# ISOLATED ELDERS PROGRAM PHASE II

A Summary Report

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Mrs. Fowler brought in an old brown teapot, and two rather pretty old china cups and saucers. It was the hardest thing I ever did, to drink out of the dirty cup. We did not speak much because I did not want to ask direct questions, and she was trembling with pride and dignity. She kept stroking the cat -- "My lovely, my pretty," in a hard but appealing sort of way -- and she said without looking at me, "When I was young my father owned his own shop, and later we had a house in St. John's Wood, and I know how things should be".

And when I left she said, in her way of not looking at me, "I suppose I won't be seeing you again?" And I said, "Yes, if you'll ask me." Then she did look at me, and there was a small smile, and I said, "I'll come on Saturday afternoon for tea, if you like."

~*The Diaries of Jane Somers* by Doris Lessing.

# ISOLATED ELDERS PROGRAM

During a period of health reform, characterized by uncertainty and system-wide restructuring, the Isolated Elders Program continues to evolve. This second report describes activities following Phase I, with a focus on activities spanning the period from January to June, 1998. It offers the collective wisdom of all those involved in the program concerning the many challenges of isolation in later life. New knowledge is documented that we hope will inform the future development of this program and others like it throughout the province.

For their commitment and contribution, we would like to thank the following people:

Steering Committee
- Pat Catton
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Century House Staff
- Joy Barkwill
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Support Staff
- Carole Richards, Administrative
- Margaret Hansen, Program Assistant
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# EXECUTIVE SUMMARY

## 1. INTRODUCTION

The purpose of the Isolated Elders Program is to identify seniors who are isolated in New Westminster, and to help them get out of their homes and back into the community. It is an innovative program located within a dynamic, changing healthcare system and this report summarizes a process of documentation and research designed to assist service-providers develop the most effective strategies for reducing and preventing social isolation. The focus in Phase I was on the development and evaluation of a training program for senior volunteers: Phase II focuses on a description of the client population, services delivered to them, and what we have learned about isolation.

## 2. DESCRIPTION OF PROGRAM ACTIVITIES

This is a part-time program, requiring a total of 3 1/2 months per year for the program manager, working with a researcher, 5 senior volunteers, a program assistant, and a practicum student. Methods and procedures for gathering data and preparing the report included: analysis of (a) tracking forms and client information records; (b) interviews with building managers, previous clients, and volunteers; (c) participant observation records of team meetings; and a focus group. (Forms and interview protocols are provided in the Appendix.)

## 3. RESULTS

Using revised tracking forms, files were updated on 44 clients, and 12 agreed to be interviewed by the practicum student to gather further information on isolation; 4 new clients were referred by apartment managers, and completed the life review with volunteers. Records show 48 clients, ages ranging from 68 to 96 years with average age 82.7 years, 33 living in subsidized apartments in the Glenbrook North area, 1 in a subsidized apartment in the Uptown area, 8 in other apartments, 4 in private

homes, 2 unknown; 3 live with a family member, 10 have family visiting at least once a week, 10 have family visiting occasionally, with no family data for 24 people. Other social contacts include homemakers (12 people), friends in same building (6), adult day centre (3), outside club or church (3). Health concerns are: mobility (13), eyesight (11), hearing (11), heart (5), osteo (3), stroke (2), mental illness (1), substance abuse (1), polio (1), allergies (1) with many having multiple problems. A portrait of a client is provided on pages 16 to 18.

A constructed base of knowledge incorporates many perspectives and outlines the common understanding of (1) what isolation means; (2) who is an isolated elder; (3) why it is important to reduce isolation; (4) the causes of isolation (physical, circumstantial, related to family and personality); (5) how to identify seniors who are isolated; (6) how to reduce it; and (7) how to prevent it. Issues to be addressed relate to transportation, safety and security, identifying elders, and limitations of the program.

## 4. RECOMMENDATIONS

Isolation is a regional challenge. To prevent people from becoming isolated, requires a regional commitment on many levels to address the issues raised in this report. Recommendations include particular attention to transportation, safety and security, and protection of privacy. Education and sensitivity training is needed, not just for staff and seniors, but for all members of the wider community to change negative images of aging to positive compassionate images of isolated elders as people who are worthy of our respect and support. It is recommended that ongoing research and evaluation serve to develop a regional perspective and support the documentary on isolation to be used in a comprehensive community development program (i.e., encompassing education, program development and evaluation, research, sensitivity training, building commitment and participation) to meet the challenge of isolation throughout the Simon Fraser Health Region.

# ISOLATED ELDERS PROGRAM

## 1. INTRODUCTION

Independence and rugged individualism are hallmarks of Western Society, often leading to isolation. In recent years, research has identified the risks to morbidity and mortality that isolation represents for the older adult population. A social network is essential to healthy aging for many reasons that were outlined in the previous report (Cusack, 1996); and are expanded in this one. To reduce health risks, many communities throughout the province and across the country are developing strategies to address and reduce the challenges of isolation. The solution requires innovative programs that build on each community's strengths while forging new links in the evolving network of community care.

