

**Report on the FPT Expert Consultation:**

# **Workshop on Social Isolation and Seniors**

**Winnipeg, Manitoba  
November 25 – 26, 2004**

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## **Workshop on Social Isolation and Seniors Winnipeg, November 25-26, 2004**

A group of individuals (see Appendix I) with interest and expertise in the topic of social isolation among seniors met in Winnipeg in November to help inform federal, provincial and territorial ministers responsible for seniors. They discussed the current knowledge regarding social isolation, its definition, characteristics, and negative consequences for Canadians. The goal of the workshop was to determine whether social isolation is an emerging issue warranting attention, and if so, what could be done to address it. This report is a synthesis of preliminary information provided as background information for the discussion, the discussion itself which highlighted the importance of the issue, and recommendations for action in the areas of policy, programming, and research.

### **Introduction**

Social integration and the participation of older adults in society are frequently seen as indicators of both healthy aging and healthy communities. However, an increasing number of seniors may be at risk of being socially isolated. This can be precipitated by a number of factors such as increased likelihood of living alone in older age, multiple role loss through retirement or the death of a spouse, mobility problems, financial difficulties, and/or poor health. With current trends such as those that encourage seniors to live longer at home or in the community, a highly mobile society and changes in family structure such as fewer children per family, the issue of social isolation takes on increasing importance. Previous research exploring these and other influences on isolation is meagre and debate continues as to the extent of social isolation evident among Canadian seniors and negative outcomes relating to a lack of social engagement. As well, effective means to identify those living in situations of isolation remain elusive, which may hamper the development of intervention strategies.

### **Definition**

Delisle (1988:361) suggests that social isolation, or solitude, “denotes a lack of...quantity and quality of social contacts”. In other words, a situation of social isolation involves few social contacts and few social roles, as well as an absence of mutually rewarding relationships with other people. This situation can occur in older age as a result of retirement and the loss of daily contacts related to work, from death of family members or friends, or through a change of residence that may be necessitated by declining health coupled with the absence of regular caregivers. The continuum of social integration puts social isolation at one extreme and social participation at the other.

*Social isolation* occurs on three levels, micro (individual), meso (community<sup>1</sup>) and macro (society), and encompasses physical dimensions<sup>2</sup>, mental health and

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<sup>1</sup> The term community is used broadly to refer to groups of people with common interests.

<sup>2</sup> Physical isolation occurs when ecological obstacles (such as characteristics of where one lives) impede a person's ability to communicate with others.

psychological dimensions<sup>3</sup>, and social dimensions<sup>4</sup> (Delisle 1999, Delisle 2005). Most of these phenomenon occur at the individual (micro) level, but they also have mesosocial and macrosocial dimensions. For example, at the individual level, physical isolation could occur due to geographic distance coupled with inadequate transportation (e.g., living alone or far from other people), architectural features of a building or the time schedule of the individual and categories of people (e.g., spending long periods of time alone because of the lifestyle of the relatives). For groups, physical isolation refers to the fact of living in a remote area, to residential segregation in urban environment or to the occupation of some places by groups permanently or at some periods (e.g., segregated housing, senior centers). Social isolation can be more or less severe, and has a temporal dimension; that is, it could be permanent, periodic, or episodic if related to life cycles or life transition phases.

According to Delisle (1988:365), social isolation results “from a combination of socio-economic/cultural factors related to industrialization which interact with individual characteristics”. Social cohesion is dependent on a society’s politics, religion, mores, and norms. For example, relations in pre-industrial society were guided by the logic of mutual assistance, where extended families were the norm and older family members were cared for as long as possible. With industrialization, however, young adults have tended to separate from their families, and extended families have become scarce. Delisle (1988:369) suggests “these factors have contributed to the marginalization of the elderly, reducing them to ‘collective solitude’ and in danger of imminently becoming individually alone.”

Most important are the activities that form social roles. In pre-industrial societies older and younger people lived and worked in similar temporal, spatial and social spheres; for example, working side by side in farming communities. Today, younger and older people tend to do different activities, with the expectation that older people will retire from work activities and thereby lose their traditional social roles related to work. We might then described older people as marginalized, or socially excluded, in that they have lost their opportunity to participate in their communities because they no longer have a role or a voice. If new activities are created, however, older people can become re-integrated. Social isolation will be less likely if mutual assistance is a principle in the community and if reciprocity is the norm. Personal social skills obviously also influence the experience of isolation. These are more developed for some people than others, and are determined partially by culture, social class and gender.

