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Scoping Review of the Literature Social Isolation of Seniors

2013-2014

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Introduction

Social isolation is a prevalent phenomenon that has a substantial impact on many aspects of seniors' lives. As Canada's population experiences a profound demographic transition via the aging of the baby boom cohort[1] and lengthening life expectancy, the importance of this issue may become magnified in coming years. An increasing number of seniors may be at risk of social isolation due to such factors as increased probability of living alone, compromised health status, changing family structures, death of family members or friends and retirement from the workplace.

The National Seniors Council (NSC) was directed by Ministers in August 2013 to consult with representatives from the not-for-profit, public and private sectors—as well as seniors themselves—to assess how social isolation affects seniors and to explore ways to prevent and/or reduce it in Canada. To obtain a broader understanding of the phenomenon, a scoping review assessed relevant literature using the following research questions:

- *How does social isolation affect seniors?*
- *What are the best practices and methods to prevent/reduce the social isolation of seniors in Canada?*

Methodology

This scoping review involved a systematic selection, collection and summarization of existing knowledge relating to the social isolation of seniors in broad thematic areas to identify which were well covered and where there were gaps.

Sources of information included electronic databases, government websites, and an e-mail consultation with representatives from various levels of government. Relevant studies identified included peer-reviewed articles as well as grey literature (e.g. research reports, government reports, government and non-government evaluations of programs/services, theses, and policy analyses).

While the intent was to focus on Canadian information, the scope was also expanded to include a number of international sources of information as well. Since seniors are often referred to as "older adults" in the literature, documents including information relevant to both were consulted.

The process started with a list of 214 documents identified using pre-determined search terms (Appendix A) that broadly touched upon social isolation. Fifty-two articles remained in the scoping review after the application of screening criteria (Appendix A). NSC members and Secretariat staff then wrote a summary of each article and created a summary table.

[1] The baby boom cohort generally includes those born between 1946 and 1964. This is the largest age cohort in Canadian history—in 2013 they represented approximately 8.4 million individuals, or nearly a quarter (24%) of all Canadians.

Defining Social Isolation

The concept of social isolation is multi-faceted and defined inconsistently in the literature. It cuts across many areas affecting seniors, including healthy aging, active participation, income security, elder abuse, caregiving, transportation, aging in place and age-friendly communities. Creating a single definition of the concept is therefore highly challenging.

Social isolation is commonly defined as a low quantity and quality of contact with others, and includes "number of contacts, feeling of belonging, fulfilling relationships, engagement with others, and quality of network members to determine social isolation" (Nicholas & Nicholson, 2008).

Socially isolated persons lack social contacts, social roles, and mutually rewarding relationship (Keefe, Andrew, Fancey & Hall, 2006; North Sky Consulting Group Ltd., 2013). As noted in the 2013 Senate Report, physical, economic and social barriers can impact a person's opportunity to participate and be engaged in society. Marginalized individuals tend to be disconnected from society (Senate Committee on Social Affairs, Science and Technology, 2013). Based on a report prepared for the City of Nanaimo, British Columbia, the identification of isolated seniors is influenced by the lack of understanding about the meaning or characteristics of isolated seniors (North Sky Consulting Group Ltd., 2013). The severity of isolation can vary from person to person depending on whether it is voluntary or involuntary; permanent/chronic, episodic, or temporary; or a result of multiple risk factors (British Columbia Ministry of Health, 2004; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007; North Sky Consulting Group Ltd., 2013).

It is important to understand how social isolation and loneliness are related and defined, as well as how researchers attempt to objectively measure prevalence rates, risk factors and consequences. Loneliness is often described as the subjective counterpart to social isolation (Windle, Francis & Coomber, 2011). While social isolation can be measured objectively by observing the social network and interactions of seniors, loneliness can be measured subjectively by questioning perceptions and feelings with regards to social relationships and social activity (British Columbia Ministry of Health, 2004). People can feel lonely even when in the company of others, and conversely, lonely persons are not necessarily socially isolated. At the same time, the effects of social isolation can lead to feelings of loneliness. For example, when an individual expresses or feels discontent with their solitude (Hall, 2004).