The purpose of the Isolated Elders Program is to identify seniors who are isolated in the community of New Westminster; and to help them get out of their homes and back into the community. This innovative program is located within a dynamic, changing healthcare system, and the research and evaluation component is designed to provide information that will be useful in developing the most effective strategies to address the problem of isolation. The focus in Phase I was on the development and evaluation of a training program for senior volunteers: Phase II focuses on a description of the client population, services delivered to them, and what we have learned about isolation and how to most effectively reduce and prevent it in the community of New Westminster, British Columbia, Canada.

### 1.1 Outline of the Report

This second report provides documentation of activities in Phase II, a summary of services provided, what we have learned, and recommendations for the future. Section 1 contains background material, a summary of Phase I, and the objectives for Phase II. In Section 2 the roles and responsibilities of the program team are

outlined, the client tracking system, research and evaluation methods explained. Results are summarized in Section 3, which describes what services are delivered to whom and what we have learned about isolation. The knowledge base, our collective understanding of isolation and of the issues in the Simon Fraser Health Region, is contained in pp. 18 - 24). Section 4 provides recommendations for the future directions of the program and for research and evaluation.

First, a brief summary of Phase I.

## 1.2 Summary of Phase I

The process of development and evaluation exemplifies principles of participatory research -- i.e., it combines community development, education, and research. In Phase I (January 1995 - January 1996), a descriptive evaluation focused on the training of senior volunteers, identifying isolated elders, and the process of linking elders with community resources. Methods included (1) a pre and posttest written evaluation; (2) take-home questionnaires; (3) description based on documentation; and (4) a focus group. (NB. "elder" refers to the client group).

Activities

(1) Ten volunteers received 40 hours of intensive training. The evaluation of training showed significant improvements in (a) confidence in communicating with elders and (b) knowledge of community services to seniors.
(2) Thirty-six elders (aged 60 to 100 years) were identified who lived independently in the community and "didn't get out much."
(3) Twenty-three elders engaged in a life-review process with volunteers.
(4) Linking elders with community services was in the initial stages.

The first phase was successful in demonstrating the value of expert education and training to senior volunteers who play an increasingly important role in the network of formal and informal support services to seniors. The kind of education volunteers received affected not only what they are able to do, but their health, their energy, their enthusiasm, and their commitment to serving the community.

1.3 Phase II: Goals and Objectives

Research and evaluation activities in the second phase formally began in January of 1998, two years following the completion of the evaluation of Phase I. Immediately following Phase I (January 1996), we proposed to shift the focus from the volunteers to the clients, and to design an effective tracking system. Once the system was in place, we proposed to track isolated elders in the system in order to assess the appropriateness and the impact of both the intervention (the life review) and the referral. Approximately 1/3 of the clients interviewed in Phase I had requested a visitor -- a request that we hoped to fill when the new friendly visitor's program was established. The process of putting a new program in place, recruiting and training volunteers takes time, and for many of the clients in Phase I, it was too long to wait (as was the case for George, the elder profiled on pp. 16 - 18). For this reason, we felt it was premature to assess client satisfaction when many of the needed services -- notably transportation and a visiting program -- were not in place. Furthermore, with a part-time program assistant and a practicum student joining the team, a joint decision was made to adapt the proposed design in order to gather the most useful data to assist regional decision-makers in planning future directions of the program.

1.4 Objectives

(i) To develop a list of key questions with respect to the problem of isolation and how to reduce and prevent it;

(ii) To design a system of documentation (i.e., client tracking forms and procedures);

(iii) To expand our collective knowledge base of the problem of isolation with a focus on increasing understanding of the most effective ways of identifying those who are at risk, and making the initial contact;

(iv) To describe the client population in the system with respect to age, gender, housing, ethnicity, religious affiliation, community location; health status; family and social contact and frequency, and a brief history of their lives based on the life-review;

(v) To summarize what we know about isolation from the perspective of: (a) staff, (b) senior volunteers, (c) clients revisited, and (d) building managers.

(vi) To develop recommendations for future directions.

## 2. DESCRIPTION OF PROGRAM ACTIVITIES

This section outlines the roles and responsibilities of the program team (which consisted of a manager, a researcher, 5 senior volunteers, a program assistant, and a practicum student). Documentation procedures and research methods are outlined, with forms and interview protocols provided in the Appendix. (It is important to note that this is a part-time program, requiring a total of 3 1/2 months time per year for the program manager.)

### 2.1 The Program Team: Roles and Responsibilities

Program Manager (3.5 months per year)

The program manager's activities during Phase II included: planning and coordinating team meetings; liaising with the steering committee; serving as member of the advisory committee to the New Westminster Friendly Visiting Program; facilitating on-going training and educational sessions for volunteers; support and problem-solving with volunteers; collaborating with the program evaluator in developing the tracking forms, negotiating data collection procedures; preparing the job description, interviewing and hiring, training and supervising the program assistant; collaborating with the program researcher in designing, supervising, and evaluating the practicum student; making formal service links; coordinating and facilitating the final evaluation and focus group; conducting personal feedback interviews with each volunteer; planning and hosting the final recognition luncheon for the program team and staff at Century House; supporting, encouraging, recognizing and appreciating the work of the volunteers; planning sessions for the documentary with Communications Department personnel, director, and photographer; assisting with the evaluation and writing of the final report.

