Connector programs as a promising means of addressing social isolation and loneliness among older adults: a review of the evidence.

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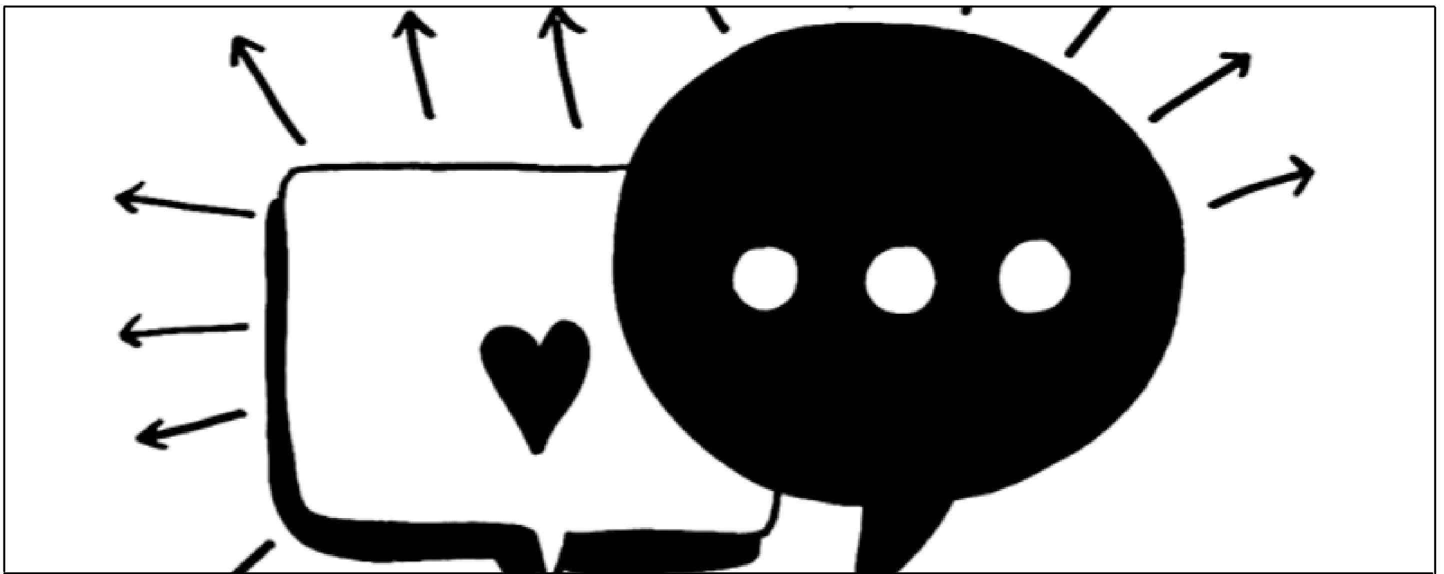
We gratefully acknowledge funding from the Government of New Brunswick, the Healthy Senior's Pilot Project, the NBHRF Research Chair in Community Health and Aging and the Social Sciences and Humanities Research Council which enabled the research and writing of this report.

2022



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Executive Summary

About the project

There are many reasons an older adult may become socially isolated or lonely (Ouellet, 2021). Experiencing either is the result of complex interactions between individual (micro), community (meso) and systemic (macro) factors. Not recognizing the impact that both meso- and macro-level factors have can result in over-emphasizing individual factors. Consequently, the responsibility for addressing social isolation and loneliness should not be left to the individual but should be understood as a social challenge that requires a multi-level approach.

One promising approach to alleviate social isolation and loneliness is the use of community connector programs. Community connector programs are over-arching strategies that aim to provide support to those experiencing social isolation and loneliness by connecting them to existing interventions and community support services. Community connectors are individuals, involved in such programs, who enable the flow of information, resources and relationships across cultural, social and organization boundaries. In the case of social isolation and loneliness, community connectors facilitate connections between individuals and existing community supports and interventions.

This project sought to understand how community connectors are defined in academic literature, the types of connector programs that exist and their implications for older adults experiencing social isolation and loneliness. An ecological framework was identified as a promising means of understanding the individual, community and systemic structures that can both facilitate and create challenges in ensuring one remains connected to the supports and relationships that exist around them.

Key Findings

Following a review of the literature and analysis of international case studies of community connector programs, this project found that:

-There are a wide variety of community connector programs (e.g., door knocking initiatives, phone wellness check ins, public library navigators).

-Various terms have been used to label community connectors. They may be known as health champions, peer support workers, navigators, community health workers and more. Connector programs reach, understand and support older adults who are experiencing social isolation and loneliness in numerous ways.

-Not only are there a range of terms, but community connectors can occupy various positions on a spectrum, ranging from being embedded in an organization (e.g., health institution or public library) to being situated within the community (e.g., taxi driver). Depending on their position, their reach and role may differ.

Goal: understand Community Connector programs as defined by the academic literature and how they might assist older adults who are socially isolated and/or lonely.

Executive Summary cont'd

Key findings continued:

-By far, social prescribing (SP) has received the most research attention. A defining characteristic of SP is its close orientation to health institutions. SP works from a social determinants of health perspective. SP originated as a means of enabling health providers, such as physicians, to address these broader determinants (e.g., financial planning, capacity to cook healthy foods, etc.). SP enables health providers to 'prescribe' a cooking class or dance class to address health needs. The connector in this case may be the health care provider. Or they may refer the 'patient' to someone whose role is to determine needs and connect them to appropriate resources.

-Our research identified several useful typologies of SP programs. For instance: Signposting, SP Light, SP Medium, and SP Holistic. This typology, created by Kimberlee (2013; 2015) differentiates SP programs by the type of needs assessment performed. Signposting typically involves pointing the patient to a service that targets an identified medical need whereas SP holistic involves an extended discussion with the person to identify needs and ensure they are connected to relevant organizations within the community. These needs may or may not be medically oriented.

Policy implications

Community connector programs are beneficial as they use already existing resources to help address isolation. Indeed, they may benefit existing programs by providing new members. While social prescribing is the most studied form of connector program, community connector programs need not be located within health care institutions. They, therefore, may relieve some of the burden on health care institutions while providing an avenue for community groups (e.g., churches, private businesses) and public organizations (e.g., libraries) to address social isolation and loneliness.

Public policies should identify existing connector programs, create knowledge hubs allowing promising practices to serve as sources of inspiration and guidance, and develop funding mechanisms to enable organizations to build or incorporate connector programs into their activities.

As a relatively new strategy, more research is required to understand the various dimensions of connector programs. For instance, they rely on conversations to identify needs. What sorts of support or training is helpful to enable connectors to facilitate productive conversations in these often sensitive areas? Another challenge we identified is the development of an up-to-date list of resources, organizations and supports that connectors may direct socially isolated or lonely individuals to. This is an area that could be supported through policy. And of course, means of access (e.g., transportation or communication technologies) is heavily dependent on policy supports.

Introduction

Mrs. Tremblay has had visual disturbances for the last 30 years as a side effect of her diabetes. She is social, enjoys the company of a select few, but equally has come to value and enjoy her solitude. She was in a challenging marriage for most of her life. She would retreat physically and emotionally out of self-preservation. This is a coping mechanism she continues to adopt to this day. Being alone and not speaking to anyone for weeks is not seen as abnormal by her. With the arrival of COVID-19, she was well adapted to deal with isolation and did not feel as lonely as others who were experiencing isolation for the first time of their lives. However, because of where she lives, just on the outskirts of town, she is having difficulty getting to her regular medical appointments and has been experiencing food insecurity. When she does get lonely, her first inclination is to access her family physician in the hopes of making a connection to others.

There are many reasons an older adult might come to be socially isolated and/or lonely. The arrival of the pandemic gave those who have never been isolated or lonely a glimpse into the reality many had lived with for years. Indeed, in 2017 several years before the COVID pandemic arrived, the US Surgeon General referred to the levels of social isolation and loneliness as a "global epidemic," (Murthy, 2017). In Canada alone, it has been estimated up to 24% of older adults have experienced social isolation, up to 30% are at risk of isolation and up to 50% of Canadians report feeling lonely (Freedman & Nicolle, 2020; Government of Canada, 2016; Keefe, J et al., 2006).

Defining Social Isolation and Loneliness

The issue of social isolation and loneliness has received considerable attention for many decades, with much of the focus on older adults (Cumming, Henry & Henry, 1961; Fromm-Reichmann, 1959; Weiss, 1974). Despite the terms being used interchangeably, they do have different meanings. Social isolation tends to be used more objectively, for example to quantify the number of people one has in their social network (Holt-Lunstad et al., 2015), whereas loneliness is a term to describe the subjective feelings one has in regards to the quality of the relationships within that network (Courtin & Knapp, 2017; Poscia et al., 2018). Loneliness has been described as the discrepancy between the actual and desired relationships one has (Peplau & Perlman, 1982).

Social isolation: related to quantity

Loneliness: related to quality

Risk factors and interventions for social isolation and loneliness have been studied both separately and together. Different outcome measures are generally used to detect changes in social isolation and loneliness if they are discussed within the same paper (Courtin & Knapp, 2017; Czaja et al., 2018; Dickens et al., 2011). Some definitions have sought to incorporate both concepts into one term, such as defining social isolation as: "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships" (Nicholson, 2009, p. 1346). This definition is useful in integrating both but trades the mental imagery of the aspects of loneliness over the acknowledgement of the quantity of relationships. Also, loneliness has been defined as: "a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want." (HM Government, 2018). Again, the subjective supersedes the objective dimensions.