While the concept of social isolation refers generally to individual situations, it should be remembered that these situations are socially determined. As Delisle summarized at the workshop, “social isolation thus describes the absence of relationships between individuals or groups in terms of minimal sociability. Social isolation is socially produced, and society recreates and reinforces new forms of

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<sup>3</sup> Mental solitude is an individual phenomenon that refers to the cognitive states of mind of people who are not in communication with others, such as might result from preoccupation with personal issues. These states could be temporary, episodic or permanent, total or partial. Biopsychic causes of mental solitude include physical and mental health problems.

<sup>4</sup> The social dimensions of isolation refer to politico-economic or sociocultural factors, including phenomenon that contribute to the marginalization of groups such as socioeconomic status or minority group status influenced by factors such as language, religion, social values, and norms of behavior

isolation.” Marginality and group exclusion enhance the probability that group members could be mentally or socially isolated because marginality reduces the number of people with whom an individual could interact and could develop gratifying relationships (Delisle, 2005). While most older Canadians are integrated within their families and communities, opportunities for interactions are affected by such trends such as changing family structures that reduce access to familial supports among those with no/few children and/or those who become divorced or separated, and changing access to social resources such as the dismantling of the welfare state and with it, provisions for those in need of supportive resources (Penning, 2005).

*Loneliness* is distinct from social isolation. Some individuals choose to live alone (self-exclusion) because they prefer it. It is when one feels or expresses a sense of dissatisfaction with his or her solitude that the effects of social isolation become feelings of loneliness. In other words, as DeJong-Gierveld (1987) suggests, loneliness can be described as negatively perceived social isolation. Loneliness is therefore a possible outcome of a small number of social relationships; but socially isolated persons are not necessarily lonely, and lonely persons are not necessarily socially isolated. Some people with a small number of social contacts will consider themselves lonely, while others will not. The latter situation might also apply to people who prefer to be alone or who opt for privacy as a means to avoid unwanted or unnecessary social contacts and relationships, perhaps as a lifelong preference. While many of the factors relating to isolation are believed to relate to loneliness, no direct association between loneliness and isolation has yet been documented (Wenger et al., 1996). The important difference is the aspect of choice. Choosing solitude, or self-exclusion as opposed to social exclusion (not a choice), will likely not result in loneliness.

*Social structures*, such as social networks and social support, are also relevant to the concept of isolation. Social networks are characterized in different ways, for example, size, density, distribution, dispersion etc., with network size receiving the most attention (Binstock & George, 1996). Chappell and Badger (1989) concluded that social networks can affect one’s psychological well being. The size of the social network presumably measures one’s potential social supports, which is the actual interaction with others including the assistance that a person provides and/or receives from another. Social networks can therefore be viewed as the structure through which social support may be provided and that facilitates interaction. They are the ties that link people together in definable patterns, such as family relations, friends, colleagues, or acquaintances (McDowell & Newell, 1987).

While the aging process itself forces people to change relationships and roles (as in married people becoming single again due to death of the spouse, or workers becoming retired), the remaining question is why some older people are more likely to experience the negative consequences of isolation than others. Knowing the characteristics of these individuals and the circumstances of their communities would help to determine what could be done. Understanding an individual’s ability to participate, as well as the community’s ability to encourage participation can help to enhance individual capacities on the one hand and community capacities on the other.

## **Possible Factors Contributing to Social Isolation**

Research into social isolation has consistently found a link to various individual and social characteristics related to older age. Female gender, widowhood or divorce, culture, education, income, and health have all been found to influence the experience of social isolation (Adams et al., 1989; DeJong-Gierveld and Van Tilburg, 1995; Holmen et al., 1992; Mullins & Elston, 1996). Other factors include changes in life events such as retirement and widowhood, nursing home placement, living alone, reduced participation in social activities and transportation problems (Hicks, 2000; Holmen et al., 1992; Ryan, 1998; Walker & Beauchene, 1991; Woodward & Queen, 1988). While the research has shown all these risk factors to be associated with social isolation, it has been difficult to determine interrelationships among them. For example, does poor health lead to isolation, or does living in an isolated situation predispose one to poor health?