Senior Volunteers (1/2 day per week per year)

The senior volunteers' activities involved attending bi-monthly training and meeting sessions, engaging clients in a life review process (approximately 3 sessions per client); documenting all

client information; and consulting with the program manager regarding referrals and client follow-up.

Program Assistant (part-time position -- 1 day per week/year)
The activities of the program assistant, which were arranged and supervised by the program manager, included: organizing and maintaining files and information; organizing meetings and appointments; taking notes and participating in team meetings; organizing information from tracking records; setting up interviews for the practicum student, program manager, and volunteers; interviewing apartment managers; interviewing prospective clients; referring clients; drafting letters and forms (e.g., to new referrals, to interview clients, for criminal record checks); coordinating, collecting, and collating information for the New Westminster Seniors Resources Booklet; pickup and dropoff of library books, films, sundry supplies; meeting with community service-providers; miscellaneous information and video searches; and organizing the final volunteer recognition luncheon.

Practicum Student (280 hours or 8 weeks)
The activities of the practicum student, which were contracted with the manager and the researcher, included: searching and summarizing the findings of recent research on isolation and aging; revisiting and interviewing clients in the system who had completed a life review with a volunteer during the period November '96 to December '97 (questions contained in Appendix G); interviewing the volunteers (questions contained in Appendix E); transcribing and summarizing the interviews; presenting the summary at a team meeting; creating profiles of clients based on records and interviews (e.g., pp. 16 - 18). The final task was to prepare an article on isolation for a lay audience for publication in the Simon Fraser Health Region Newsletter and/or the Gerontology Research Centre News, Simon Fraser University.

Program Researcher. (20 days)
The researcher's activities included: continuing to research the literature concerning the challenges of isolation, analyzing and summarizing findings; consulting with the manager during the 2-year interim period between Phases I and II*; obtaining ethical approval of the research from Simon Fraser University*; attending meetings as required; working with the manager in designing, supervising, and evaluating the student practicum*; working with the members of the team to design the system of documentation, develop tracking forms and procedures, and implement data gathering; preparing the protocol for focus group discussion concerning strengths and weakness of the project, and what we know about isolation; recording and analyzing the focus groups; summarizing the findings and preparing the final report; disseminating the results amongst professional and academic communities*.

2.2 Documentation and Research
The following methods were used to gather information:

(a) Tracking forms -- analysis provided a description of the services delivered;
(b) Life review and client information records -- analysis provided a description of the client population and individual profiles of clients;
(c) Semi-focused interviews with building manager's, clients revisited, and senior volunteers -- analysis elicited new perspectives on isolation and how to identify people who are at risk.
(d) Participant observation records of team meetings and a focus group discussion -- analysis extended the team's collective knowledge and understanding of isolation, how to reduce and prevent it.

* This is a value-added service made possible by the partnership with the Gerontology Research Centre at Simon Fraser University.

## 3. RESULTS

This section contains a descriptive summary of the services delivered, the client population, and what we know about isolation.

### 3.1 Services Delivered

(a) Follow-up of Old Clients -- Files were updated on 44 clients who had participated in a life review with senior volunteers during the period from November '96 to December '97. Of the 44 clients:

28 had been referred by apartment managers
5 -- by the health department
3 -- were self-referrals
2 -- seniors centre
2 -- seniors housing information
1 -- public health inspectors
1 -- physician
1 -- church
1 -- unknown.

Subsequent to the life review and assessment:

- 12 clients were referred to the visiting program; 2 have moved out of town; 1 was also referred to CNIB talking books; 1 was also referred to Peer Counseling; and 1 was also referred to Vital Connections.
- 9 clients no longer needed our services.

Follow-up in March and April of 1998:

- 12 clients agreed to be interviewed by the Practicum Student
- 10 clients did not wish to be interviewed
- 7 clients asked for no further contact
- 15 clients were not contacted because: 4 have died; 3 no longer have phones in service; 2 have moved to care facilities; 2 could not be reached by phone; 1 was referred to Mental Health and Long Term Care; 1 was referred to the Seniors Well Aware Program; 1 maintains contact with the manager; and 1 moved out of town

(b) New Clients (March - June 1998)

•4 clients were referred by apartment managers of which 2 were referred to the visiting program, and 2 are still connected with volunteers.