In tackling this definitional issue, Newall & Menec (2019) highlight the importance of preserving the separate concepts, as well as considering them in tandem. For instance, it is important to note that someone might be socially isolated but not lonely and these people differ from those who are both socially isolated and lonely. The latter group could be seen as most vulnerable, as they will be at an increased risk of consequences related to both conditions and both are associated with stigma (Jopling, 2020; Kerr & Stanley, 2021; Weldrick & Grenier, 2018; Newell & Menec, 2019).

Within this document, in order to preserve the elements of each concept, but to incorporate brevity, the acronym SILo will be used. This allows for the terms "social isolation and loneliness" to be both represented, yet respects that components of each term are being considered. The visual analogy to a silo helps illustrate the impact these have on the individual, leaving them "siloed" and disconnected. When necessary, the terms will be used separately if the discussion relates to a singular concept.

SILo: abbreviation for "social isolation and loneliness"

It is worth noting that in Europe, and particularly in European welfare states, the concept of "social exclusion" is sometimes favoured over social isolation. The conventional distinction between the terms, according to Huisjman and van Tilburg (2021), "is that social isolation is conceptualized and operationalized as an individual-level characteristic of being detached from social contacts, whereas social exclusion emphasizes broader and multifaceted or multidimensional societal conditions that produce poverty and inequality which reduce people's abilities to participate in society" [p.99]. However, in practice research on social exclusion tends to emphasise material conditions (e.g., poverty, workforce participation, civic engagement, welfare policy) while neglecting isolation and loneliness, in particular its psycho-emotional dimensions. We do not use the terms social exclusion in this report, nor review research on this concept. The research on isolation and loneliness as we note in the next section understands its causes to be multidimensional, both individual and social, and often in complex interactions.

Risk factors for SILo

The risks for SILo occur at the micro (individual), meso (community) and macro (societal) level (Victor & Pikhartova, 2020; Keefe, et al., 2006; Weldrick & Grenier, 2018). Risk factors for becoming socially isolated or lonely at the micro level are numerous and can occur simultaneously, or singularly. These include physical factors, such as poor body image as might be present with obesity, chronic illnesses and urinary incontinence. Impaired vision and hearing loss have also been associated with the potential to become socially isolated or lonely as communication becomes difficult. Psychological factors may play a role as with depression or cognitive decline (Nicholson, 2012). Living alone has been associated with an increased risk of SILo (Cohen-Mansfield et al., 2016; Greenfield & Russell, 2011; Havens et al., 2004). Change in family and work roles, such as the loss of a close family member can also place one at risk, as can changes in mobility (Nicholson, 2012). Life course transitions also place individuals at a greater risk of SILo (Government of Canada, 2016; Hawkley & Kocherginsky, 2018; Newall et al., 2014; Weldrick & Grenier, 2018).

SILo risk factors have been observed at many levels: individual, community and systemic

Meso-level risk factors address factors at the level of community, such as the status of one's neighborhood, including safety or availability of affordable transportation. These can impact one's ability to engage meaningfully in the community (Weldrick & Grenier, 2018). Macro-level risks are more structural, such as policies that impact one's socio-economic status, or availability of education or healthcare (Government of Canada, 2016; Keefe, J et al., 2006; Menec et al., 2019; Weldrick & Grenier, 2018). Minority status can also contribute to isolation, with studies finding sexual orientation, race and language being associated with increased risk of social isolation (Fredriksen-Goldsen et al., 2014; Government of Canada, 2016; Mulligan, K et al., 2020; Na & Hample, 2016; Weldrick & Grenier, 2018).

Not recognizing the impact that both meso- and macro-level factors have can result in overemphasizing individual factors or conflating social with individual factors, such as marginalization resulting from identity status and income inequality (Weldrick & Grenier, 2018). Consequently, the responsibility for addressing social isolation should not be left to solely to the individual but should be understood as a social challenge that requires a multi-level approach (Tadaka et al., 2016).

Consequences of social isolation and loneliness on the individual

Many negative health consequences are associated with SILo. There is an increased risk of mental health challenges as a result of SILo (Fratiglioni et al., 2000; Hawkley & Cacioppo, 2010, O'Luanaigh et al., 2012), as well as of cardiovascular disease (Friedmann et al., 2006; Valtorta et al., 2016, 2018). Social isolation has been associated with an increased risk of diabetes (Brinkhues et al., 2017) and loneliness has been associated with an increased predisposition to depression in older adults (Jaremka et al., 2013; Taylor et al., 2018).

Perhaps most striking is the impact on mortality. Oft quoted, Holt-Lundstad's research found social relationship changes are as strong a risk factor for increased mortality as is smoking or alcoholism, and surpasses the risks associated with obesity (Holt-Lunstad et al., 2010). They followed this analysis with another meta-analytic review which revealed that loneliness increased the likelihood of death by 26% and social isolation increased this risk by 29% (Holt-Lunstad et al., 2015). Conversely, they found those with stronger social relationships had a 50% increase in odds of survival. This jumped to 91% when it included having a sense of communality and active engagement in a variety of social activities or relationships (Holt-Lunstad et al., 2010).

Stresses on the healthcare system

Given the health consequences SILo can have on the individual, it should not be surprising this translates into having an impact on the healthcare system at large. It has been found that SILo is associated with an increase in spending on healthcare services, however for different reasons (Fulton & Jupp, 2015; Meisters et al., 2021; Mihalopoulos et al., 2019; Shaw et al., 2017). Loneliness has been associated with an increased rate of spending on mental health (Meisters et al., 2021) and residential care (Fulton & Jupp, 2015). Social isolation has been associated with increased inpatient costs (Shaw et al., 2017). Interestingly, Shaw (2017) found a decrease in overall healthcare spending after adjusting for socioeconomic and health status for loneliness. They suggested this decrease was the result of the lonely individual delaying access to healthcare services. Thus feeling lonely acted as a barrier to accessing services in a timely manner.

Trying to make a difference: interventions for SILo

Much focus has been placed on interventions aimed at alleviating SILo, and clearly they need to be in place as a means of incorporating a holistic approach to one's health and well-being and strengthening social integration. They are broad, diverse and can be delivered in a group format, or as one-to-one interventions. Results are mixed in terms of their effectiveness, likely due to the multi-factorial nature of SILo (Bagnasco et al., 2020; Cattan et al., 2005; Cohen-Mansfield et al., 2009; Dickens et al., 2011; Holt-Lunstad et al., 2015; Masi et al., 2011; Poscia et al., 2018; Stojanovic et al., 2017). Among the most studied interventions are leisure activities (Cohen-Mansfield et al., 2009; Toepoel, 2013), technological interventions (Baker et al., 2018; Choi, 2011; Poscia et al., 2018), intergenerational strategies (Bagnasco et al., 2020; Cerruti & Shepley, 2016; Nicholson & Shellman, 2013; Sakurai et al., 2016), animal therapy (Carver et al., 2018; Krause-Parello, 2012) and physical activity programs (Masi et al., 2011; Robins et al., 2018; Shvedko et al., 2018).

An additional challenge for researchers is that interventions that assist in alleviating SILo are not always defined as such. Many community support services (CSSs) employ a variety of strategies that target the medical, financial, social and psychological needs of individuals. They are delivered by private, public, non-profit/community organizations (Denton et al., 2010; Gallagher & Truglio-Londrigan, 2004; Tindale et al., 2011). These CSSs may also decrease SILo, however this may not be explicitly stated as their goal (Jopling, 2020).

Many CSSs are underutilized due to a variety of barriers, including lack of awareness (Strain & Blandford, 2016) or challenges in accessibility, such as availability, affordability or transportation (Montoro-Rodriguez et al., 2003). Improving access to CSSs can therefore contribute to addressing SILo. For example, transportation is an oft cited barrier to accessing appropriate interventions (Government of Canada, 2016; Marr, 2015; Weldrick & Grenier, 2018). Improving transportation access for older adults will support connection, even though these improvements may not be framed as a strategy to address isolation (Hanson & Hildebrand, 2011).

Developing appropriate interventions for any given community has been found to be more effective when adapted to local context (Cohen-Mansfield et al., 2016; Gardiner et al., 2018). Communities are well poised to understand the needs of their residents and what resources they have and are able to develop, as well as address barriers.

Example of CSS which address Silo in Fredericton, New Brunswick:

-Meals on Wheels: a not-for-profit whose mandate is to provide nutritious meals and social support with the goal of maintaining healthy and independent lifestyles. They offer a Wheels to Meals event bringing together many isolated clients (Meals on Wheels, 2022)

-Adopt a Grandparent/Elder: an intergenerational support system targeted at creating a caring community through interactions in the form of sharing (Adopt a Grandparent/Elder Fredericton, 2022).

-Urban/rural rides: a registered charity powered by volunteers who assist those in need to have access to safe, affordable and reliable transportation to a variety of community support services (Urban/Rural rides, 2022).