Participants at the Workshop on Social Isolation and Seniors (WSIS) listed the following factors that contribute to social isolation:

### Physical dimensions:

- Living alone (and other unsatisfactory living arrangements)
- Displacement (involuntary: e.g., move to a nursing home)
- Distance to/from (geography)
- Harsh Climate
- Homelessness
- Lack of space to gather (e.g., no places to socialize)
- Housing
- Transportation (inability to access, not able to drive, etc.)

### Mental Health dimensions:

- Lack of interest (in social resources and opportunities)
- Abuse issues
- Cognitive impairment
- Mental health issues
- Depression
- Introversion
- Interpersonal conflicts/other social problems
- Social skills/personality (e.g., lack of self esteem)
- Perceived in/security
- Coping with loss

Social dimensions:

Minority group member  
Being alone  
Language/literacy  
Education  
Lack of adequate income  
Older age  
Gender  
Widowed/divorced  
Care giving/receiving  
Expectation of self-reliance  
Family conflicts  
Disenfranchisement from formal care services  
Ageism  
Out-migration of youth  
Change in family structure (children later, less of them, etc.)  
Lack of awareness resources and opportunities  
Lack of access to resources and opportunities  
Cultural expectations  
Narrowing of support systems  
Lack of means to communicate (phones, computers, bank machines, voice mail)  
Lack of sense of community (cocooning of society, e.g., gated communities)  
Isolating influences of technology (technology replacing people)  
Norms of self-reliance/independence ("logic of privacy")

The following physiological characteristics also contribute to social isolation:

Physical impairment  
Vision and/or Hearing loss  
Illness  
Frailty

## Possible Consequences of Social Isolation<sup>5</sup>

WSIS participants identified the following consequences *for individuals*:

- Declining health (physical & mental)
- Depression
- Diminished quality of life
- Loneliness
- Inappropriate social contacts (as in use of health care workers for social contacts, and being alone on the street due to lack of continuity of social contacts)
- Potential for abuse (substance & other)
- Service utilization (more or less than needed)
- Caregiver burden - greater/lesser reliance on a small number of caregivers
- Premature institutionalization
- Premature death

Consequences *for community and society* were also noted:

- Lack of social cohesion
- Neighbourhood deterioration
- Ageism (stereotypes limit interaction)
- Economic costs (increased utilization and inappropriate responses, i.e., medications)
- Negative attitudes about quality of life for older people (may mean that resources are not in place when needed)
- Lack of engagement in citizenship (individuals are not benefiting from being involved in their communities, and the community does not benefit from their participation)

**NB:** WSIS participants noted it is difficult to distinguish clearly what could be a cause or a consequence. It was suggested then that we might rather think in terms of the **attributes** associated with social isolation, i.e., either causes or consequences depending on the context and the particular group in question (Delisle, 2005).

Many researchers have documented a negative relationship between isolation and/or loneliness and health. Mullins et al. (1996), for example, found that a decline in physical mobility may impede one's ability to get out and about and therefore interact socially. Similarly, a decline in vision and hearing can affect the ability to communicate,

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<sup>5</sup> It was noted by the WSIS participants that there is a strong interaction between many of the consequences, for instance, declining health and risk of institutionalization, and also that social isolation may result not just from the level of contact, but also from changes in the frequency and quality of contact, perhaps as a result of declining health and cognition.

which can have an isolating effect. Recent research from the USA found that disease combined with disability in later life has a significant impact on social engagement, thereby influencing life satisfaction (Jang et al., 2004). Keller-Cohen and associates (2004) have also reported that communication skills may be diminished with social isolation, and it has been suggested that a poor self-rating of health and low morale might exacerbate social isolation (Wenger et al., 1996). For those who become ill and are homebound, home care workers may provide the main social contact (Hall et al., 2003). Illness can also be especially limiting for caregivers, who are often spouses. When caregiving becomes a full-time activity, the spouse's opportunities for social contact also become severely restricted (Hall & Havens, 1999).

The direction of causality between social support and health is unknown; that is, the lack of a social support network may lead to ill health, but also, ill health may lead to disintegration of social support. Auslander and Litwin (1991) found that people who viewed their social networks as supportive showed a higher level of emotional and functional health, resulting in higher self-ratings of health. In another study, Foster and Stoller (1992) examined the impact of health and social support on mortality of people aged 65 or older. They found no evidence that a larger social network or help with instrumental activities increased the likelihood of survival.