The concepts of social isolation and loneliness often appear in a single definition. Some literature argues for keeping the terms separate since combining them may lead to misinterpretation and inaccurate policy development (Cloutier-Fisher, Kobayashi, Hogg-Jackson & Roth, 2006). Other research indicates that a combination of subjective and objective elements should be considered when defining social isolation (Nicholas & Nicholson, 2008).

Overlap with Other Concepts

Lack of consensus on the definition of social isolation poses a challenge for researchers. In addition to feelings of loneliness, the concept of social isolation overlaps with other terms, such as social vulnerability (Social Planning and Research Council of British Columbia, 2011; Association québécoise des centres communautaires pour aînés [AQCCA], 2012), social exclusion, and social disconnectedness (Cornwell & Waite, 2009; Keefe et al., 2006). On the positive side, concepts such as social integration, social engagement and social capital are discussed in the literature (Keefe et al., 2006).

Social disconnectedness is defined as a lack of contact with others. More specifically, it is a lack of participation in social activities, having a small social network or irregular social interactions. Perceived isolation is considered as the subjective experience of lack of social interaction and support (Cornwell & Waite, 2009).

Lack of social integration, networks and engagement are three distinct concepts, even though they are akin to social isolation. Berkman (1995) described social integration as the degree that individuals sustain close personal relationships with others (as cited in Nicholas & Nicholson, 2008, p.1349). Social network relates to the number and structure of social interactions and the proximity of those who can interact with the individual. Lastly, a person who is integrated and engaged interacts regularly with people and participates in social activities. One who is socially isolated does not have a sense of belonging and lacks contacts (Nicholas & Nicholson, 2008).

Prevalence

Research regarding the prevalence of social isolation to support policy measures to address this issue is limited. As per the Report on the Federal/Provincial/Territorial Expert Consultation, conducted in Winnipeg, Manitoba, reports of prevalence of loneliness range between 10 and 90%, depending on the definition and population used (Hall, Havens & Sylvestre, 2003; Hall, 2004). The Centre for Addiction and Mental Health reports that loneliness affects approximately 10% of older adults and is linked to depression and the risk of suicide. This study also noted that loneliness is inversely related to physical health, is more frequent in women, and increases with age (Centre for Addiction and Mental Health, 2010).

According to Victor (2011), in various parts of the UK, it is suggested that between 5 to 16% of older adults are lonely. An estimated 10% of the UK population aged over 65 is lonely at all times or most of the time (as cited in Bolton, 2012, p.5). Victor (2011) also stated that, since 17% of older people are in contact with their families, friends and neighbours less than once per week, and since 11% are in contact less than once per month, the number of isolated older adults at risk of loneliness is probably larger (as cited in Bolton, 2012, p.5).

Risk Factors

The literature confirms that a variety of risk factors increase the likelihood of seniors becoming socially isolated. These have been grouped under five themes: life transitions, economics, health/mental health, caregiving and social.

Life Transitions

Critical life transitions such as retirement (Hall et al., 2003; Winningham & Pike, 2007; Cotten, Anderson & McCullough, 2013), death of a spouse (North Sky Consulting Group Ltd., 2013; O'Luanaigh & Lawlor, 2008; Cloutier-Fisher et al., 2006; Wenger & Burholt, 2004; Stewart, Craig, MacPherson & Alexander, 2001; Hall et al., 2003; AQCCA, 2007; Truchon, 2012), inability to drive (Winningham & Pike, 2007), or moving to a long term care facility or other residence (Winningham & Pike, 2007; Cotten et al., 2013) increase the risk of becoming socially isolated (Keefe et al., 2006). Changing family structures, such as younger family members migrating for work, and smaller social networks in later-life also have an impact on social isolation (Keefe et al., 2006; Butler, 2006; AQCCA, 2012; Cotten et al., 2013). The more critical life transitions and associated risk factors seniors face, the more likely they are to experience episodic or chronic social isolation.