3.2 Profile of the Client Population (44 from follow-up; 4 new)

Ages ranged from 68 to 96 years with an average age of 82.7 years (ages of 9 people were unknown);

Gender: 44 female; 4 male

Types of Housing:

| | |
|---|---|
| (a) apartment: | 18 - Apartment A (subsidized, age 55+) |
| | 9 - Apartment B (subsidized, age 60+) |
| | 5 - Apartment C (subsidized, any age) |
| | 1 - Apartment D (subsidized, 65+) |
| | 1 - Apartment E (not subsidized, 55+) |
| | 8 - other apartments |
| (b) private homes | 4 |
| (c) unknown | 2 |

(NB. Apartments B, C, and D are in the Glenbrook North area; Apartment A is in the Uptown area)

Religious Affiliation:

•Christian - Salvation Army - 3; Catholic -- 3; United -- 1

•Unknown -- 36

Family Contact:

family member living with them -- 3
frequent/at least weekly -- 10
infrequent/occasional -- 10
does not want contact -- 1
unknown -- 24

Social Contact:

homemakers -- 12
friends in bldg. -- 6
attend adult day centre -- 3

outside club or church -- 3
friends phone -- 2
little social contact -- 1
unknown -- 29

Health Concerns:
physical mobility -- 13
eyesight -- 11
hearing -- 11
heart -- 5
osteoporosis-- 3
stroke -- 2
mental illness -- 1
substance abuse -- 1
polio -- 1
allergies -- 1

(NB. Many people had multiple health concerns, e.g., with diabetes, heart, hearing and mobility)

3.3 Portrait of an Isolated Elder

George MacDermid (not his real name) is a 92 year old man living in a one-bedroom apartment in a seniors residence in uptown New Westminster, who is affiliated with the Catholic Church. George describes his health as good, although he has trouble with eyesight and mobility, and has a noticeable hearing loss. Despite these problems, George sys he doesn't worry about his health: he has a homemaker during the week, and uses Meals-on-Wheels for lunch and supper.

George's parents were born in Scotland and immigrated to Canada in 1924. He was born in Glasgow, where he lived in a tenement house with his mother and father, 4 brothers and 2 sisters, and grandparents living next door. George remembers spending a lot of time with his grandparents, and his favourite family memories are of picnics and special celebrations. From Glasgow, George moved to Red Deer, Alberta, and then to South Burnaby before settling in New Westminster. As a young man he

enjoyed playing the bagpipes, woodworking, painting, and pencil sketching. He still likes to paint and work with pastels, also enjoys listening to bagpipe music on his CD player, watching hockey games on TV, and getting out on his scooter. He is clearly proud of his Scottish heritage and enjoys meeting other Scottish people at the Highland Games.

George had many jobs during his working years, as a clock and watchmaker for Birks and later in his own repair business; and he also worked on the farm and in the shipyards. He takes pride in his family and the time he helped to build a new town and parish in Alberta. The most difficult time was getting settled on his land after the war, and the happiest time was when he moved to South Burnaby with his family.

Mrs. MacDermid died in 1989, and George has been living alone for the past eight years. His siblings, too, have all passed away. He does have three daughters and one son; 11 grandchildren, and a number of great-grandchildren, but no family living in New Westminster. One daughter who lives at Cultus Lake used to phone him daily, and visit him weekly. However, she recently purchased property in Mexico and has been there for the past five months with no plans to return. Another daughter lives in Prince George; and he phones her every Sunday. His son in Spokane phones him occasionally, though not as often as he used to. A grandnephew comes to visit him every week or two, and a grandniece phones, writes or visits him every week. George recognizes that his family is busy, and may not be able to spend a lot of time with him. He had a friend for many years living in the building who has recently passed away.

This elderly man is charming, friendly, and an impressive artist. He is also a member of the Royal Canadian Legion and has a lifetime membership at Century House, although he no longer uses it. He enjoyed the painting classes that used to take place in his building, and would like to see that program return. George was referred to this program because he doesn't have family in New Westminster, and initially thought he would like to have a visitor. He particularly enjoyed visiting with the volunteer, but on

completion of his life review in May of 1997, he decided he didn't want a friendly visitor, and consequently no referral was made.

Like many others, George has family living at a distance -- the daughter upon whom he has relied most is now living in Mexico. George has few social contacts, and he doesn't get out much. The question for all of us is: What can we do to support George and to prevent further isolation from occurring?

(profile by practicum student)

3.4 What We Know about Isolation?

(1) What is social isolation?

Social isolation is a state of having little or inadequate social contact with other people. A person becomes isolated for a variety of reasons throughout life, generally a combination of factors leads to social isolation in later life. One building manager referred to isolation as "having no meaningful contact with anyone -- you can be in a crowd but still feel alone". As one of the volunteers reminded us,

> *I remember on the prairie in the old days when people were really isolated. This program brings new meaning to isolation -- now we are talking about somebody in an apartment, maybe right across the street from the seniors centre.*

(2) Who is an "isolated elder"?

An isolated elder is someone who lives alone, doesn't get out much, and lacks social contacts with family and/or the wider community. There are no age-restrictions -- one can be isolated and "at risk" at 50. A building manager recalls, We had one man in here who was quite young, divorced at 57 and it was like you pulled the rug out from under him. Now he is out and about, but it took a few years." What is important here is how the person feels: i.e., lonely and "vulnerable." Wealth is no deterrent, for isolation knows no socio-economic boundaries. In fact, people who are wealthier may be

more at risk, living lives of quiet desperation behind closed doors in their luxury condominiums.

