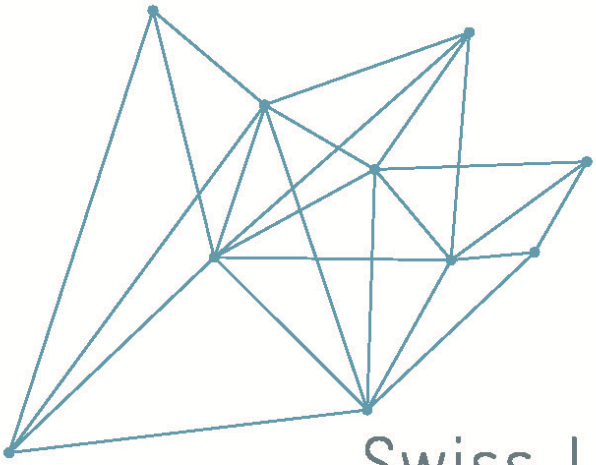


Swiss Learning Health System

How do we identify socially isolated and lonely older people in Switzerland?

Yanmei Liu, Sarah Mantwill

Policy Brief #10

Keywords

Social isolation, loneliness, older people, identification, data, awareness raising, stigma

Authors

Yanmei Liu, MSc, PhD candidate –Department of Health Sciences and Medicine, University of Lucerne, Switzerland

Sarah Mantwill, PhD – Swiss Learning Health System, University of Lucerne, Switzerland

Address for correspondence

Yanmei Liu
Department of Health Sciences and Medicine
University of Lucerne
Frohburgstrasse 3
6002 Lucerne
E-Mail: yanmei.liu@unilu.ch

Suggested citation

Liu, Y., Mantwill, S. (2021). How do we identify socially isolated and lonely older people in Switzerland?. Swiss Learning Health System.
https://www.slhs.ch/images/learning-cycles/topics/2021-Liu/PB_final_social_isolation2.pdf

Table of contents

Definitions of key concepts and organizations 4
The Policy Brief 5
Key Messages 6
Executive Summary 7
Background and Context 10
The Challenge 16
Stigma 16
Preference for isolation 17
Lack of evidence on how to identify the socially isolated or lonely 17
Lack of awareness of the problem 17
Privacy issues 18
Recommendations to identify socially isolated and lonely older adults in Switzerland 19
Recommendation 1: Enlist personnel in the community in the process to identify at-risk older adults 21
Recommendation 2: Build strong databases using assessment tools and use existing data to create heat maps 26
Recommendation 3: Use campaigns to raise awareness and reduce stigma attached to social isolation and loneliness 27
Implementation considerations and key points of recommendations 31
Summary 34
Acknowledgements 35
References 36
Appendix I 43
Appendix II A 44
Appendix II B 45
Appendix II C 46
Appendix III 47

Definitions of key concepts and organizations

Social isolation

It is an objective state that refers to the quantity of social relationships a person has with family, friends, groups, the community and society (de Jong Gierveld et al., 2006 and Jopling, 2015).

Loneliness

It is a subjective and negative experience that addresses difference between the quantity and quality of relationships and contacts we wish for and those we actually have (de Jong Gierveld et al., 2006 and Jopling, 2015).

Older people, old age, elderly, later life

They all refer to individuals aged 65 and over. In consistence with the previous policy brief (Dawson-Townsend et al., 2017) of the Swiss Learning Health System (SLHS), we focus on older adults aged 65+.

Spitex Schweiz

The non-profit home care in Switzerland. It provides services that can be to a large part reimbursed by health insurance.

Pro Senectute Schweiz

The biggest service provider for the elderly Swiss. It gives advice and assistance and organizes leisure activities.

Gesundheitsföderung Schweiz

Health Promotion Switzerland

The Policy Brief

The Swiss Learning Health System (SLHS)[1] was established as a nationwide project in 2017. One of its most important objectives is to bridge research, policy, and practice. For this, an infrastructure supporting learning cycles will be provided. Learning cycles enable the ongoing integration of evidence into policy and practice by:

- continuously identifying issues and questions that are relevant to the health system,
- summarizing and providing relevant evidence from research, and
- presening potential suggested solutions and courses of action.