Economic

Economic factors, such as living with low income (North Sky Consulting Group Ltd., 2013; Raymond, Gagné, Sévigny, & Tourigny, 2008; Truchon, 2011; Truchon, 2012), lacking accessible and affordable transportation options (North Sky Consulting Group Ltd., 2013; Hall et al., 2003; Abbott & Sapsford, 2005; AQCCA, 2007; Raymond et al., 2008; Sherman & Lacarte, 2012), the absence of affordable and suitable housing (Hall et al., 2003), and limited access to primary health care services (Abbott & Sapsford, 2005) to meet the varied needs of seniors are also known risk factors for social isolation. These economic factors may also have a cumulative effect on social isolation, for instance, seniors with low income and living in a rural or remote area with few transportation options may be significantly isolated even if they would like to become more engaged with their local community.

Health and Mental Health

Studies show that the lack of a good social network is linked to a 60% risk increase in dementia and cognitive decline; while socially-integrated lifestyles protect against dementia (Fratiglioni, Wang, Ericsson, Maytan & Windblad, 2000). It is likely that mental health affects the likelihood of social isolation, and that persons experiencing social isolation are more prone to mental health issues. As many as 44% of seniors living in residential care in Canada have been diagnosed with depression or show symptoms of depression without diagnosis, and men over the age of 80 have among the highest suicide rate of all age groups (Canadian Institute for Health Research, 2010; Public Health Agency of Canada, 2010). Therefore, the link between mental health and social isolation, while complex and likely bi-directional in nature, cannot be ignored.

Similarly, having a compromised health status (Cloutier-Fisher et al., 2006; Paul, Ayis & Ebrahim, 2006; Raymond et al., 2008; AQCCA, 2011; Truchon, 2012; Cotten et al., 2013), whether it is physical (Butler, 2006; Truchon, 2011) or mental health issues (AQCCA, 2007; Truchon, 2011) has been identified as a risk factor for increased social isolation (O'Luanaigh & Lawlor, 2008). Health problems include but are not limited to: dementia, multi-morbidity (Keefe et al., 2006; Hall et al., 2003), addiction (AQCCA, 2007; Truchon, 2011), and vision or hearing issues (Wenger & Burholt, 2004; Hall et al., 2003). Other late onset or age-related disabling conditions, such as incontinence, frailty, fear of falling when going to and from venues, or general loss of independence (AQCCA, 2007) have also been identified as risk factors for social isolation (Ramage-Morin & Gilmour, 2013).

Caregiving

Another group that is at a higher risk of social isolation are seniors who are caregivers for parents, siblings, or other relatives (Sherman & Lacarte, 2012; North Sky Consulting Group Ltd., 2013; O'Luanaigh & Lawlor, 2008). High levels of caregiving, especially when providing long hours and/or intensive caregiving to someone with significant physical and/or mental challenges, can result in disconnecting from others, and can result in caregiver burden, stress, and depression, all of which are associated with social isolation (Cloutier-Fisher et al., 2006; MacCourt, 2007).

Social

Specific groups of seniors were also identified as being at greater risk of social isolation, such as Aboriginal seniors (Health Canada, 2009), seniors who are newcomers to Canada or immigrant seniors, especially those with language barriers, seniors who are caregivers (Wenger & Burholt, 2004; MacCourt, 2007; Cotten et al., 2013), as well as lesbian, gay, bisexual or transgendered seniors (Guasp, 2011).

Older immigrants (Cloutier-Fisher et al., 2006; Senate Committee on Social Affairs, Science and Technology, 2013; Li, 2010; Truchon, 2011; Social Planning and Research Council of British Columbia, 2011), minority groups and lower income seniors, such as older women living alone (Senate Committee on Social Affairs, Science and Technology, 2013; Truchon, 2011), experience higher risks of loneliness and limited social interaction for a number of reasons, such as language barriers (Li, 2010; Truchon, 2011), literacy, discrimination, lack of sense of community and limited social interactions in their new communities (North Sky Consulting Group Ltd., 2013). Aboriginal seniors face similar issues including language and cultural barriers, socio-economic disadvantages and regional differences, such as living in rural or remote areas (Health Canada, 2009; Cotten et al., 2013).