(3) Why is it important to reduce social isolation?

> Human beings are social animals and find being alone very difficult. Our individual bodies share in a living social body and the health of each depends on our social connectedness.
>
> (Ornstein & Sobel, 1989, p. 223)

> Single, separated, divorced, or widowed people are two or three times more likely to die prematurely than are their married peers. They also wind up in the hospital for mental disorders five to ten times as much. Heart disease, cancer, tuberculosis, arthritis, and problems during pregnancy all increase in those with weakened social connectedness.
>
> (Ornstein, 1987, p. 226-7)

Isolation is a problem for people of all ages because it can lead to depression, grief, anxiety, health problems, vulnerability to dementia, alcohol and drug use, and suicide. Social isolation is a particular problem for older people because people who are isolated are less likely to rebound from the common losses associated with aging, they don't recover as quickly from illness, and they don't live as long. There is also a higher rate of suicide among older people.

> *We had a 79 year old man living in our building who was quiet and a nondrinker, who jumped to his death. I saw him just two days before -- and there are others too. Severe isolation leads to suicide.*
>
> (a building manager)

When they are isolated, people have less access to information about the many services that are available to them -- services that would reduce their sense of isolation and help them to take better care of their health. They may not have anyone who

can ensure they take their medications, get to doctor's appointments, etc. All of these issues relate to quality of life -- physical, mental, emotional, and spiritual.

Furthermore, when older people become lonely and unhappy, everyone with whom they have contact -- the building manager, the letter carrier, the clerk in the corner store -- may be negatively affected. In some cases, one person's isolation puts others in grave danger. In one building with 180 residents,

> *We have a man who is confined to a wheelchair completely. He has few visitors -- his daughter brought him to live here, but he shouldn't be living alone. He has fallen often and needed an ambulance. We are scared of fire, and he already set his mattress on fire once.*

Ultimately, on a practical level, reducing isolation will reduce healthcare costs that are expected to rise dramatically unless we develop strategic services to reduce isolation and increase access to formal and informal community services. Historically, the elderly have accounted for a large proportion of the total hospital days in Canada.

> Of the 35.5 million hospital days in 1995/96, the elderly accounted for 60% (or 21.3 million days), although they represented only 12% of the population that year. As the number of people aged 65 and over and their share of the total population continue to increase over the next several decades, total hospital bed requirements such as long-term care are expected to increase.
>
> (Statistics Canada, 1996)

(4) <u>What are the causes of isolation?</u>

For people who lived in remote areas of the country, (i.e., many older Canadians) isolation was a fact of life. However, there are increasing numbers of people of all ages in the "urban jungle" whose only connections to the world are through radio, TV, CDs, computers, and books. In 1997, the average person over 65 in the

US watched 43 hours of TV a week -- more hours than a full-time job! (Dychtwald, 1997).

In order to reduce or prevent isolation, it is important to understand its causes. Causes may be (a) physical, (b) circumstantial, (d) related to family, and/or (e) personality. One or a combination of factors, may lead to social isolation in later life.

(a) Physical reasons are hearing loss, loss of sight, fear of falling, poor health, being overweight, illness, lack of energy, maybe they can no longer drive and have no way to access public transportation.

(b) Circumstantial: Isolation may be caused by circumstances. The person may live in a dangerous neighbourhood. He or she may have had bad experiences, been robbed, assaulted, abused, etc., and is distrustful of others for good reason. They may have financial problems, no money for transportation. They may have a language or cultural barrier, or they may be illiterate.

(c) Family-related: People who have frequent or somewhat regular visits from family may have adequate social lives -- however, family members don't always fulfill a need for social contact, especially if family relations are troubled or distant. Many older people are without a family member to visit them; maybe they never had any family, or no one lives nearby. They may have survived their siblings; perhaps they never had any children. In some cases, family neglects them. (NB. Less than 1/2 of the client group mentioned contact with family; and 1 specifically said he/she did not want family contact).

(d) Personality: Some people are isolated because they say they prefer to be on their own; they may be shy or lack social skills. They may be somewhat paranoid or may fear rejection. Some people are fiercely independent and don't want to be obligated

to others. Some may be proud -- ashamed because they can't look after themselves very well and don't want anyone to know.

A major factor leading to isolation in later life is that so many family members move apart in order to secure employment, one's children and grandchildren may be transferred to other parts of the country or the world. Furthermore, with the trend toward smaller families and more people choosing to remain single, we can expect social isolation to increase in the future, unless we take strong action to reduce it. That means using all of this community's resources to find those people who are hidden away, and to make contact with them.

(5) How do we identify people who are socially isolated?