Policy briefs of the SLHS aim at: (1.) identifying available research evidence on a specific policy issue and (2.) presenting relevant recommendations for policy as well as program options in a comprehensive way to key stakeholders.

This policy brief aims to provide all interested parties and stakeholders with relevant information on the topic of "identifying socially isolated and lonely older people over the age of 65 within the Swiss setting".

Articles used for this policy brief include both academic and grey literature (materials or research produced outside of academia) on loneliness and social isolation, published in the past three decades. We first searched Google scholar using key terms including "loneliness" or "social isolation", and "identify" or "recognize" and "older people" or "old age" or "later life" or "elderly". More than 1200 papers were found. After reviewing all the abstracts as well as full texts of some articles/reports, roughly 100 of them were selected based on the following inclusion criteria: the article or report mainly or in part focuses on older people; topic of the study or project is about loneliness and/or social isolation. The entire policy brief is generated on the basis of all the selected articles as well as several websites in relation to the theme of lonliness/social isolation. However, for approaches to identifying lonely and socially isolated older people , we extracted information from two sources, i.e., one systematic review (1) and one report in relation to the Campaign to End Loneliness (2).

We also searched in German for initiatives and publications on Google and Google scholar with the key terms "Einsamkeit", "Vereinsamung", "soziale Isolation", "Alter" and "Schweiz". Scientific articles, reports or news with regard to loneliness and social isolation were reviewed and assessed. In the end, the policy brief was compiled based on evidence from academic and grey literature, at both the international and national levels.

[1] This policy brief will be available in May, 2021 on the SLHS website: https://www.slhs.ch/en/learning-cycles.

Key Messages

The Challenge

Social isolation and loneliness in older age have adverse health effects such as cognitive decline. Identification of older people who are lonely and isolated or at risk contributes to improved health outcomes in this group. However, this is a challenge because:

- Some individuals find it hard to reach out to others or ask for help due to the stigma attached to loneliness and isolation;
- Some individuals who prefer to live alone may not desire for high social connectness;
- There is limited evidence on how best to find the affected population and those who are at risk;
- Many people are not aware of the problem of social isolation and loneliness in Switzerland;
- Data protection and privacy are of great concern in the Swiss society and thus may impede data sharing between different institutions or organisations.

Options to address the challenge

- Enlist personnel in the community to identify lonely or isolated older people with assessment questionnaires and refer them to community activities that improve social networking;
- Use existing data to create heat maps that demonstrate the relative risk of loneliness and isolation at neighborhood level within a certain geographic area;
- Launch campaigns to raise awareness regarding social isolation and loneliness and destigmatize.

Implementation Considerations

Barriers to implementation include:

- Some people who feel lonely or isolated may feel embarrassed to admit their feelings, whereas others prefer to live in solitude;
- Loneliness and social isolation are public health issues that are not yet recognised by the majority of the society and there is lack of study evidence on this topic;
- Some identification strategies may be related to data protection and privacy concerns, which should be considered in program planning and implementation.

Potential windows of opportunity include:

- Local healthcare professionals, municipality employees, social workers, non-profit organizations such as the Red Cross, etc., can be included in program planning and implementation;
- Many potential partners come into direct contact with older adults in their everyday fields of work;
- Programs that target older adults, and those that address community participation or social networking can be easily established.

Executive Summary

The Issue

Anyone can experience social isolation and loneliness, but older people are particularly at risk. As people age, their social connections are likely to decline, due to various factors, such as retirement, mobility problems and loss of life partners or close friends. Decrease in social interaction can lead to social isolation and loneliness, which are strongly linked with a number of physical and mental health conditions. The negative health consequences include high blood pressure, cardiovascular diseases, cognitive decline, and depression. The association of social isolation and loneliness with mortality can be comparable to risk factors such as smoking fifteen cigarettes a day and obesity. In addition, older adults who are lonely and socially isolated have greater risk of negative health behaviors such as smoking and lack of exercise. Furthermore, they are more likely to have increased GP (general practitioner) visits as well as emergency admissions to hospitals, which could be considered excessive use of health services.