As per a report published by the Stonewall organization in the UK, older lesbian, gay and bisexual people, when compared to heterosexual groups, are more likely to be single, live alone, have a smaller social network, see their family less frequently, drink more alcohol and are more likely to take drugs, have a history of mental illness, and have more barriers to accessing necessary health care (Guasp, 2011). As these factors are associated with social isolation, older lesbian, gay and bisexual people are more at risk of becoming socially isolated (Guasp, 2011; Truchon, 2011).

Living alone, increasing age (Keefe et al., 2006; Wenger & Burholt, 2004), low education (Cloutier-Fisher et al., 2006; Raymond et al., 2008), rural vs urban living (Raymond et al., 2008), ageism (Truchon, 2011) as well as having no children or limited contact with family (Wenger & Burholt, 2004) have also been identified as factors that increase risks of social isolation. Some older adults also fear leaving their dwelling because of concerns of physical safety in public places due to higher crime rate or perceived higher crime rate (Abbott & Sapsford, 2005; Sherman & Lacarte, 2012), lack of information or awareness to access community services and programs (Raymond et al., 2008; AQCCA, 2011) or being reluctant to form new relationships, or not wanting to go alone to activities (North Sky Consulting Group Ltd., 2013; Gilmour, 2012).

Consequences

Social isolation can have deleterious consequences for seniors that are often difficult to separate from the risk factors associated with isolation (e.g. mental health and social isolation); and furthermore, it is difficult to determine the inter-relationships among these various factors. The results of this association can be self-reinforcing or cyclical patterns of social isolation that become difficult to break. In addition, since social isolation is by definition separation from one's social networks and community, it is often a hidden problem. Consequences of social isolation have been grouped under three themes: economics, health/mental health and social.

Economic

The contributions of seniors to the community, such as through volunteering, decrease when they experience social isolation (British Columbia Ministry of Health, 2004; Raymond et al., 2008). Given the degree to which seniors volunteer and the valuable contributions that seniors provide to the community as a whole, the negative impacts of social isolation should be considered an issue for the entire community (British Columbia Ministry of Health, 2004).

Older Canadians also make an important contribution to the paid economy (Edwards & Mawani, 2011). Seniors themselves and society in general benefit from continued engagement in the labour force (National Seniors Council, 2010): increased income, increased intergenerational learning opportunities, and retention of technical skills, leadership talent and corporate memory. However, many of the risk factors associated with social isolation are also barriers to labour force participation (i.e. poor health, information caregiving responsibilities, ageism, and lack of awareness of opportunities) (National Seniors Council, 2011).

Physical Health, Mental Health and Utilization

The British Columbia Ministry of Health (2004) noted that there are multifaceted interactions between the variables of social isolation, loneliness, use of social services and one's health status. Therefore, it is difficult to determine the direction of causality; that is, the lack of a social network may lead to poor health and/or poor health may lead to the breakdown of the social network (Keefe et al., 2006). Some research indicates that lonely individuals are more likely to use health services (Geller, 1999, as cited in Bolton, 2012, p.20; AQCCA, 2011) or demonstrate inappropriate service utilization (Keefe et al., 2006; Medical Advisory Secretariat, 2008), while other research reveals no significant differences with regards to the use of health services between isolated individuals and their non-isolated counterparts (Cloutier-Fisher et al., 2006).

According to Mistry, Rosansky & McGuire (2001), research has revealed linkages between social isolation and readmission to hospital (as cited in Seymour & Gale, 2004, p.41). Cloutier-Fisher et al., (2006) noted the possibility that socially isolated individuals will be more of a financial burden on the healthcare system in the long run as they often do not seek the medical attention they require until they are older and in poorer health.