Addressing SILo needs an all-encompassing approach

Given the complexity of the issue of SILo and the range of CSSs and interventions that can address them, it is most useful to envision the components that are necessary to address SILo as an ecosystem that works together. The concept of ecohealth has been spearheaded by Canadian researchers since the 1980s and understands that health is a combination of biophysical, social, economic and political environments. It recognises that a more comprehensive approach to health is needed, grounded in the determinants of health, where environmental, social, lifestyle and genetic factors must be taken into consideration (Lalonde, 1974; Webb et al., 2010). It sees health not as the absence of illness, but as 'harmonious participation in the resources of the environment, which allows the individual the full play of their functions and aptitudes" (Lebel, 2003, p. viii)

SILo and its position in the ecosystem

Ecohealth approaches have proven to be especially useful in addressing issues strongly experienced by the most vulnerable (Webb et al., 2010). Understanding the processes and structures that impact the individual, and are impacted by that individual, can bring in a multi-level, multi-faceted and multi-disciplinary strategy to understand how all of these components influence the 'pattern of connection'. This is important as it understands that one singular solution or effort will not address these complex issues, and that a variety of strategies can be brought in at various times and places (Hancock, 1993).

The Mandala of Health is a model that has been developed within ecohealth to illustrate the holistic nature of health and has been recently updated to address gaps in the original iteration (See figure 1; Hancock, 1985; Langmaid et al., 2020). It situates individual health within a broader health field that includes not only the social determinants of health but our relationship to the natural environment. The circular motif highlights interconnection and the inseparability of parts within the whole. The newest version uses broken lines to illustrate the interactive nature that exists between any of the identified layers (Langmaid et al., 2020). The original model labeled the healthcare system the 'medical care system', later naming it the 'sick care system', while the newer model has assigned the label 'health prevention services' (Hancock, 1985; Langmaid et al., 2020). It is worth noting that the mandala situates health care organizations further from the individual than social relationships, community and psycho-social environments. This is to represent how the latter have more influence on the individual health outcomes due to proximity (Hancock, 1985; Langmaid et al., 2020). This is echoed in other research. For instance, Hood et al. (2016) have estimated that up to 80% of health outcomes in general are related to the social determinants of health. Thus, strategies that target supports that exist outside of the healthcare sector could lead to better health outcomes than those that simply increase health services (Hancock, 1993; Hood et al., 2016; Langmaid et al., 2020; World Health Organization, 2021).

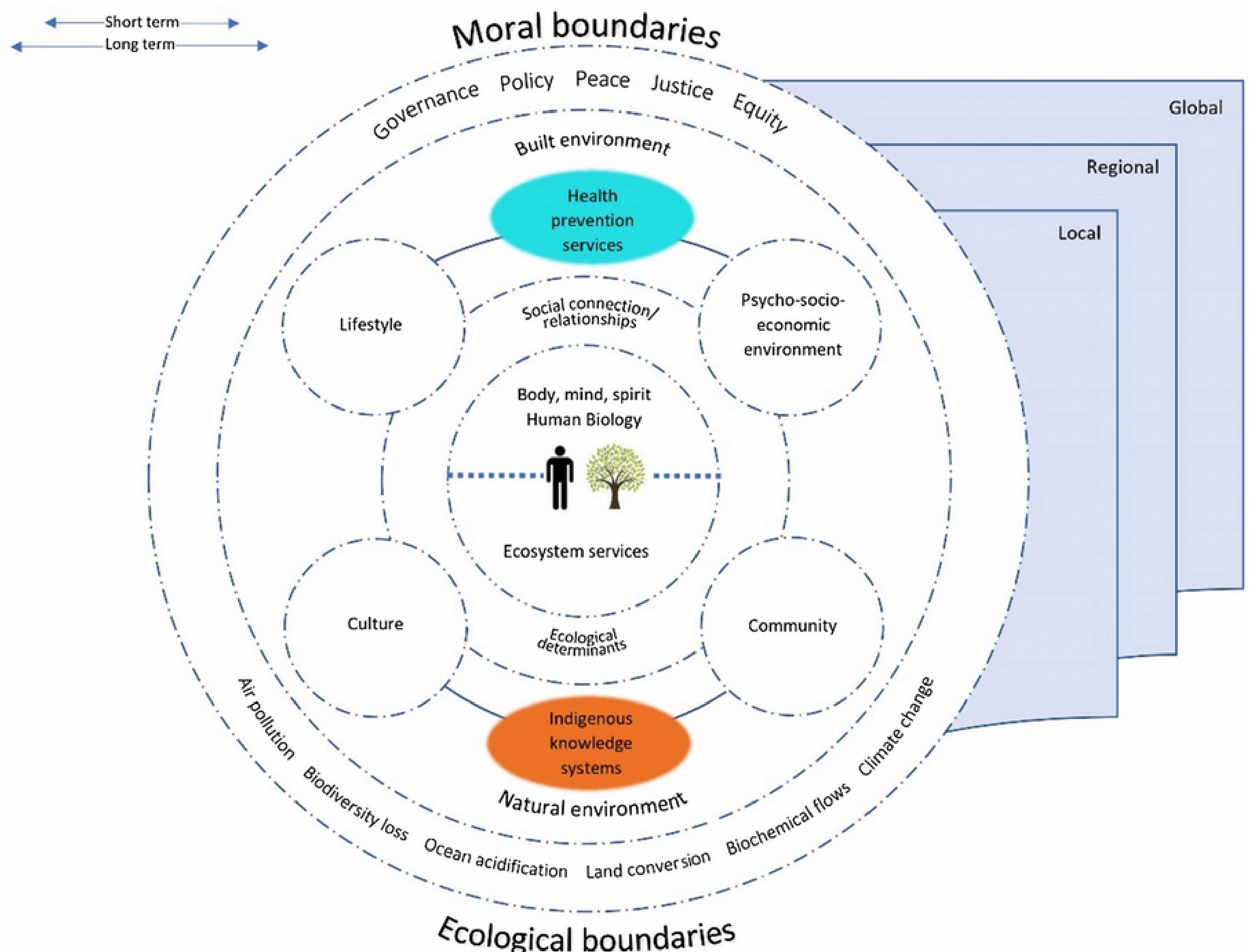


Figure 1. Mandala of health, used to represent the universe as a whole, the individual at the centre, and all the components that impact one's health around them. From Langmaid et al., 2020.

Community Connectors: those who move between boundaries to improve SILo

Community connector programs (CCPs) are over-arching strategies that aim to support those experiencing SILo by connecting them to existing interventions and CSSs that are already in place (labeled as 'ecosystem services' in the Mandala of Health) by helping span any barriers, or boundaries, that might otherwise prevent older adults from accessing them (Jopling, 2020; Wallace at al., 2018).

The Mandala of Health will be used as a model to explore where CCPs can assist the individual when they are experiencing SILo. The interplay between social relationships, the place of the community, psycho-social environments and more can be targeted by a variety of community connectors with the overall goal of improving social connection and harmony between the individual and the ecosystem. How community connectors might support increasing connection and address SILo will be examined. The role of connectors, their ability to reach those who experience SILo, how they understand them and connect and support them to the appropriate sector in the ecosystem will be the focus of this analysis. Community connectors programs come in many different forms and we will explore some of this diversity.

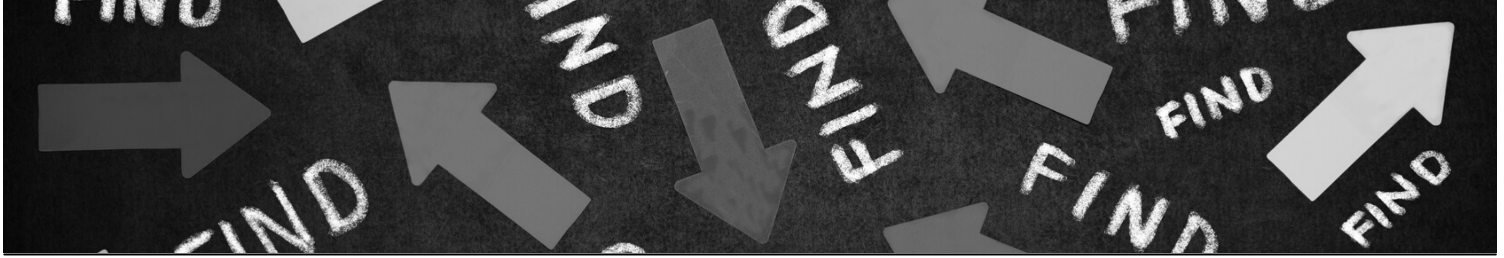
Methods

This literature review employed an iterative approach consisting of two phases. The first phase included a search of research literature with the assistance of a research librarian. Search terms included: community connector, community supports, social prescribing, social isolation, loneliness and older adults. Both peer reviewed and grey literature were included. Databases searched included PubMed, Medline, CINAHL, EBSCO, Google, Google Scholar, Web of Science, ProQuest Nursing and Allied Health Database and Joanna Briggs Institute EBD. A total of 64 articles were identified using search terms health access, community connector, boundary spanning, community health worker, navigator, and community support services. A total of 16 were included in the analysis of English articles published after 2010. Articles included those related to individuals carrying out actions to improve awareness and/or access to community and health services for older adults. Of interest were how individuals were trained, their activities and roles, and whether aligned with healthcare institutions or community services.

Case studies of established community connector programs were conducted between April 2022 and June 2022. Semi-structured interviews were completed with five programs, two in Canada, two in the United Kingdom and one in Australia. Questions focused on the development of Community connector programs, local supports needed for success, barriers in continued development and sustainability of the program, challenges and successes in recruiting Community connectors, the role of their community connector, among other topics.