A relationship between social engagement and health service use, either more or less use, has also been suggested. For instance, some researchers have found an increase in the use of health care services such as home care, and medication use has been associated with the perception of a restricted social environment (Bosworth & Schaie, 1997; Russell et al., 1997; Hall & Havens, 1999; Wilkins & Beaudet, 2000). Penning (1995), however, found that isolated seniors with high levels of instrumental support from families tended to use fewer services. It has been suggested that social support may exert an indirect influence on health status and service use through need or perceived need (Kouzis & Easton, 1998).

### **What more do we need to know**

While there appears to be considerable interest in social isolation and loneliness<sup>6</sup>, the research to date is meager and inconclusive. Reports of prevalence range from 10% - 90%, depending on the populations studied and the definitions used

(Hall et al., 2003; Delisle, 1988; Duggan & Kivett, 1994; Forbes, 1996). Gender differences have not been fully explored, with some studies suggesting women are at greater risk (Kivett, 1979) and others that men are at greater risk (Mullins & Elston, 1996, Mullins et al., 1996). A Manitoba study, for example, found that women were more likely to be widowed, live alone, and experienced poorer health; however, female gender was not found to predict either social isolation or loneliness (Havens et al., 2004). Other sub-populations of seniors may also be a risk, such as the geographically

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<sup>6</sup> Over the past year alone, The Aging in Manitoba study has received over 30 requests nationally and internationally, from researchers, practitioners, students, teachers, and policy makers for information on their research on social isolation and loneliness.

isolated, those living in poverty, and those who may be isolated because of cultural expectations and/or language. These influences, however, have not been fully explored.

In addition, while research has consistently demonstrated a strong association between isolation, loneliness and health, debate remains as to which is the cause and which the consequence (Ryan, 1998). For example, some researchers have suggested that loneliness may result from less contact with others due to ill health (Jerrome, 1991; Mullins et al., 1996), while others feel that loneliness and limited social contact precede ill health (Cattell, 1988; Koedoot & Hommel, 1993; Ryan & Patterson, 1987; Wenger, 1984). Therefore, forthcoming research on social isolation requires 'methodological imagination' because of the holistic character of the phenomenon. Comprehensive qualitative and quantitative research should consider the interactions of different factors at different levels of determination (Delisle, 2005).

## **Development of a Policy Framework: Discussion of Directions for Action**

To facilitate the discussion of a recommended framework for the development of policies and programs to address social isolation for seniors, WSIS participants focused on the gaps in existing information, issues regarding existing policy, and recommendations for the development of new programs and policies.

### Gaps in Current Knowledge

1. In light of the confusion about what constitutes social isolation, there is little information to date about the extent of the issue. For example, there is no existing profile of older Canadians who are socially isolated: who are they, where are they, what are the consequences of isolation? Having sufficient and valid information is a key priority to enable effective decision-making around policies and the creation of successful interventions.
  - The first challenge to obtaining this information for the Canadian context is to define specifically what social isolation is; that is, how isolation can be defined for individuals and what influences situations of isolation at the mesosocial and macrosocial levels. A holistic study of multiple contextual influences and the interactive effects among them will help us to understand the complex social processes that produce situations of isolation.
  - A profile of Canadian seniors who are isolated must focus on diverse social contexts. This will require multiple studies examining differences in terms of ethnicity, gender, geographic location, income levels, living arrangements, access to services, different patterns of care-giving and preferences for care-receiving, etc.).
    - While it is understood that seniors are not a homogeneous group, there appear to be patterns and precipitating characteristics that may be common (such as lack of affordable transportation), and others that are specific to a particular context (such as lack of services in various languages).
    - It is also understood that certain groups of people, such as widows and those living alone, are at increased risk of isolation. The exploration of the dynamic

paths that lead to isolation will enhance knowledge and more adequately target interventions.