Likewise, social isolation and loneliness have been associated with decreased use of services due to lack of awareness or an increased used of services as a substitute to companionship (British Columbia Ministry of Health, 2004; Hall, 2004). Nonetheless, British Columbia Ministry of Health (2004) indicated that seniors with a healthy social network seem to appropriately use health and social services.

Hawton, Green, Dickens, Richards, Taylor, Edwards, Colin & Campbell (2010) investigated the relationship between social isolation and the health status and health-related quality of life of older people who were either socially isolated or at risk of becoming isolated. They demonstrated that social isolation is negatively associated with the health status and health-related quality of life of older people. Moreover, they concluded that the effect is clinically relevant and independent of other factors such as depression levels, physical co-morbidities, age, gender, etc. which has implications for policy makers and researchers (Hawton et al., 2010)

As per Keefe et al., (2006), consequences of social isolation include physical and emotional harmful effects (Li, 2010; Timonen & O'Dwyer, 2010; Cotten et al., 2013), which result in depression (AQCCA, 2011), poor nutrition, decreased immunity, anxiety, fatigue, premature institutionalization and perhaps even death (Keefe et al., 2006). More specifically, the disintegration of the social networks and loneliness from lack of relationships has been identified as detrimental to older people's mental health and well-being (Seymour & Gale, 2004; Hall et al., 2003; Medical Advisory Secretariat, 2008). Fratiglioni et al. (2000) noted that individuals who live alone and do not have a close social network have an increased risk of developing dementia. Therefore, close social ties are seen as a protective factor against the onset of dementia (as cited in Seymour & Gale, 2004, p.37).

Social

Consequences of social isolation can have a negative impact on the community and society as a whole. For example, inappropriate service usage, lack of social cohesion and reduced civic participation and involvement in community activities (Keefe et al., 2006).

Overall, social isolation of seniors can cause communities to suffer a lack of social cohesion (Hall, 2004), higher social costs, and the loss of unquantifiable wealth of experience that older adults bring to our families and communities (British Columbia Ministry of Health, 2004). It can also result in reduced social skills, vulnerability to elder abuse and alcohol or drug addiction (Hall, 2004; Truchon, 2011; Social Planning and Research Council of British Columbia, 2011).

Suggested Approaches to Counter Social Isolation

Hawton et al., (2010) suggested that policy and practices should target seniors at risk of social isolation as individuals need to be identified early with interventions before deterioration of their health or quality of life occurs. By contrast, Dickens, Richards, Greaves & Campbell (2011) indicated that interventions that target people who were socially isolated or lonely were less likely to report positive effects than studies with no explicit targeting. Additionally, Seeman (2000) suggests that social supports can have both health promoting and health damaging effects in older adults. Therefore, aspects of the social environment play an important role in health promotion efforts for older adults (as cited in Seymour & Gale, 2004, p.61).

Literature demonstrates that seniors should be actively involved in program development as well as implementation of changes because they know what is meaningful in their lives, the factors that could place seniors at risk of social isolation, and how to promote social inclusion (Senate Committee on Social Affairs, Science and Technology, 2013; MacCourt, 2007; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007; Hall et al., 2003; Cattan et al., 2005). It was noted by Butler (2006) and the AQCCA (2007) that elder-helping-elder programs tend to be advantageous from a social contact perspective for both the volunteer and the elder. Intergenerational programming has also been deemed a positive approach to help counter social isolation for both seniors and the younger generations (AQCCA, 2007).

As per British Columbia Ministry of Health (2004), most interventions for socially isolated seniors available in the literature are small programs that are population specific. Knowing the target population and assessing possible consequences of planned interventions is deemed important (British Columbia Ministry of Health, 2004). For example, the needs of specific groups such as lesbian, gay, bisexual people were discussed in the literature. It was suggested that guidance for care providers was necessary as was a public campaign on older lesbian, gay and bisexual social and health issues (Guasp, 2011). Health Canada (2009) indicated home assessments could be used to identify isolated seniors in their summative evaluation of the First Nations and Inuit Home and Community Care. Furthermore, they stipulated that by addressing social problems, such as poverty, housing, substance abuse and depression, social isolation among elders could be alleviated.