Data was analyzed into themes to both inform the second phase of the literature review, as well as to inform the case study briefs included in this report. The second phase of the literature review included a re-examination of research literature, with the aforementioned databases being included in the search, resulting in an additional 10 articles being identified and an additional 5 articles were included in the final analysis.

Goal: Understanding the position of the Community Connector in the ecosystem for SILo



Results

The first phase of the literature review revealed the breadth of the topic and the challenges this posed in understanding all that is involved. As a relatively new area, there are definitional challenges. Community connectors and their programs are not always identified under this specific term, although they have the same roles and carry out the same activities. Additionally, community connectors and their programs may be labelled as such, but then have differences in their roles and activities.

Upon completion of the case studies, it became clear that there were similarities with all programs. Documenting their scopes would prove useful. As such, this literature review was able to clarify what community connectors and their programs are, identify a range of terms in the literature used to label them, and outline their roles and activities. The Mandala of Health was incorporated as the framework to understand how community connectors and their programs can assist an older adult who is experiencing SILo.

Community Connectors defined

Community connector programs are those that support hard to reach individuals to access and engage in CSSs and interventions. The term "hardly reached" rather than "hard to reach" will be used following Wallace et al. (2019; 2020) to shift the responsibility of inclusion away from the individual and onto the system, its services and resources (Sokol & Fisher, 2016; Wallace et al., 2019; 2020).

The individuals who carry out the actions of connection within community connector programs are referred to in this report as community connectors (Figure 2). Community connectors are "members of the community who enable the flow of information, resources and relationships across cultural, social and organisational boundaries" (Wallace et al., 2019,p. 366). In the case of SILo, community connectors bring together the individual who is typically hardly reached by the various layers within the ecosystem to the CSSs and interventions that could assist them in achieving balanced health and well-being.

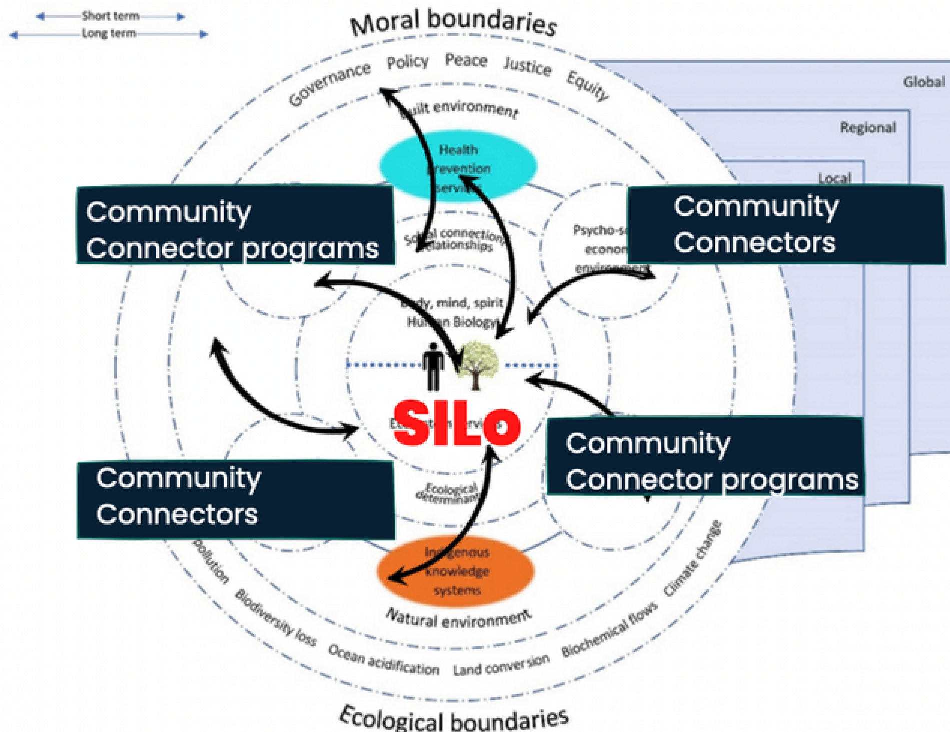
Community connectors are socially engaged individuals who can cross boundaries

(Community connectors defined)

Community connectors act as a bridge between the individual and the CSS and/or intervention that benefits the individual through the work of boundary spanning (Wallace et al., 2018; 2019; 2020). The concept of "boundary spanning" has been used in business literature and increasingly in healthcare research. It refers to the work that is required to cross boundaries, whether the boundaries be organizational, social or cultural in nature, by an individual who is able to reach across these unrelated and traditionally disconnected spheres and bring them in closer proximity to each other (Long et al., 2013; Pedersen et al., 2017).

Boundaries may be physical, social or cultural in nature. They may confine individuals into marginalized areas in the ecosystem for long periods of time, even generations, impacting their ability to participate in community life or access community services (Pedersen et al., 2017; Wallace et al., 2018). The work of boundary spanning, according to Wallace and colleagues (2019) means community connectors need to have the capacity to function across a range of environments, having the interpersonal skills to navigate both sides of the boundaries they span.

Figure 2. Mandala of Health with individual experiencing SILo at centre.



Note: Mandala of Health, with position of Community Connector programs and Community Connectors. The individual at the centre of the Mandala is experiencing SILo. Adapted from Langmaid et al., 2020.

Community connectors and their many names

Community connectors exist in the ecosystem at any point and carry out a range of activities, under a variety of titles. A wide variety of terms have been used to label community connectors. They have been known as health champions, peer support workers, navigators, community health workers, gatekeepers and more (May et al., 2007; Giebel et al., 2020; Valaitis et al., 2017; Schneider et al., 2016; Wallace et al., 2018). Depending on how these positions are structured, they reach, understand and support older adults who are experiencing SILo in a range of ways.

Wallace and colleagues (2018) suggest understanding community connectors as being on a continuum. This would mean a community connector is aligned and embedded in the community, such as being a taxi driver or originating from a church or they can be within a public organization, such as a community health centre, hospital or library. Depending on their location, their reach and role may differ.

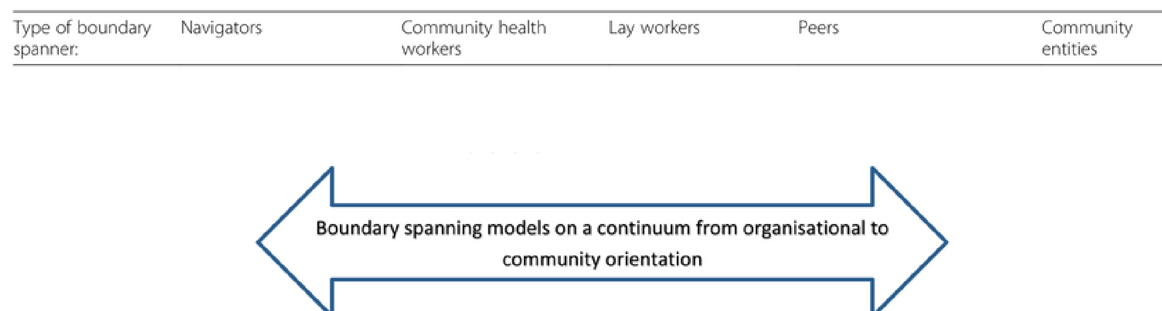


Figure 3. Adapted from Wallace et al, 2018, indicating a range of roles used for community connectors and their alignment ranging from public organization to community based.

Community connectors and how they span boundaries.

Community connectors, in whichever form they take, have been noted to be able to link those who are experiencing SILo with structures in the ecosystem using a range of activities. They do so by first noticing and responding to those who are disconnected from the larger system. This is the "eyes and ears" concept, where any and all can identify the disconnected individual, which in this analysis is the older adult who is experiencing SILo (Freedman & Nicolle, 2020; Wallace et al., 2019).

As is noted in the Mandala of Health, the layer that is positioned most closely to the individual is the social relationships and close connections they might have (Langmaid et al., 2020). For those experiencing SILo, this network might be very small. Furthermore, those they are in contact with, whether a large or small network, may not be equipped with knowledge of the broader layers of the ecosystem. As such, the concept of 'weak ties' to act as the 'eyes and ears' is useful to employ in community connector programming. 'Weak ties' are those individuls who do not necessarily have deep relationships with one another. They may be acquaintances or even complete strangers, but they are people that may still interact together. "Weak ties' are useful in broadening one's network to obtain information from otherwise distant parts of the ecosystem (Granovetter, 1983).

Among the many risk factors that places an older adult at risk of SILo in Canada is lack of awareness of existing community resources (Government of Canada, 2016). This creates a feedback loop, where those who are socially isolated or lonely will have decreasing amounts of relevant and useful community information that then further increases their risk of SILo. Indeed, loneliness has been defined by the subjective quality of relationships being important to the individual, and social isolation as the objective number in one's network. The definition of social isolation would benefit from noting the quality of that relationships as well to denote that close ***and*** weak ties are important. If one is to have only close ties as being defined as important, this restricts the individual to a low-density network, placing them at risk of deprivation of information and resources from distant parts of the ecosystem (Granovetter, 1983; Newall & Menec, 2019). Employing any and all members of the community, all people who might come into contact with the older adult who is socially isolated or lonely, will better serve that individual and thus broadens their ability to remain connected.