- A profile of those who are socially isolated would also benefit from an investigation of those who are socially integrated, and those who do not experience the negative aspects of isolation despite experiencing situations similar to those who are negatively affected (e.g., focus on the positive as well as the negative aspects). As well, there exists little information about what might contribute to prevention. Those with similar risk factors but who are not negatively influenced by isolation will provide additional information to aid the development of preventive programs and services.
  - The discussion of social isolation and social integration must also involve questions of measurement; for example, distinguishing differences and similarities in degree of social interaction, as 'coffee with friends' versus more formal opportunities for interaction such as through seniors' clubs.
  - A comprehensive picture of socially isolated individuals must include longitudinal as well as cross-sectional information in order to understand how situations of isolation might remain stable across adult years or might change in light of particular circumstances (e.g., widowhood, residential moves, health and economic changes, shifts in social trends, etc).
    - A few longitudinal studies are currently available that can be utilized to answer some questions about previous cohorts of seniors (i.e., Aging in Manitoba, and the Canadian Study of Health and Aging). Combining existing quantitative data with retrospective qualitative data will help to focus more specifically on questions regarding the components and consequences of social isolation.
    - A focus on only existing data however would provide limited information about future generations of seniors. The forthcoming Canadian Longitudinal Study of Aging (CLSA) will also help to answer questions about future populations of seniors. For instance, changes in technology, the increased mobility of Canadians, the trend toward smaller families, and more women in the paid work force will mean that future seniors may face different situations of social isolation. In this regard it will be essential that the CLSA be adequately funded for the continuation of data collection and data analysis over the next decades, and especially over changes in federal government authority.
2. A second area where more information is needed concerns the consequences of social isolation.
- The extent of individual and social costs in terms of lost opportunities for social participation is not well understood.
  - The economic costs of isolation, specifically in terms of use of health and social services (appropriate vs inappropriate), have not been examined.
  - The nature of the relationship between social isolation and health and well-being is still open to speculation. More information is required to clearly understand

how physical and mental health status influence isolation and how situations of social isolation influence overall and long term health.

3. Third, there is a need for comparative information from other countries to help assess Canadian experiences of social isolation. This could include information about determinants, consequences, and programs for prevention and intervention.

### Problems with Current Policies and Programs

1. There is little clear information about how existing policies and programs affect social integration or situations of isolation among seniors, at any level.
  - Current public policies should be assessed to determine how they influence social isolation, positively or negatively. Examples include changes in provincial home care, and programs of tax credits.
    - There is an understanding that those who are invisible, as are the socially isolated, are often unaware of options and resources that may be available, such as the Guaranteed Income Supplement for low income seniors.
  - An evaluation of existing programs at the community, provincial, and national levels will identify which are particularly effective, and where gaps remain. For instance, are targeted activities achieving what they were meant to; if not, why?
    - Policies relating specifically to housing and transportation need to be critically reviewed to assess impacts (e.g., housing with little or no space for socializing, and transportation programs that are restricted to daytime trips, or for medical appointments only).
  - Knowledge transfer also needs to be explored; for example, how is information on effective programming helping to inform policy; conversely, how does policy affect service delivery?
2. It is important to recognize effective initiatives that may already be in place; e.g., beneficial low cost interventions are already in place in some communities, such as congregate meal programs, home visits, informal groups of volunteer drivers, etc.
  - Programs and policies that have positive affects must be sustainable, requiring in many instances, long-term continuation of short-term project funding.
  - Many effective community programs are volunteer run, often by seniors themselves. Recognizing volunteer contributions and supporting their efforts will help to sustain commitment.

### Recommendations for the Development of New Programs and Policies

1. The Need for a Multi-faceted Approach
  - Services should be integrated, for instance through a team approach linking health and social services.
    - An integrated system could affect the continuum of isolation, from prevention through intervention, helping to further the understanding of what is meaningful for both.

- Integration could be based on a service coordination approach, for example, combining programs such as family services and housing.
- Integration would need to be non-bureaucratic in order to ensure access by those most in need and ensure access at numerous points along the continuum of service.
- Policies that are embedded in one domain may have pre-determined results; e.g., if policies to address isolation are developed only with health ministries, the issue might be perceived as one of individual mental illness, which therefore would not likely address what is needed at the broader levels of public health or social service.
- Social policies need to support and reinforce community infrastructure.
- Appropriate models should be based on community development, complemented by community-based programming.
  - Neighbouring and small, informally based activities should be encouraged or enhanced.
  - A community development infrastructure will support and enable people to make connections on their own.
  - Informal community based programming must not be seen to be a replacement for needed supports, such as home care.
- Policies that are multi-faceted must not be so broad that interventions will not be focused on those most in need.
- There is a potential for private/public partnerships to address isolation; for example, housing initiatives, meal programs, fundraising for community services, etc.
- The development of policy, programs, services and related activities at all levels must include the meaningful input and involvement of seniors.
- Support for integrated policies and programs must be sustainable. If funds are tied to a particular portfolio, for instance, they may be in danger of being reallocated to other initiatives.