Dickens et al., (2011) concluded that future interventions should incorporate specific characteristics that have proven to be successful in targeting socially isolated older people. In fact, research literature reports that group interventions are effective for some individuals (Wenger & Burholt, 2004; Cattan, White, Bond & Learmouth, 2005; Medical Advisory Secretariat, 2008; Raymond et al., 2008; MacCourt, 2007). These include social support activities within a group format (e.g. regular meetings at rehabilitation centre, involving elderly individuals, therapeutic writing, physical activities, such as Nordic stick walking, swimming, etc.), and interventions developed within the context of a theoretical basis and where seniors are active participants (Dickens et al., 2011; Pitkala, Routasalo, Kautiainen & Tilvis, 2009). Moreover, it was demonstrated in a study by Winningham & Pike (2007) that by exposing older adults in an institutionalized setting to a cognitive enhancement programme (group-based intervention), it may have a positive influence on the quality of their social networks, cognitive functioning, mental health and quality of life. Support groups can also provide opportunities to share experiences and help to develop coping skills (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007).

Support can arise from a variety of sources. Raina, Waltner-Toews & Bonnett (1999) demonstrated that social isolation and loneliness could be improved by companionship from a pet (as cited by Seymour and Gale, 2004). Another study supports pet companionship as an accessible coping mechanism for older women living in the community (Krause-Parello, 2008).

In a report for the Mental Health Commission of Canada, it was noted that there is a need to raise awareness among seniors, the general public, and health and social service providers to dispel the myths about aging. As well, helping individuals to identify the signs and symptoms of mental health problems could increase early detection and interventions (MacCourt, Wilson & Tourigny-Rivard, 2011).

The use of the internet as a means to reduce feelings of loneliness and increase well-being was studied by Sum, Mathews, Hughes & Campbell (2008). It was suggested that increased use of the internet as a communication tool was associated with decreased social loneliness (Sum et al., 2008; Seymour & Gale, 2004). White, McConnell, Clipp, Branch, Sloane, Pieper & Box (2002) also conducted a randomised controlled trial that assessed the psychological effect of providing internet access to older adults, where this resulted in lowering loneliness and depression (as cited by Seymour & Gale, 2004). The feasibility of using low cost videophones between nursing home residents and their families was conducted by Mickus and Luz (2002) and demonstrated that this technology reduces isolation of older people living in institutions (as cited by Seymour & Gale, 2004, p.62). Authors stipulated that seniors should be trained to use specific internet functions to help reduce loneliness and increase well-being (Sum et al., 2008). Cotten et al., (2013) also indicated that internet use helps to counteract effects of social isolation. As per Lennon & Curran (2012) attitudes towards social networking (e.g. Twitter, Facebook) are positive among older users; however, they do not like to be pressured into being active on social networking sites.

Federal Initiatives

The federal New Horizons for Seniors Program (NHSP)[2] is also described in the literature as a program that encourages seniors to contribute to their communities through active and social participation (MacCourt, 2007; Senate Committee on Social Affairs, Science and Technology, 2013). The summative evaluation of the NHSP (2010) revealed that projects that are based on community collaborations and raise awareness of or improve seniors' access to available resources and services help seniors to form and strengthen connections and engage in formal and informal social support networks. The evidence indicates that in many cases, these connections endure beyond the life of the projects.

In addition, the federal government collaborates with provinces to promote the World Health Organization's Age-Friendly Communities Initiative that has a purpose of making communities better, healthier and a safer place to live for seniors. Included among its goal are ensuring transportation is accessible and improving access and opportunities for seniors to participate in civic, cultural, employment and volunteer activities in their communities (Senate Committee on Social Affairs, Science and Technology, 2013.