Jopling (2020) has also developed a framework to make visible the work of community connection. In a 2020 report reviewing promising practices to address social isolation, she explains that connector programs must **reach** lonely individuals, **understand** their unique perspecti;ve and **support** them to access appropriate services. The concepts of reaching, understanding and supporting provides a useful framework to identify the various facets of connector programs. They also may be used to understand key differences between programs. For instance, a door knocking program may use a database to identify and reach lonely individuals which is a very different means of reaching people than a public library, which typically requires SILo'd individuals to come to them.

(Community connectors and how they span boundaries)

There are also a variety of means to support individuals in connecting with CSSs and interventions. One may simply provide information, what is referred to as signposting, or a connector may drive them to the event itself. Jopling notes that the level of support distinguishes connector services from other services. Befriending services, for instance, not only take an individual to an event but they may attend the event as well.

In its most basic format, community connectors can be absolutely any member of the community who has decided to assist even one individual to remain connected. This organic form of a community connector requires no training, it just takes someone who is internally motivated to make a difference for an individual they have encountered and identified as needing support. As described in one project in the UK, "the extent to which champions (their word for community connector) become involved and the intensity of the role depends on individual motivations" (Woodall et al., 2013).

Appendix A describes a series of case studies which illustrate some of the variety in the way the community connector might be positioned in the ecosystem, how they reach the individual, understand them and then support them in connecting with their community and its CSSs and interventions. Below we turn to an exploration of social prescribing, as it is a form of community connector program that has received much research attention. Social prescribing too contains much diversity but has a stronger organizational orientation than those which are more organic. It will serve to outline the many activities community connectors can carry out in an effort to address SILo as experienced by older adults.

Social Prescribing

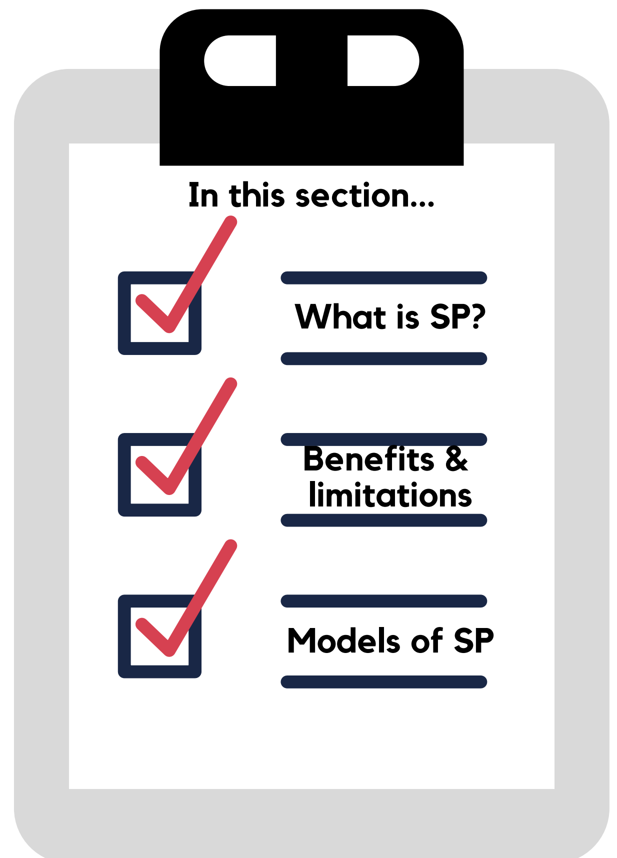
Social prescribing (SP) is a type of community connector program that has been identified as a promising practice to address SILo in older adults (Jopling, 2020). SP emerged as a response to the growing recognition of the importance of the social determinants of health (Drinkwater, et al., 2019). While definitions vary, simply put:

> **"Social prescribing empowers clinicians to connect people to community supports that have been shown to improve health and well-being."**
> (Nowak & Mulligan, 2021, p. 88).

Husk, et al. (2020) uses the term "pathway," to describe SP because this connector program is intended to support the needs and overall well-being of the patient by establishing links, or pathways, from an isolated individual who has made contact with a health care provider, to community-based supports, services, and activities. Therefore, this work will anchor investigations of SP as a promising practice to address issues of SILo to Husk, et al.'s (2020) conceptualization of SP as "not a single intervention but a pathway and series of relationships, all of which need to function to meet patient need" (p. 319).

From Consult to community

A defining characteristic of SP is its' close proximity to medical structures. Whether the specific SP scheme was developed out of a medical centre or alongside the medical system, SP aims to strengthen integration between health and social care (Dixon and Polley, 2016). SP can enable health care providers to be more "proactive and preventative" in their approach (Kimberlee, 2015, p. 103).



Nowak and Mulligan (2021) note that despite many primary care providers' awareness of the social dimensions affecting their patient's health, their ability to address health concerns arising from social isolation or loneliness is greatly restricted. "Limiting primary care to medical needs for medical illnesses," according to Nowak and Mulligan, "represents a missed opportunity for addressing the fundamental

cause of illness" (p. 88). In identifying this common shortcoming within healthcare provision, SP takes advantage of the power medical institutions hold, being that they are cultural symbols of health, and as such, are understood as acceptable sites for health promotion initiatives to occur. A recent report indicates:

> **primary care practitioners spend at least a third of time on social issues that can be better addressed by others. Through a prescription to collaborate with another support, medical and social needs can be adequately addressed by the appropriate resource.**
>
> (Alliance for Healthier Communities, p. 10).

A consultation, therefore may mark the beginning of a pathway to meaningful community support.

It is important to note that the benefit of SP extends beyond the clients to also aid health service providers (Dixon and Polley, 2016). One general practitioner described their experience with a SP scheme as an "extra pair of arms" wherein the connections between their practice and a community partner enabled them to provide quality care which addressed complex social issues through social means (Kimberlee, 2015, p. 108). So, in a nutshell, a SP approach "widens the scope of what is possible to do as a community of health practitioners" (Dixon and Polley, 2016, p. 4). SP schemes achieve this by transforming a simple interaction into a pathway.

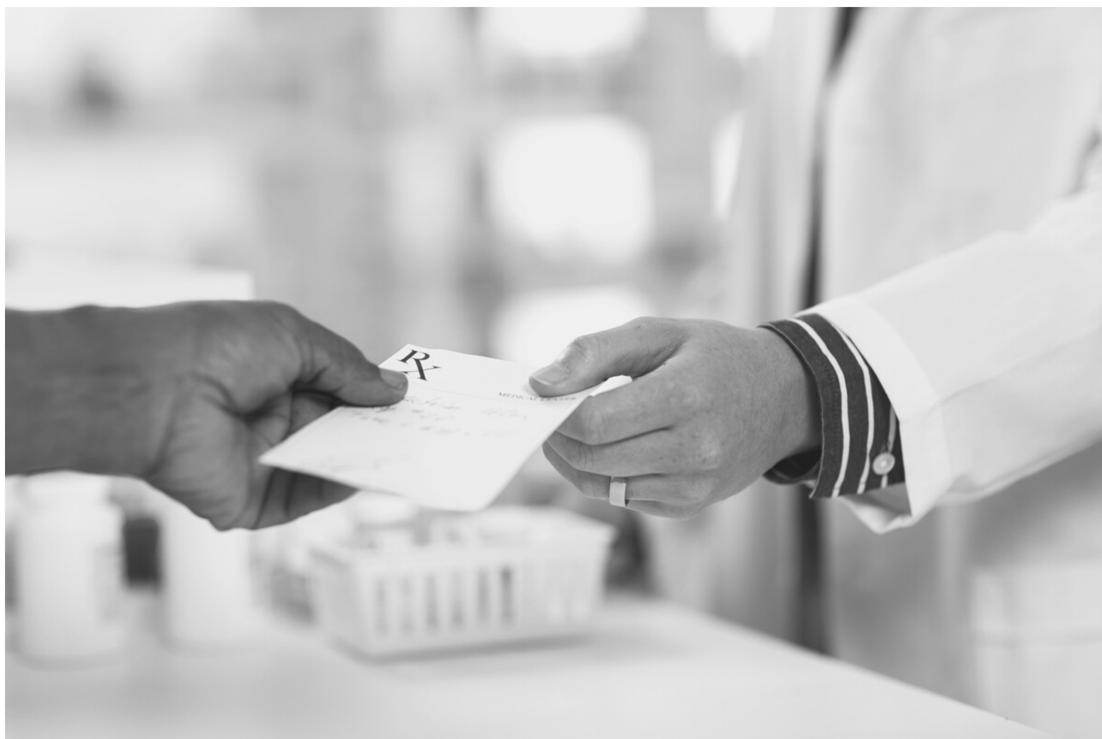
Maximizing existing community resources

Connection with the community is supported through the creation of a "social prescription" which is a referral or pathway designed to connect a SILoed individual, who has made contact with a health care provider to beneficial supports already available in their community (Drinkwater et al., 2019). This connection is reliant on integrating and maintaining necessary infrastructures within and around the existing health system. For example, to be effective, SP interventions depend on a community having robust services and activities. SP programs also require reliable knowledge of this availability (Kimberlee, 2015). In some cases, the health care provider first contacted acts as social prescriber and thus connector or they may refer the individual to a person whose job it is to assist with community/health care navigation. Given this variety, a typology of SP practices is useful. We consider this next.

Utilizing Existing Supports
SP is understood as linking clinical practice with services already available within the community, therefore, SP is not intended to facilitate the development of new services or supports.

Abel et al., (2018) emphasizes that efforts must "build on what is already there. Elements of good practice already exist, building on these means that some of the infrastructure work is done and proper respect is given to the efforts already made." (p. 809).