Some ways to identify isolated elders are by contacting:

- Managers of seniors housing
- pensioner's associations
- churches, synagogues, and temples
- Salvation Army
- Royal Canadian Legion
- family
- library bookmobile
- referrals from the health department
- Continuing Care
- physicians
- Hospital social workers know who is being discharged who hasn't had a visitor in hospital
- homemakers
- referrals from the seniors centre
- peer counseling program
- Meals on wheels
- Handidart
- GATC -- the geriatric assessment and treatment centre
- Seniors Bureau support call service

- Adult daycare programs
- banks

Ideally, every member of the community should be aware of the problem of isolation and willing to make the connection themselves, and/or contact someone (i.e., a member of the program team) who will. We would particularly like family to be involved. However, seniors need to have their privacy protected, and people need some guidelines. One building manager expressed concern,

> *I don't know if it is legal for building managers to give out names of tenants. I use my own discretion, and it depends on how the name is going to be used. If I feel it's right and there is a problem, I act on it. Are we doing it right? Bank manager's don't give out names. What is the best way for us to get help for these people? I want to protect the rights of isolated elders, building managers, and service-providers.*

(6) <u>How can we reduce isolation?</u>

These strategies were suggested by the program team:

- Institute a buddy system in all buildings -- designate someone to escort an isolated person to activities in the building until they are comfortable enough to go by themselves.

- Make wheelchairs available in the building so family members or friends can take seniors outside or on trips away from the building.

- Try a variety of different programs in the building to get people out of their rooms. As one of the volunteers observed,

  > *Men have been "doers" most of their lives and when they no longer have things to do they seem to be more inclined than women to isolate themselves. Women want to share and talk.*

  One way to get men out is to offer them an activity (e.g., George, the elder who is profiled in this report used to attend a

painting class in his building and it has been discontinued -- he would like to see it offered again.)

- Make sure all the buildings have information about services and programs for seniors.

- Supply new forms of transportation designed to reduce isolation -- e.g., a shuttle bus to the seniors centre for those who need it; a free shuttle bus to the Mall.

- Have a trained activity coordinator for every BC Housing Building.

- Connect people with adult daycare centres.

- Get people to Operation Friendship at Century House.

- Increase security at every sky train station, so seniors aren't afraid to use public transit.

Of the many strategies that have been identified, the most obvious solution is a program of trained friendly visitors with connections to all potential sources of referral. However, relying on a supply of trained friendly visitors is not the only solution to the problem of isolation for a number of reasons, e.g., "less and less people want to volunteer -- we have real difficulty getting volunteers for various programs." Furthermore, having a friendly visitor may be a panacea that doesn't always get at the real problem. For example, a volunteer told the story of a woman she interviewed who has recently been in hospital for surgery to have her veins repaired and was referred by her doctor.

*Emma doesn't like strangers and she doesn't want a visitor. If she can get out and see who she wants to see when she wants to see them, she'll be fine. She says she doesn't need anything. And once she can get behind the wheel of her car again, she'll be fine.*

There are many seniors for whom driving a car is critical to their sense of independence and self-esteem. More than reducing isolation, being able to drive one's own car has a powerful impact on self-confidence and personal freedom. Providing a friendly visitor when what the client needs is renewed confidence in their driving skills (maybe through a driver training program) may be encouraging dependence instead of reinforcing healthy independence.

(7) <u>How can we prevent social isolation?</u>

Everyone agreed that the most effective strategy for reducing isolation is to prevent it before it starts. The task is to identify people at risk as early as possible before they lose their social skills and their desire for the company of others, and to find the key, something unique that will work for each person. The life-review process is the most effective way to determine just what the answer might be for each person. In the case of one woman, for example, it might be "finding one person in her apartment building who would walk with her every morning".

There are many references to loss of a close friend or companion leading to isolation and loneliness, therefore, caregivers and widows are at particular risk of isolation. They need to be drawn out of their solitude and engaged in activities. One of the volunteers told us a story about . . .

*a woman who came to an art class I was taking. She had just lost her husband and she was grieving. I heard it every time in my ear, "Oh, I'm suffering." This went on for 3 months. Now it's all gone -- the husband and the suffering -- and she's really into the art.*

One of the building managers felt that isolation couldn't always be prevented.

> *Circumstances in life can trigger isolation. We had a 90 yr. old couple who were loners, very private, and there is nothing wrong with that. When he went into a care home for Alzheimers, she made more friends in the building.*

In this case, it was the caregiver who was isolated, and only temporarily. When her burden of care was relieved, she was fortunately able to reach out to others. But not everyone has the confidence to give themselves the "extra little push that is needed".

3.5 The Issues

(a) Transportation -- In Phase I, two important gaps in service identified were the need for (a) a friendly visiting program and (b) improved transportation. While a friendly visiting program is now in place, there are always more clients than volunteers. Transportation remains a major problem.

(b) Safety and Security -- Personal and home safety continues to be a critical community issue: scams are prevalent and crime is a major concern that not only causes isolation but prevents community access to people who need service. We educate seniors not to interact with strangers -- and yet all members of the program team who made contact with the elders are strangers.