[2] The New Horizons for Seniors Program (NHSP) is a federal government program that provides funding ($45M annually) to for-profit and not-for-profit organizations to support projects involving seniors. More specifically, through NHSP funded projects that support the program's objectives of promoting social participation, mentoring and volunteering, communities are able to support seniors' involvement in their communities, therefore mitigating the risk of social isolation. Currently, 24 pilot projects are being funded under NHSP to specifically address social isolation.

The federal government also supports numerous programs that indirectly reduce risk factors associated with social isolation; these include pension programs and housing support programs.

Provincial/Territorial Initiatives

There are many provincial and territorial programs and services that currently address social isolation either directly or indirectly. Ciliska, Hayward, Thomas, Mitchell, Dobbins, Underwood, Rafael & Martin (1996) demonstrated that home visits by public health nurses with all groups in Canada has been shown to be effective in countering depression and showed reduced levels of care required for older people (as cited by Seymour & Gale, 2004). Likewise, recommendations from Hall et al. (2003) include establishing home visiting services for seniors who are unable to participate in community programs as well as supporting service providers and volunteers to spend extra time with homebound individuals who are at risk of social isolation. As per Timonem & O'Dwyer (2010), delivery volunteers of meals on wheels programs can also have a positive impact on the lives of socially isolated seniors.

British Columbia Ministry of Health (2004) noted that peer visiting models are the most common type of programs with the goal of reducing social isolation and that many Canadian cities have established this type of program. Cattan et al. (2011) examined the impact of telephone befriending programs on older people's well-being. Their study found that such a low-cost program helped older people to gain confidence, re-engage with the community and become socially active.

Another strategy that facilitates access to community resources is the *BC Health and Seniors' Information Line,* which provides information to seniors about provincial and federal health and social services via a 1-800 telephone number. Information representatives can also respond to questions about services for seniors, provide direct contact to other agencies and assist in filling out forms (MacCourt, 2007). Examples of strategies that facilitate social participation and promote wellness include the *BC Healthy Aging through Healthy Living: Blueprints for healthy aging* (MacCourt, 2007).

Community Initiatives

Since caregiving places seniors at increased risk of social isolation, adult day programs or in-home respite can provide caregivers with relief to run errands, attend appointments and remain socially engaged (MacCourt, 2007; Wenger & Burholt, 2004; Sherman & Lacarte, 2012). Furthermore, by providing in-home support for activities of daily living, frail seniors may be able to conserve their energy for activities that are meaningful to them, such as social activities (MacCourt, 2007).

Linkages between transportation and level of participation in social activities were discussed in the literature. Access to public transit, taxis and car pools are of great value especially for seniors (particularly women) who are less likely to drive after the age of 85. It was stipulated that organizations that offer services to seniors should also be encouraged to offer them transportation and/or for communities to ensure that accessible transportation options are available for those with limited mobility (Turcotte, 2012; Hall et al., 2003; Pinquart & Sorensen, 2001; Abbott & Sapsford, 2005; AQCCA, 2007).

Other than transportation, access to information about available resources, services and education for seniors using a variety of methods that are sensitive to potential barriers such as literacy and communication impairments are also strategies that facilitate access to community resources (MacCourt, 2007; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007; Hall et al., 2003; AQCCA, 2012). Moreover, staff and volunteers should be supported and provided with ongoing training opportunities to ensure that they understand social isolation and identify those at risk of social isolation (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007; Cattan et al., 2005; Paul et al., 2006).

The Ottawa Public Health Community Connect Program (2013) provides information on the signs that older adults may be at risk of social isolation. The program helps to link socially isolated or at-risk older adults with services and supports to ensure their safety and independence in their home. It also offers training to those who have regular contact with older adults.

Conclusion

Social isolation is being examined in Canada and abroad and promising practices are emerging. However, preliminary literature scans suggest that data remain limited and that more studies of efficacy and effectiveness are needed to improve evidence-based interventions.

Numerous documents recommended further research in various areas associated with social isolation, such as addressing psychological and emotional characteristics of urinary incontinence (Ramage-Morin & Gilmour, 2013), and interventions for other common causes of aging-related disability and loneliness, such as mobility issues and vision loss (Medical Advisory Secretariat, 2008).