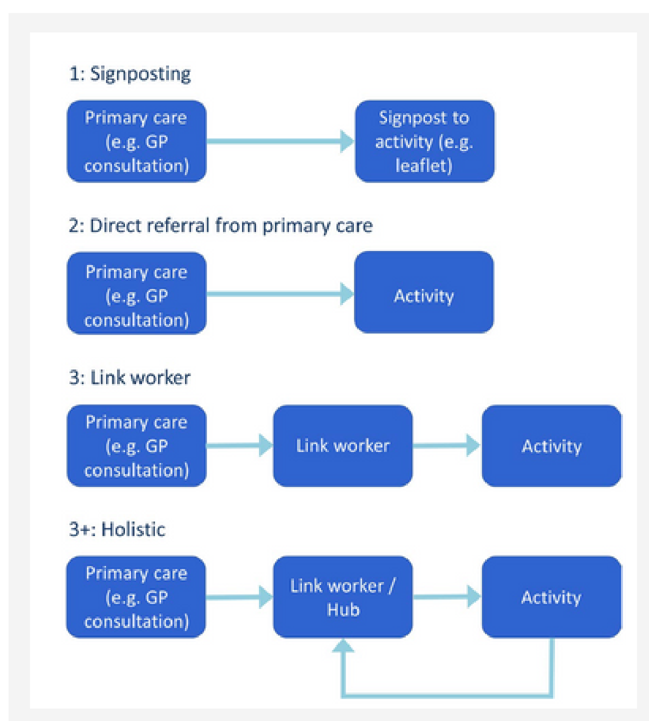
However, an advantage of SP's location with relatively powerful health care institutions (as compared to other community agencies) is that the prescription process may illuminate gaps in support networks and inform to the development of new programs. in response to patients' needs (Abel et al., 2018).



Social prescribing: 4-Model Structure

Kimberlee (2015) delineates between 4 models of social prescribing which are as follows: Signposting, SP Light, SP Medium, and SP Holistic. Husk et al., (2020) provides an illustration of a similar set of models to visually represent the 4-pathways through which patients are connected to support (Figure 4). The development of these pathways, including the infrastructures necessary for their development and consequently the differences and similarities present between them, has a significant impact on how SP, as a connector program, can reach, understand, and support SILoed older adults. The following descriptions of the pathways synthesizes information from across the literature, mainly Kimberlee (2013, 2015), whilst utilizing the illustration from Husk, et al. (2020). Our intention for using this framework is to demonstrate variation between what constitutes SP and how additional components integrated into the program can affect the functionality and outcome of the connector program.

Figure 4. Models of Social Prescribing.



Note: This figure is derived from Husk, et al, (2019) and depicts a simplified illustration of 4 types of pathways through which patients are connected to support. This is by no means a quintessential framework as SP schemes may be transitioning between models or not align with a specific characterization.

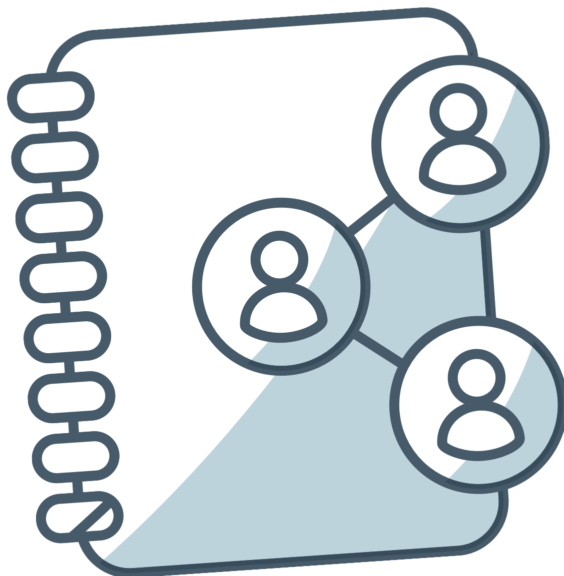
1. Signposting

Kimberlee (2015) notes that all of the proposed models of SP have elements of signposting, but the simplest approach, referred to as 'signposting,' is, in essence, a simple "brokerage approach" with the initial SP intervention "highlighting gateways to other services" (p. 106). This pathway relies on very simple directing of a patient, from a health care provider to relevant information about community supports and activities. The benefit of this model is its simplicity; however, it can also be a limitation because it offers minimal opportunity for follow-up, feedback, or personalised support (Mulligan et al., 2020). Moreover, its success is contingent on overcoming the significant structural barrier of mapping local assets.

Mapping is an integral step in community connection. It can lead to the development of a formal directory that supports signposting efforts. However, mapping local assets can be a tedious and time-consuming process requiring constant updating. A Scotland-based SP project found that "only 20 per cent of staff thought they had adequate links with community resources," (Mulligan et al. 2020, p. 15). Ensuring adequate support directories is therefore a key component in effective signposting.

2. Social prescribing light

The second pathway is referred to as SP Light or direct referral and is identified by Kimberlee (2015) as the most common form of SP, involving "interventions which refer at risk or vulnerable patients to a specific programme to address a specific need or to encourage a patient to reach a specific objective" (p. 106). Once again, this approach to SP is quite simple but is reliant on a physician's knowledge of supports existing in the community sector. It is also objective or outcome-driven which is indicative of current biomedical responses to illness wherein support, mainly medical treatment, is offered as a reaction to a problem or risk behavior.



Due to SPs close orientation within health institutions, biomedical understandings of when and how to offer support to patients often informs SP. We identify this as a significant limitation of SP as a connector program because, while the medical setting empowers the program, it can also constrain the type of support offered. The following approaches to SP strive for more holistic responses and understandings.

3. Social prescribing medium

SP Medium, also referred to as the "link worker model," (Husk et al., 2020, p. 310), involves the use of a link worker, health facilitator, or community connector who is dedicated to providing advice, promoting self-care, and signposting patients to various supports.

Drinkwater et al. (2019) emphasizes that the link-worker model for SP has the advantage of being able to offer a moderate to high level of support to assist beneficiaries in identifying their personal needs and goals. This contrasts with lower level of support available in the previous pathways. The link worker is in a position where they can foster a meaningful and constructive relationship that can then be used to tailor the activities or services for the individual.

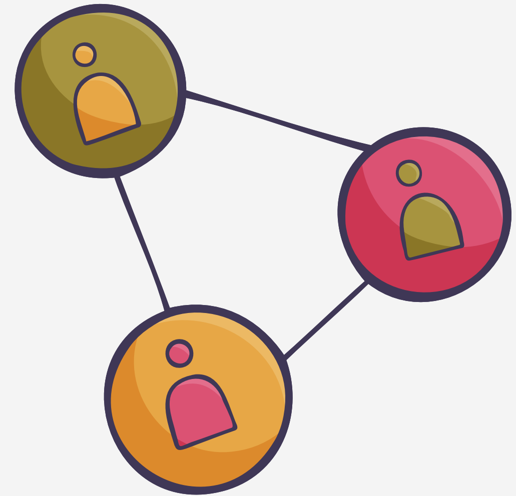
The link worker role can be an employed or volunteer position and there is often variation in the position title, training, experience, and specific responsibilities. Still, the link worker role is recognized across the literature as an integral component in successful SP schemes (Bickerdike et al., 2017).

However, as Kimberlee (2015) notes about this model, while it does enhance the program's ability to attend to individualized interests, it does not inherently seek to engage with the individual in a holistic way. It "aims to address specific needs or behaviours identified by the GP" (p. 107). This model is objective driven and reactive to health concerns. As noted, this is common with SP as it is intertwined with health institutions. This inadequacy paves the way for an adaptation of the link worker model that Husk et al. (2020) refers to as 3+ or Holistic.

4. Social prescribing holistic

Kimberlee (2015) notes that interventions conforming to a Holistic model of SP have evolved over a period of time and have often emerged from organic partnerships between primary care and community organizations. Holistic interventions have distinct features including a direct primary care referral to a knowledgeable SP worker through clear and formalized communication avenues. The patient's needs are addressed in a holistic manner wherein a GP's referral on, the basis of poor diet for example, may lead to broader supports on budgeting, loneliness, or access to employment through conversation with the link worker.

The Link Worker Role



Husk, et al. (2020) assert: "link workers are necessary, they have the potential to contribute to multiple elements of successful uptake, but not sufficient to the smooth running of the pathway. Whether referred to as a community navigator, health champions or so on, our analysis indicates that well-trained and knowledgeable link workers are beneficial for accessing, developing knowledge of activities and assisting transitions between services." (p. 319).

Key aspects of the link worker role vary greatly but may include: "working with patients to identify meaningful goals; co-producing an action plan with the patient; enabling access to activities and sources of support in the community, and providing ongoing motivational support to help patients achieve their goals." (Drinkwater et al., 2019, p. 3).

This highlights the necessity of communication in efforts to connect individuals to their communities and is why below we have chosen to pay close attention to how conversations occur and function within various CCPs, including SP. We have identified these conversations as an 'infrastructure' that enables pathways of connection. Additionally, Husk and colleagues (2020) argue that follow-up is an essential component in improving the SP pathway and adapting the initiative to local contexts, strengths, and capacities.

Conversation: a key tool for understanding.