(c) Identifying Elders -- It is becoming increasingly difficult to identify elders because of confidentiality and protection of privacy. As one building manager said, "Seniors, of all people, need to have their privacy protected."

(d) Limitations -- A major issue is whether there are cases where isolation simply cannot be prevented or reduced. Are there people who would really rather be alone? Negative attitudes toward seniors as useless and a burden on the healthcare system are powerful barriers that prevent people from either seeking help or accepting it when it is offered. They may say, "Don't worry about me. I can manage."

## 4. RECOMMENDATIONS

Isolation is a regional challenge. To prevent people from becoming isolated, requires a regional commitment on many levels to address the issues raised in this report. Recommendations include specific attention to transportation, safety and security, and protection of privacy. Education and training is needed, not just for staff and seniors, but for all members of the wider community to change negative images of aging to positive compassionate images of isolated elders as people who are worthy of our respect and support. It is recommended that ongoing research and evaluation be designed to support the documentary on isolation in a community development program to meet the challenge of isolation throughout the Simon Fraser Health Region.

IT IS RECOMMENDED THAT:

*An improved transportation system be put in place with special consideration for the following:*

- *volunteer drivers to get people to the seniors centre*
- *a free shuttle service between the seniors centre and the Mall*
- *an escort service to get people out at night*
- *increased security for public transit*
- *a driver training skills program for seniors*

IT IS RECOMMENDED THAT:

*A strategic plan be created for developing, delivering, accessing, and evaluating community services to isolated elders throughout the Simon Fraser Health Region.*

IT IS RECOMMENDED THAT:

*All regional healthcare staff and volunteers be specially trained in identifying, reducing, and preventing isolation.*

IT IS RECOMMENDED THAT:

*A Community Education and Isolation Awareness initiative be launched that will serve to mobilize every member of the community (professionals, volunteers, and citizens) to create a region that cares about all its members and is specifically committed to eradicating individual isolation.*

(To this end, a documentary is in progress).

IT IS RECOMMENDED THAT

*In the next phase of the program, the ongoing research and development component be designed to develop a regional perspective and to support the documentary on isolation that will be used in a comprehensive regional community development program that encompasses education, program development and evaluation, research, sensitivity training, building community participation and commitment to meet the challenge of isolation throughout the Simon Fraser Health Region.*

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# APPENDICES

A

# RECONNECTING SENIORS VOLUNTEER PROGRAM R.S.V.P.

## CLIENT TRACKING FORM

Client: _____ Date: _____

Address: _____ Volunteer: _____

_____

Phone Number: _____ Age: _____

Reason for referral: _____

_____

_____

_____

Has the client been informed and agreed to have contact? Yes ☐ No ☐

Please explain: _____

_____

_____

First contact: _____ / _____
Date Hours

Comments: _____

_____

First visit: _____ / _____
Date Hours

Comments: _____

_____

Second visit: _____ / _____
Date Hours

Comments: _____

_____

A2

Third visit: _____ / _____
Date Hours

Comments: _____

_____

Life review completed: _____ (Date)

Not completed? Reason: _____

_____

_____

Total hours spent: _____

Referral source:

Name: _____ Phone Number _____

Address: _____

_____

Referred to: _____

Follow up: _____

_____

Closure Notes: _____

_____

_____

_____

_____

Please complete and return to:

Wendy Thompson, M.A.
R.S.V.P. Project Manager
537 Carnarvon Street
New Westminster, BC V3L 1C2
Phone: 525-3661

B

# RECONNECTING SENIORS VOLUNTEER PROGRAM
# R.S.V.P.
# CLIENT INFORMATION

**DATE:**_____

1. **CLIENT NAME:**_____ **VOLUNTEER:** _____

   Age _____ Sex _____ Church affiliation _____

   Community location _____

2. Health

   a) How would you describe your health?

   Excellent ☐ Good ☐ Satisfactory ☐ Poor ☐

   b) Do you have any particular health concerns?

   Eyes ☐ Hearing ☐ Mobility ☐ Other _____

3. Social Contact

   Do you have brothers and sisters?_____

   Contact? Not at all ☐ Occasionally ☐ Weekly ☐ Daily ☐

   Do you have children?_____

   Contact? Not at all ☐ Occasionally ☐ Weekly ☐ Daily ☐

   Do you have grandchildren? _____

   Contact? Not at all ☐ Occasionally ☐ Weekly ☐ Daily ☐

   Other family?_____

   Friends?_____

   Neighbours?_____

   Other support, Long Term Care, Home Care, etc.?_____

   _____

C

# RECONNECTING SENIORS VOLUNTEER PROGRAM
# R.S.V.P.
# LIFE REVIEW QUESTIONNAIRE

1. Where were you born? _____

   What was it like to live there? _____

   _____

   What kind of school did you go to? _____

2. Have you always lived in New Westminster? _____

   Have you lived on your own very long? _____

   What major moves did you make? _____

3. Where were your parents born? _____

   When did they immigrate? _____

   Do you have brothers and sisters? _____

   Other family members? _____

   Grandchildren, etc.? _____

   What were the favorite things you did in your family? _____

   _____

   Did you have a favorite animal or favorite toy? _____

   _____

   Try to find out about any church associations, service clubs, etc. _____

   _____

   _____

   _____

   _____

C2

# RECONNECTING SENIORS VOLUNTEER PROGRAM
# R.S.V.P.
# LIFE REVIEW QUESTIONNAIRE

4. What hobbies and activities did you do as a young person? _____

_____

What do you enjoy doing now? *(If they say I don't/can't get out now. Say: If you could get out, what would you enjoy doing?)*