Research that would develop a profile of seniors who are socially isolated, which describes characteristics and consequences of social isolation at various levels (individual, community and societal levels), as well as national consultations on social isolation among seniors is recommended by Hall (2004). Hall (2004) also discussed further investigation into sustainable funding and evaluation components for social programs and services. In addition, it was recommended that evaluating existing programs at the community, provincial and national levels and scanning these programs/services to determine where gaps remain is needed (Hall, 2004; Cattan et al., 2005).

The British Columbia Ministry of Health (2004) suggested future research directions that included exploring the experiences of different ethnicities with loneliness and social isolation; examining the interaction of loneliness with poverty; focusing research on transportation; investigating the experience of caregivers of spouses who have a disability; identifying direct linkages between social isolation and service usage; and exploring what elements of social support enhance health.

Research evidence is necessary to guide program and policy development as well as to justify funding for program evaluation to ensure that programs addressing social isolation are able to demonstrate efficacy, effectiveness and accountability (MacCourt, 2007).

This scoping review has identified that, while there is a considerable amount of knowledge pertaining to the causes, consequences, services and programs addressing social isolation of seniors, numerous gaps remain.

Appendix A: Criteria for the Selection of Literature

Research question: What is known from the existing literature about "how social isolation affects seniors and best practices and innovative ways to prevent and/or reduce the social isolation of seniors in Canada?

Identifying Relevant Literature: The process to identify relevant literature involved searching accessible electronic databases, government websites and an email consultation with representatives from various levels of government. Relevant studies included peer-reviewed articles, along with grey literature (e.g. research reports, government reports, government and non-government evaluations of programs/services, theses, and policy analyses) within the 2000-2013 time range. The National Seniors Council (NSC) Secretariat staff provided support through this process.

Search terms: The following search terms were used when searching databases, journals, and government websites. These were applied in both English and French. Per the search criteria, article titles had to contain words related to the topics of social isolation and seniors. The full body text of articles had to contain words related to the causes, consequences and potential best/promising practices. A variety of synonyms were applied to identify a broad amount literature:

- Social… isolation, desolation, remoteness, segregation, aloneness, detachment, reclusiveness, retreat, withdrawal, capital, exclusion, integration, participation, networks, loneliness
- Seniors, older adults, elderly, elder, aging, frail, retired
- Causes, risk factors, determinants, root, antecedent
- Consequences, effects, repercussion, reaction, aftermath
- Initiatives, best/good/promising practices, interventions, solutions, activities, support

Inclusion Criteria:

- Written between 2000-2013 inclusively (greater value is placed on more current sources of information)
- Focus on social isolation *and* seniors
- Contain original research on the following themes:
    - risk factors and/or consequences related to social isolation of seniors
    - the extent of the social isolation of seniors in Canada
    - best/promising practices to prevent/reduce social isolation of seniors
- Contain a transparent and clear methodology
- Provide gap-analyses (of data and of programs/services)
- Both the NSC and the Government of Canada has permission to:
    - access the text
    - reference the text in the scoping review and the NSC's 2013-2014 final report
- Meeting fair proportion of material/content quotas, including:
    - the themes identified above (risk factors, extent and best/promising practices)
    - diversity of seniors groups
    - information (evidence) drawn from the different Canadian regions
    - international and domestic information
    - qualitative and quantitative empirical evidence

- Articles that have been specifically recommended for inclusion, or identified as key/critical to seniors' social isolation by consulted partners
- Key/critical publications identified during the consultation process, including the regional roundtables

Exclusion criteria:

- Published in or prior to 1999 inclusively
- Unrelated to social isolation
- Articles that are non-seniors-related
- Commentaries, editorials, or news articles
- Non-English/non-French language
- Topics already covered (need to ensure proportionality of studies as per the content quotas). In the event of duplication, articles that meet a greater number of inclusion criteria will be given preference.

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