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Communication

Lonely but No Longer Alone: A Review of First-Ever Clinical Guidelines on Social Isolation and Loneliness in Older Adults

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Abstract Social isolation and loneliness are major public health concerns and are associated with morbidity and mortality. As this is an increasing issue in older adults, guidance for healthcare providers is a priority. The Canadian Coalition for Senior's Mental Health (CCSMH) has developed the first Canadian social isolation and loneliness guidelines to help providers recognize, assess, and manage social isolation and loneliness among older adults. We review and summarize these guidelines to support healthcare to apply best practices and evidence based care for older adults experiencing social isolation and loneliness.

Keywords: loneliness; social isolation; clinical practice guidelines; older adults

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1. Introduction

Social isolation and loneliness have major public health implications, and remain a challenge internationally [1,2]. Loneliness is defined as the subjective feeling of unmet social needs, while social isolation is defined as few or infrequent social contacts [3]. Older adults are particularly vulnerable to loneliness and social isolation due to changes in social structures, medical comorbidities, and living settings [4–7]. Given that over 10% of the global population is aged 65 years and over [8,9], tools to support clinicians and healthcare practitioners in assessing and managing loneliness and social isolation are imperative. Further, up to 58% of Canadian adults over fifty years of age experience loneliness and 41% are at risk of social isolation [10]. We describe the development of the *Canadian Clinical Guidelines on Social Isolation and Loneliness in Older Adults* [11], the first clinical practice guidelines on this issue, and highlight key practice points to inform healthcare providers.

History of the Canadian Coalition for Senior's Mental Health

The Canadian Coalition for Senior's Mental Health (CCSMH) is a not-for-profit interprofessional organization that was established in 2002 with the mandate of improving the mental health of older adults. Since then, the CCSMH has published clinical guidelines on mental health in long-term care, suicide prevention, depression, delirium, substance use disorders, behavioral and psychological symptoms of dementia, and anxiety.

2. Development of the Practice Guidelines

The CCSMH created a Guideline Development Working Group of nine core members (including the authors of this commentary) with diversity in gender, clinical practice/expertise, professional

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discipline, and Canadian geographical area. These included one geriatric psychiatrist, one geriatrician, one care of the elderly family physician, two social workers, one occupational therapist, and two researchers. The CCSMH completed a rapid scoping review of reviews and identification of grey literature. This was followed by a national survey to capture perspectives from healthcare providers and older adults. The working group divided the sections by area of expertise for guideline drafting, later reaching consensus during teleconference meetings and subsequently voting on the guidelines [12]. The working group applied a modified version of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) to assess the quality of the evidence (Low, Moderate, High) for each recommendation and its available strength (Weak, Strong) [13]. Recommendations that had limited evidence but were considered best clinical practice were categorized as Consensus recommendations. These guidelines were reviewed by three external academic experts to provide feedback prior to publication.

3. Applying the Guidelines to Clinical Practice

These guidelines are divided into sections on Prevention, Screening & Assessment, and Interventions (Table 1), and are briefly summarized below.

Table 1. Summary of Recommendations for Prevention, Screening and Assessment, and Interventions for Social Isolation and Loneliness.

Recommendation	Evidence	Strength
Prevention		
Health care providers should have knowledge of risk factors for social isolation and loneliness in older adults	Moderate	Strong
Education and training for health care and social service professionals	Consensus	
Health care and social service professionals as agents of change	Consensus	
HCSSPs should use targeted screening for those older adults who have risk factors for social isolation and loneliness.	Consensus	
When screening patients/clients, HCSSPs should use evidence-based screening tools to identify patients/clients who are socially isolated and/or lonely, to assess the severity of the problem, and to use in routine follow-up to determine whether the patient's/client's social situation has changed and whether interventions are effective.	Moderate	Strong
When social isolation and loneliness is identified in older adults, it should be documented in the health record like other medical conditions and risk factors. Efforts should be made to collect data on social isolation and loneliness as important social determinants of health. Loneliness and social isolation may be considered "psychosocial vital signs" given their impact on health.	Consensus	
Assessment & Screening Tools		
A thorough clinical assessment with a patient/client who is socially isolated and/or lonely should aim to explore the possible causes and identify any underlying health conditions that may be contributing factors. Other causes that may be contributing should also be identified adopting a biopsychosocial approach. A comprehensive assessment can guide the development of an appropriate management plan. The assessment may vary according to the health care and social service professional's scope of practice.	Consensus	
When screening patients/clients, HCSSPs should use evidence-based screening tools to identify patients/clients who are socially isolated and/or lonely, to assess the severity of the problem, and to use in routine follow-up to determine whether the patient's/client's social situation has changed and whether interventions are effective.	Moderate	Strong
Interventions		
HCSSPs should apply several principles to help older patients/ clients who are socially isolated and/or lonely including:	Consensus	