CCPs are over-arching programs that aim to provide support to those who are SILoed by connecting them to programs existing in their communities. To do so, connector programs, particularly of the holistic variety, need to work to "understand" the person, their needs, proclivities, idiosyncrasies if the goal is to successfully connect them with resources that will make a difference (Jopling, 2020). This typically occurs through conversation, and thus how this conversation occurs may determine how robust and effective the CCP will be. Given the possible emotional complexities that such conversations may broach, there is a role for training, boundary setting, and ensuring that the connector approach matches the skill of the connector (Jopling, 2020). One would expect that signposting would not require the time or quality of conversation that a more holistic approach would require.

Connector Training

Community connectors who are involved in organized schemes often receive some form of training or guidance to assist in their ability to facilitate connections. Training varies based on the intention of the scheme, education, experience, and the availability of resources (Bickerdike, et al., 2017). Unfortunately, empirical evaluations regarding training are lacking significantly, however, using the framework provided by Jopling (2020), we can consider the potential for training to influence how connectors come to reach, understand, and support individuals within the context of SILo.

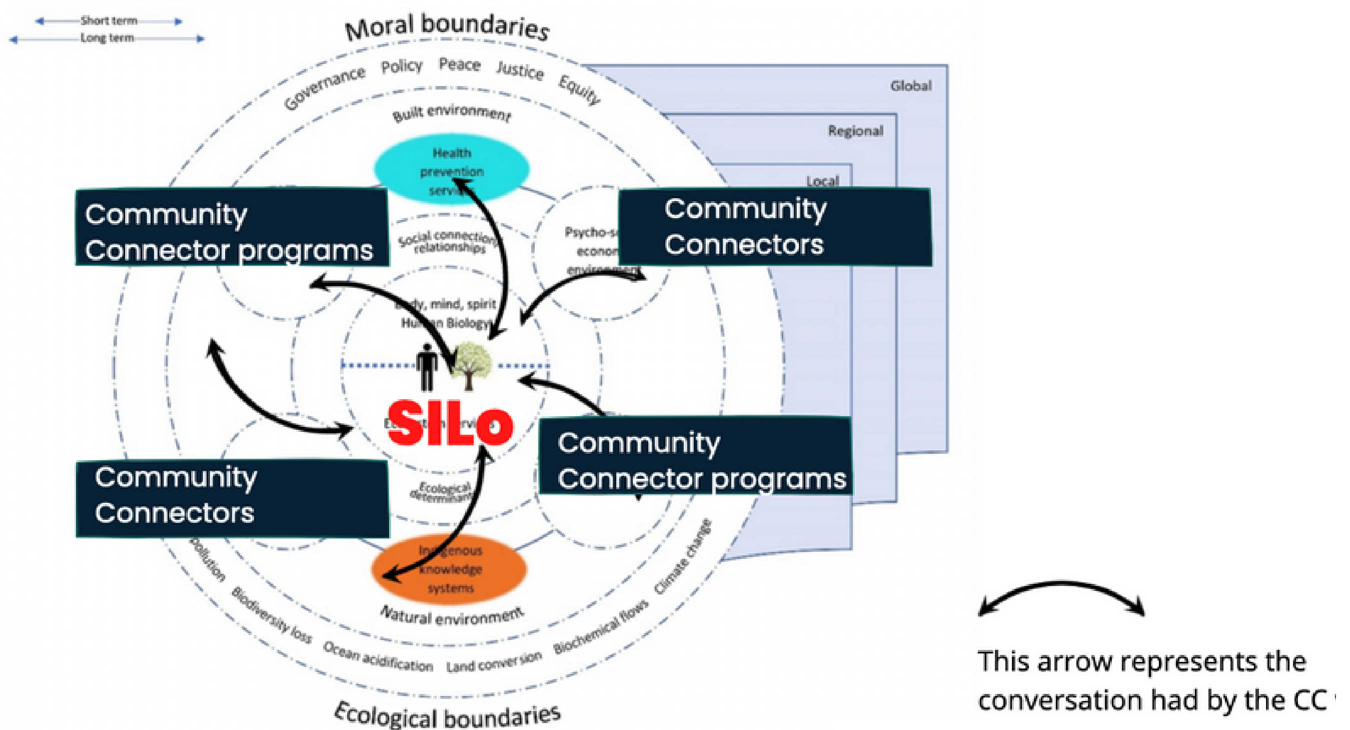
Connector training may recommend the use of a formal checklist or risk behaviours indicating when someone could benefit from links within their community (Jopling, 2020). Consequently, this will influence how the connector comes to understand SILo and when it is appropriate to offer support. A systematic review of social prescribing schemes found that a volunteer-based scheme provided connectors with 3 days of training that included basic counselling skills and team-building strategies, thus, intentions were set through training on the range of support they could offer and how they were to work collaboratively (Bickerdike, et al., 2017). This reflects a principle of successful connector schemes as identified by Abel, et al. (2018) which suggests that "working relationships across teams and organisational silos come first. Building relationships is seen as the key starting point for change" (p. 809). Therefore, training affected boundary spanning practices that can expand the reach of the connector.

-May & Contreras (2007) found that community workers in connector roles were trained with skills and knowledge on how to engage families. The CCs in this program were from the same underserved neighborhoods and thus shared the same cultural experiences as though they aimed to reach. Despite this, trust is built slowly, over time, generally with repeated visits and numerous conversations.

-In a scheme evaluated by Abel, et al. (2018), CCs were "trained to help people by signposting to services" using a directory (Abel et al., 2018, p. 805).

-Bickerdike, et al. (2017) found that some paid connectors received brief training about local services, others relied on their existing knowledge of local services, and some volunteer connectors had training that involved visits from community services they might refer people to (Bickerdike, et al., 2017). In these instances, the connectors received information on how they were expected to link people to support.

Figure 5. Mandala of Health: conversation binds the layers.



Note: The common action community connectors carry out is a conversation with the older adult experiencing SILo. This conversation can vary, can be more in depth, or brief, but it provides the connection that could assist in removing barriers within the ecosystem.
Adapted from Langmaid et al., 2020.

Supportive infrastructures: Directories

In addition to conversations, other infrastructures contribute to, and enable, SILoed individuals' access to community services (Husk, et al., 2020). We conceptualize infrastructures as physical or theoretical components incorporated into SP schemes that affect the context in which the initial conversation occurs and/or will influence the individual's access and uptake of community services.

As discussed previously, an online directory of community services can play an essential role in one's ability to become connected. Additionally, the presence of a link worker can enhance community connection initiatives by enabling increased levels of support to the beneficiary with a human touch (Jopling, 2020) and strengthening the pathway between a GP's practice and the community. These are perhaps the most pronounced infrastructures, but other features of connection programs will also affect the outcome including staff or volunteer training, and funding or supporting policy.

As noted, considerable effort is required to maintain directories up-to-date. Sending a vulnerable individual to an event that is full, waitlisted or not on the date specified may cause frustration and do more harm.

Evaluation

Research on the effectiveness of CCPs is still in its infancy and made more challenging by the diversity of types of programs and their adaptive nature. For instance, a recent attempt at a meta-analysis was hampered by heterogeneity of study designs, populations, interventions and outcome measures (Cooper et al, 2022).

Some examples of the effectiveness of CCPs have been documented, however. For instance, it has been found that the development of a CCP employing lay persons acting as an 'eyes on the ground' to signpost individuals to a community hub, supported by social prescribing, found a decrease in unplanned hospital admissions of 14%, resulting in a 20.8% reduction in hospital expenditures (Abel et al., 2018). Social prescribing has received the most attention to date; we consider some of the evidence below.

Evaluation cont'd

One systematic review of UK based social prescribing interventions, which most-commonly used a link worker model or direct referral from community services, found a statistically significant improvement in outcomes (mental well-being, mental health, loneliness and/or general health/ quality of life outcomes) (Cooper et al., 2022). Two of the reviewed studies reported reductions in primary healthcare use (consultation rates and medication prescribed). However, we note that the patient population for these studies was not working age older adults and the authors suggest these conclusions need to be taken with caution, as the majority of these studies were uncontrolled before and after studies, often had high attrition rates, and there was no long term follow up.

In another UK focused knowledge synthesis report reviewing eight studies (Mason et al., 2019) also struggled with methodological quality, noting "the studies were mostly of low methodological quality (small sample sizes, mostly with no control groups, often no statistical analysis and considerable loss to follow up)" (p. 4). The review found considerable variety in the delivery and clients, rendering comparisons across studies difficult to conduct. Additionally, there was considerable variation in the type of link worker support, ranging from only signposting events to actually attending activities with clients. These studies identified several infrastructure issues, including ensuring link workers have appropriate skills and resources, encouraging greater GP referrals, and tailoring services according to the needs of patients. "Despite widespread national support for social prescribing," the authors concluded, that the "synthesis found no clear evidence for effectiveness" (p. 4).

The role of the CC is to assist an individual to be able to access a CSS. This can be through the creation of awareness of such a resource. How CCs themselves become aware of resources in their community is yet to be evaluated. As CCs may be supported by directories, insights into directory effectiveness, evaluation of the components of the directory and requirements to maintain accurate and up to date information would be useful. Wallace et al. (2021) has examined how CCs use social media to communicate with others to spread information of community supports and resources. It will become useful to add to this important finding by understanding how CCs access the information that they pass on to those who are hardly reached. Indeed, in one analysis of the sustainabilty of community websites, it was noted that awareness of the website among residents and organizations in the community were among the top 5 considerations in developing a successful community directory (Norris & Freeman, 2006).