_____

_____

_____

Who do you do things with now? *(Ask at your discretion)* _____

_____

5. What are you most proud of? _____

_____

_____

Something from the past? _____

_____

Something from the present? _____

_____

6. Did you enjoy your working life? _____

_____

How many different jobs did you have? Tell me about them. _____

_____

_____

7. What were the most difficult times for you? _____

_____

What have been the best years of your life? _____

_____

**RECONNECTING SENIORS VOLUNTEER PROGRAM**
**R.S.V.P.**
**LIFE REVIEW QUESTIONNAIRE**

8. Did you do any work in the community?_____

_____

9. How would you generally describe your health?_____

_____

Do you have any major concerns about your health? _____

_____

_____

## QUESTIONS TO END A SESSION WITH:

Did/do you belong to any service clubs?_____

_____

_____

Did/do you like traveling? _____

_____

_____

Is there anything you wanted to do that you didn't have an opportunity to do? *(Self-disclosure "3rd from the left")* _____

_____

_____

_____

I love baking. Is there something you particularly love to do? *(Painting, writing, cooking, etc.)* _____

_____

_____

_____

D

**CLIENT NAME:**_____

**Forms completed:**

☐ **Intake referral form**

☐ **Client tracking form**

☐ **Life review questionnaire**

☐ **Outgoing referral form**

☐ **To visiting program** ☐ **To**_____

☐ **To**_____ ☐ **To**_____

**Suggested follow-up:**

☐ **None required** ☐ **In care facility** ☐ **Deceased**

**Other:**

_____

_____

_____

# THE CHALLENGE OF SOCIAL ISOLATION

## QUESTIONS TO BE ADDRESSED IN PHASE II

(1) What is social isolation?

(2) Who is an "isolated elder"?

(3) What are the reasons/ causes of isolation?

(4) Are there different kinds of social isolation?

(5) How do we identify people who are socially isolated?

(6) What are the most effective strategies for reducing isolation?

(7) How can we prevent social isolation?

(8) What are the gaps in service?

Procedures:

(a) continuing review of the literature

(b) client interviews

(c) focus groups with volunteers and professionals

F

# THE CHALLENGE OF SOCIAL ISOLATION
## INTERVIEW PROTOCOL FOR BUILDING MANAGERS

*I am involved in a program that is designed to improve services to seniors who are living independently in New Westminster. We need your help, and we are asking you because, as building manager, you have a valuable perspective on the problem of isolation and how we can prevent it. Thank you for agreeing to see me today. (Margaret)*

(1) What does the word isolation mean to you? (explain more fully what it means from the perspective of our project)

(2) Do you have people in your building who are isolated?

(3) Do you have any idea how many?

(4) Why do you think they don't have any social contact?

(5) How can we find out who these people are?

(6) Do you give out the names of your tenants?

(7) How do we connect isolated people to the community?

(8) How can we prevent a person from withdrawing and becoming isolated?

(9) Why is it important to connect these people?

G

# THE CHALLENGE OF SOCIAL ISOLATION
## INTERVIEW PROTOCOL FOR ISOLATED ELDERS

*I am involved in a program that is designed to improve services to seniors who are living independently in New Westminster. We need your help, and we are asking you because you live alone. Thank you for agreeing to see me today. (Michelle)*

(1) We know there are people who never get out of their homes from one week to the next. Why do you think this happens?

(2) How can we find out who these people are?

(3) How can we provide more social contact for people who spend a lot of time on their own?

(4) Who would you usually have contact with in an average week?

(5) Do you ever feel that you spend too much time on your own?

(6) Do you ever feel isolated?

(7) Do you ever feel that you'd like more contact with people?

(8) Is there anything this community can do to give you more support?

CALLING ALL SENIORS

The Simon Fraser Health Region is working in collaboration with Simon Fraser University to improve the quality of life for residents of New Westminster by developing more effective ways of connecting seniors with programs and services in the community. As part of our research, we would like to interview you. Your participation is strictly voluntary: any information you provide will be held in strict confidence, and you will be free to withdraw at any time.

If you are willing to be interviewed, please sign your name below. If you would like more information or would like to receive a copy of the final report, please contact Dr. Sandra Cusack at the Gerontology Research Centre, Simon Fraser University at Harbour Centre (Phone: 291 5177),

Sincerely yours,

I_____am willing to participate in this research project and I understand that any information I provide will be held in confidence.

Name:_____Date:_____

Thank you for your willingness to help.