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1. Ensure initially or concurrently that treatment is provided for any underlying medical conditions identified in their assessment; 2. Take an individualized approach, with shared decision-making; 3. Identify individuals' interests to determine interventions that may be the best fit, while appraising the individual and environmental resources available; and 4. Recognize the diversity within older adult populations and together with their patient/client consider the incorporation of their culture and lived experience. We list these interventions below		
Social prescribing	Moderate	Strong
Social activity	Moderate	Strong
Physical activity	Moderate	Strong
Psychological therapies	Moderate	Strong
Animal-assisted therapies and animal ownership	Low	Strong
Leisure skill development and leisure activities	Low	Weak
Technology	Moderate	Strong
HCSSPs should not use pharmacological agents as a treatment for social isolation and loneliness in older adults.	Low	Strong
HCSSPs should take an individualized approach to the follow-up of social isolation and loneliness.	Consensus	

Adapted from the CCSMH Clinical Practice Guidelines for Social Isolation and Loneliness.

3.1. Prevention

Healthcare providers should have knowledge of the risk factors associated with social isolation and loneliness in older adults, and these should be a core part of the educational curriculum. These risk factors include, but are not limited to: advanced age [14,15], female sex [16,17], identifying as 2SLGBTQIA+ [14,15], identifying as an ethnic minority [18], living alone, episodic mental or physical health issues [16], and being a caregiver/care partner [19].

3.2. Screening & Assessment

The CCSMH recommends targeted screening for those who have risk factors using evidence-based screening tools. These can include single item measures [20], UCLA Loneliness Scale [21], the Lubben Social Isolation Scale [22], amongst others. Care providers should recognize that each tool may not capture loneliness and isolation in its entirety. In those who have been identified as having social isolation and loneliness, a thorough review of the medical and social history, precipitating factors (e.g., life events), psychiatric symptoms, insight, and motivation for change should be prompted.

3.3. Interventions

Care providers should ensure that alternative etiologies are initially or concurrently managed (e.g., medical or mental health conditions). It is important that healthcare providers take an individualized approach with shared decision making to identify interventions that balance the individual's goals and preferences with the available evidence and local resources. Interventions may include social prescribing, physical activity, psychological therapies (e.g., cognitive behavioral therapy), leisure skill development, animal therapy, and technology [23].

4. Contextualizing the Guidelines in the Current Landscape

In 2011, the United Kingdom launched the Campaign to End Loneliness. Over a decade of later, it created a legacy as one of the first multidisciplinary hubs on the topic, with far reaching influences [24]. In 2020, the World Health Organization endorsed the United Nations Decade of Healthy Ageing [25]. That same year, the National Academies of Science, Engineering and Medicine released a consensus report on social isolation and loneliness [3]. Since then, there have been national reports

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including the U.S. Surgeon General's Advisory calling for a national strategy to improve health and social systems [26]. Australia's report on "Ending Loneliness Together in Australia" made similar recommendations and calls to action for a national plan [27]. The CCSMH guidelines echo similar national calls to action, in addition to providing practical tools that can be used in a point-of-care setting for the clinician and healthcare service provider.

5. Future Directions

Healthcare and social service providers routinely witness the inequities implicit in the social determinants of health [28]. Social isolation and loneliness are closely tied to these, and may be important in the causal pathway to negative clinical outcomes [29,30]. Policymakers, healthcare professionals, and researchers must remain *connected* to the needs of the population, identifying further areas for research and health policy.

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