Our case study participants noted the importance of maintaining an accurate, up to date directory in their own local community. For the organizations that were in the UK, they noted it was important to keep this ground level information in an online, accessible format for their residents, despite the presence of over-arching, national websites that house information. They noted their community website should provide links to these national repositories. One case study participant noted community websites should house information about activities that occur daily. They also indicated a directory should house information on supports that are provided by organizations, as well as supports that can be carried out by the individual (such as how to meditate, or tips on how to create healthy meals). Future studies understanding what should be contained in directories will further support CCPs and their CCs.

Conclusion and policy recommendations

People become socially isolated for many reasons. These may include personal proclivities such as fear of rejection, community challenges such as racism or ageism, and larger societal factors such as unequal distribution of resources. Expecting one solution to be able to address all of these for such a range of individuals is unrealistic. However, acknowledging a variety of infrastructures that are aligned with the common goal of addressing social isolation and/or loneliness could prove useful in moving forward. The Mandala of Health is therefore a framework within which one can begin to consider how these various components exist, interact and adapt.

Community connectors are individuals who can link these various components together, spanning the organizational, social, or cultural boundaries that might prevent the individual from being integrated into the ecosystem and able to benefit from its resources. Whether community connectors are formal, with a strong organizational orientation, or informal, being more closely aligned with the community, can vary (Wallace et al., 2018). They may carry different titles, including navigator, peer support worker, community health worker, link worker and more, but the underlying commonality is they are socially engaged individuals who facilitate the connection of disconnected parts of the ecosystem by facilitating the flow of information, relationships and resources across boundaries (Wallace et al., 2020). When zooming into older adults who are SILo'd, community connectors can play a pivotal role in facilitating connection to already existing resources supporting both the individual and these community services.

This review identified several areas that would be supported through policy development and resource allocation:

1) By creating a broad network of individuals through 'weak ties', as is proposed by employing comunity connectors at all levels of the ecosystem, the individual's network and subsequent access to information is broadened.

2). The creation of up to date and ongoing documentation of community activities and resources. This will ensure accurate mapping of existing services. Ongoing evaluation of their effectiveness and responsiveness to the needs of the community can then be completed.

3) SP programs have developed within health care institutions because they can build on the existing capacity, steady funding, and prestige of health care organizations. Policy and funding is required to develop CCPs within other host organizations particularly those that do not have the same type of resources or steady funding that health care organizations do.

4) Continued evaluation of training and outcomes of community connector programs. Given the complexity contained within conversations the CCs may have with a range of individuals, it is important to make every effort to evaluate their effectiveness with the perspective of those who are hardly reached incorporated. It is understood they have been underrepresented to date and working in collaboration with CCs could remedy this. Given the adaptability of good connector programs, qualitative evaluations may be more insightful than attempts to demonstrate effectiveness through controlled studies.

5) This report recognises that CCPs are in their infancy. It also identified considerable diversity as well as the importance of local adaptation. It would therefore be useful to support the creation of a network for community connector programs to share resources, learnings, promising practices and be a source of expertise for those interested in developing CCPs.

Let's look back on Mrs. Tremblay

Mrs. Tremblay continues to enjoy her solitude, however she is also functioning better as aspects of her well-being have been addressed. After attending a visit with her family physician who put her in touch with a link worker, as they have a fully functioning social prescribing program in her area, she now has taken advantage of government income benefits that she did not know she was eligible for. As such, she can afford doing her groceries on a regular basis, as well as being supplemented by Meals on Wheels (Fredericton Meals on Wheels, 2021) deliveries twice a week to offset some of those costs. She is able to get regular rides to her appointments through the assistance of Urban/Rural rides, a reliable transportation service powered by a dedicated group of volunteers (Urban/Rural rides, 2022). Her visits are fewer, she has better adherence to medical regimes and is not accessing her family physician in moments of crisis.

She has also benefited from a local non-profit, Adopt a Grandparent/Elder, where she speaks regularly with her companion (Adopt a grandparent/elder Fredericton, 2022). They have discovered they have a mutual interest in traveling to exotic places and have taken to cooking an exotic dish from a new country every month. Because there has been increased visibility in media in Canada addressing the issue of social isolation and loneliness, both Urban/Rural Rides and Adopt a Grandparent/Elder has a wide range of volunteers who are interested in connecting with older adults. The volunteers can stay up to date on their community's weekly activities with the implementation of a local, community run website that informs residents of activities ranging from local teas, gardening groups and more. Mrs. Tremblay is now well supported should a negative event occur, she will have more people to reach out to who are able to make sure she maneuvers the various levels of the health ecosystem, should she need to access them.

Appendix A: Case Studies

CCs that can act at any level of the ecosystem

Location: UK

Term used to describe CC: Community Connectors.

Reach: widest form of CC. Can train many CCs, and can act at any level of the ecosystem, thus able to reach many.

Understand: can have conversations in any setting. This allows for the older adult experiencing SILo to feel at ease, greater chance for building trust.

Support: This conversation leads to signposting to central knowledge hub.

Position: unpaid; volunteer; anyone in the community can become

Training: 1 hour by central organization responsible for community outreach programs

Limitations: as its function is quite broad, it does not provide in depth connection with the older adult experiencing SILo. There is also no follow up.

This community actually has several layers of community connectors. They have Health Connectors, who work within social prescribing parameters (to be discussed below), Green Connectors, Digital Connectors and more. Each Connector is trained by staff within their primary organization. The original, and still functioning, Community Connector program provides 1 hour training to anyone in the community who wishes to participate. Within that hour, CCs are provided with education on how to identify someone who might be experiencing SILo. After idenitifying someone who is SILo, or at risk of the same, the CC will signpost the individual to contact a central location. They can contact this central location either through a phone number, a website or a location, which in this community is a talking cafe. Any of these platforms will then re-direct the older adult with SILo to community resources that are meaningful. This can be as simple as joining a gardening group, or a more individualized, one-on-one intervention to identify their needs, develop a plan and provide follow up to ensure they are well supported.

CCs as intermediaries between the individual with SILo and organizations

Location: UK

Term used to describe CC: Community Connectors.

Reach: These CCs act as intermediaries between other forms of CCs and organizations. They also have contact with individuals with SILo, having up to 25 people on their caseload at any time.

Understand: their conversations are more in depth. They will sit one-on-one with the individual, identify their needs and will co-develop a plan with that individual.

Support: Depending on the individual's needs, they may accompany them to an activity until that individual is comfortable. Theses CCs also intersect with community champions. Finally, their role allows them to develop programs they deem needed by the community.

Position: paid; no need for prior professional training; CC needs to be enthusiastic, self-motivated, good listener

Training: several components-modules aimed at providing education on various issues, including SILo, support behaviour change and more

Limitations: individuals experiencing SILo must reach out and contact this CC for assistance. More difficult to "meet them where they are"/build trust

This community also has several layers of CCs, including social prescribing. The Community connector role is filled by one individual who has several activities. They oversee community champions, who are volunteers that carry out activities directly in the community. Community connectors can work directly with individuals experiencing SILo. The individual can be referred or self-refer. The community connector will then meet with the individual and a plan is co-created to help them reconnect with meaningful community resources. This may be further facilitated by the community connector who might attend activities with the SILo'd individual. This interaction takes place over a 12 week period. CCs may have up to 25 individuals on their caseload at any time. Furthermore, CCs have the ability to develop programs according to feedback they get from community champions as well as from the in-depth conversations they are having with individuals experiencing SILo. They then liase with appropriate organizations to create these programs, ensuring relevant, interesting and continuous community development occurs.

Case Study: CCs as working one-on-one with the individual

Location: Canada

Term used to describe CC: Library social worker

Reach: This form of CC can assist people who present to their location. It has benefits by being in a central, easily accessible location.

Understand: their conversations can be more in depth, understanding the person's unique needs in a more individualized way.

Support: This CC has a deep understanding of resources and supports available in the community. They not only assist those experiencing SILo, but individuals with other needs. They also provide a pivotal role in supporting other library staff including security officers and librarians.

Position: paid

Training: training as a social worker in an accredited program. Training to perform duties specific to the library location are mostly self-motivated.

Limitations: individuals experiencing SILo must reach out and contact this CC for assistance. More difficult to "meet them where they are"/build trust.

A Canadian library hired a social worker to support citizens who might need assistance finding or accessing community resources. This type of connector program typically requires that individuals come to them but does not necessarily require citizens to directly ask for help. Its reach is enabled by the library's Coffee Corner program that encourages people to come and congregate. Sometimes up to 100 people attend the event. This then becomes an opportunity for staff to reach out to citizens, check in, and see if they need assistance or a referral. The social worker trains staff to understand users' needs and work with individuals dealing with mental illness challenges. The training includes attention to the staff's personal and professional boundaries as well as emotional challenges of this work. Staff also maintain a directory of events and services, striving to ensure that it is up to date. As librarians describe, for some users, they have become an important part of their circle of care.

Source: Skultety, A. 2020, The Signal, For Halifax' only library social worker, a 'circle of care extends to all. https://signalhfx.ca/for-halifaxs-only-library-social-worker-a-circle-of-care-extends-to-all/

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Acknowledgements

Social Sciences and Humanities Research Council of Canada

Conseil de recherches en sciences humaines du Canada

Canada

New Brunswick Health Research Foundation

Fondation de la recherche en santé du Nouveau-Brunswick