseen, and create small openings for shared learning and change.

Looking ahead, the guidelines and the voices in this campaign point in the same direction: addressing social isolation and loneliness cannot rest on individual HCSSPs alone. It calls for cross-sector collaboration, organizational support, and policy attention that recognize social connection as a core component of health. The barriers described earlier in this report highlight where changes in policy, funding, and system design are most urgently needed. Our hope is that this report will support HCSSPs, leaders, older adults, care partners, and community organizations to keep the conversation going, to adapt these ideas to their own contexts, to advocate for the structures and resources needed to prevent and reduce social isolation and loneliness, and to continue building systems in which social isolation and loneliness are no longer accepted as inevitable parts of aging, but recognized as something we can prevent and address together.

« Personne ne devrait être seul et isolé. La plupart de ces gens ont donné leur vie à la société et ont contribué à ce que nous sommes et ce que nous avons… Briser l’isolement signifie une meilleure qualité de vie et aide à une santé psychologique plus saine. »

(No one should be alone and isolated. Most of these people have given their lives to society and contributed to who we are and what we have. Breaking isolation means a better quality of life and helps support better mental health.)

– Community Worker, Quebec

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