## 2. The need for Evaluation and Follow-up

- There was general agreement among the WSIS participants that an evaluation component must be included to assess the potential for negative consequences of all new and existing programs and policies.
  - This would involve an inter-sectoral scan to determine what is not being done in order to help establish a framework to identify risks and negative consequences of isolation.

### 3. Suggestions for the Federal Role<sup>7</sup>

- Implement action to define what needs to be done to address isolation among Canadian seniors by bringing people together to discuss the issue.
- Help to disseminate information by making current knowledge readily available. Information should include current and on-going Canadian and international research, and national and provincial program initiatives (such as New Horizons projects).
- Ensure CLSA surveys include a component relevant to the determinants of social integration/isolation, and the effectiveness of intervention programs over time.
- Develop a national home care program to complement the community development process in assisting frail seniors to remain in their community.

### **Conclusion**

Participants at the WSIS were asked to determine whether social isolation is an emerging issue for Canada, and if so, what suggestions could be made for policies and program to address the issue.

#### Emerging Issue:

While the extent of social isolation among Canadian seniors is still unknown, there exists evidence that researchers, policy makers, practitioners and the public are concerned about its potential consequences in terms of social costs, economic costs, and quality of life for individuals and their families. It was noted, for instance, that the recent New Horizons initiative has defined reducing social isolation for seniors as a national priority, and it is a priority as well for many of the individual provinces. Now is the time to implement a strategy to address isolation.

It was suggested that more evidence is needed to address the current knowledge gap; specifically, research should be undertaken to develop a profile of the characteristics of those who are isolated and those who are not in order to determine risk factors and consequences. This information will help to guide the development of appropriate programs for prevention and intervention.

Secondly, little is known to date about how current social policy drives and responds to situations of isolation, either at the level of the individual, or the level of the community. A scan of programs and services relating to seniors was suggested as a means to determine what is already in place, and what is already effective in addressing isolation; or, on the other hand, what shifts in policy, such as changes in access to home care services, might be having negative effects.

#### Recommendations for Policy and Program Development:

Workshop participants suggested that new policies must be inter-sectoral and multi-faceted, with support for integrated community-based services. Utilizing a

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<sup>7</sup>The role of the Federal government was not a specific agenda item. Suggestions and recommendations were offered in response to a question regarding the federal role. Workshop participants did not address specific recommendations regarding the role that might be undertaken by provincial/territorial governments.

community development approach, programming should emphasize private/public partnerships, must include senior involvement, and must have access to sustainable funding. All new initiatives should also include an adequate evaluation component to ensure they are appropriate for their intended target groups, and that they do not have adverse results for seniors. Any policy that could effectively help older Canadians to be less isolated and better integrated will contribute to their well-being and to the cohesion of Canadian society as a whole.

### Recommendations specific to the Role of the Federal Government:<sup>7</sup>

Workshop participants felt the Canadian government could help to define what needs to be done to address isolation among seniors by encouraging national discussion. They should ensure that the upcoming Canadian Longitudinal Study of Aging seeks answers about the determinants of social isolation, and the effectiveness of intervention programs over time to complement other research. The Federal government should also assist with dissemination of information about current and on-going research and national and provincial program initiatives. Lastly, it was stressed that Canadians require a national home care program to complement and support provincial initiatives in assisting frail seniors to remain in their community.

### **Suggested Recommendations for Immediate Action:**

#### **Research**

1. Fund research (via Canadian Institutes of Health Research, Social Sciences and Humanities Research Council, federal and provincial government departments, etc.) targeted to the development of a profile of those who are socially isolated; specifically to describe the attributes of isolation (characteristics and consequences) at individual, community and societal levels.
2. Hold a national consultation on social isolation among seniors with input from national and international researchers, health and social service practitioners, seniors' organizations, etc.

#### **Programs and Services**

1. Provide sustainable funding for all projects, large and small, that can be seen to have positive effects on isolation.
2. Ensure all health and social programs and services include an evaluation component to assess their impact on situations of isolation.

#### **Policy**

1. Develop tools, for use across all sectors of government, to scan current FPT policies and evaluate new policies as to positive/negative impacts on isolation.
2. Provide a mechanism by which community programs can disseminate nationally the positive efforts they undertake to prevent isolation or to intervene when isolation has negative consequences for individuals and their communities.

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