As there is a growing awareness of the impact of social isolation and loneliness on the health and well-being of older people, solving the problem of social isolation and loneliness has become one of the newest challenges in public health. The Swiss Federal Council has recognised the importance of social participation in building up good mental health among all age groups and addressed a number of targeted programs in the Health2020 Strategy (69). Meanwhile, Gesundheitsförderung Schweiz (Health Promotion Switzerland) launched an inter-cantonal initiative “Soziale Teilhabe” ("Social Participation") in 2013, aiming to support interventions tackling isolation and loneliness in later life (105). In 2019, Health Promotion Switzerland published planning guidelines “Förderung der sozialen Teilhabe im Alter in Gemeinden” (Promoting social participation of older people in communities) in order to assist cantonal governments, local governments, and communites increasing social participation of retired people (69, 105). The Swiss Red Cross in canton Geneva established a similar program in 2000 to mainly improve integration of lonely and isolated immigrants over the age of 55 (see Appendix I). In spite of the interventions targeting social isolation and lonliness, there is still limited evidence about how to effectively identify the affected or at-risk older adults. Thus, lack of validated evidence remains an obstacle for service providers and policy makers. Older people with low levels of social interactions are vulnerable and often invisible. They are usually afraid or ashamed to talk about their feelings and seek help. Thus, it is hard to reach out to those who are most in need of support, to identify individual needs, to allocate resources as well as offer personalized services. Strategies are needed to help recognise older people who are experiencing and most at risk of social isolation and loneliness in order to link them to target interventions and strengthen social networks.

The challenge

Identifying socially isolated and lonely older adults or at-risk individuals is still a challenge in Switzerland for a variety of reasons. First, there is a stigma associated with social isolation and loneliness that results in feelings of shame, uneasiness and social incompetence. Fear of stigma can make it difficult for people to report their condition to professionals and ask for help. Second, although lack of social ties or social interactions may lead to loneliness and social isolation, some individuals may not desire companionship and rather wish to spend their

time alone. Third, despite a growing body of evidence on health consequences or interventions targeting social isolation and loneliness amongst the elderly population, little good-quality evidence exists regarding the reliability and validity of approaches to identify those who are socially isolated or lonely. Fourth, few attempts have been made to bring awareness to social isolation and loneliness amongst the Swiss population. Lastly, data security and patient privacy are important public concerns in Switzerland, which may be barriers to the adoption of any system for sharing isolation/loneliness related or personal data between different institutions.

Three recommendations for action

Based on the available evidence, three recommendations for action have been generated to address the issue of identification of older adults who are experiencing or are at risk of social isolation and loneliness in Switzerland.

The first recommendation for action describes enlisting personnel working in the community in the identification process. Healthcare workers, public servants, or trusted community members can be trained to measure levels of loneliness and social isolation with established identification methods, such as guided conversations. After a preliminary assessment, they can refer lonely older people to social support programs and activities.

The second recommendation for action describes how to build a strong data base using assessment tools and strategies as well as how to identify loneliness and social isolation by analyzing existing data. As mentioned in recommendation one, enlisting personnel working and living in the community assessing levels of loneliness and isolation is the first step in identifying at-risk individuals. They serve as gatekeepers and collect important data in the assessment process. This data can be shared with the appropriate organizations that ultimately provide the intervention strategies. In addition, exisiting data such as local registration data or representative national survey data can be used to map areas of high risks and low availability of social support services.

The third recommendation for action is to raise awareness and reduce stigma around social isolation and loneliness through campaigns. Awareness campaigns can be launched via a variety of tools, including information events, mass media and social media, etc. Both the aims and targeted population should be taken into consideration when designing such a campaign. It is a useful means to help both the trained personnel and the general public to better understand the problem of social isolation and loneliness, and be better equipped with knowledge in identifying at-risk and affected older adults.

Implementation Considerations

Barriers to implementation

There are several barriers to implementation of these recommendations. First, owing to stigma around the social isolation and lonliness, it may be difficult for the affected older adults to open up and share their feelings with organizations that provide helpful services. Second, many people are not yet aware of the issue. Moreover, it may be difficult to get ethical approval with regard to data sharing among different organizations or agencies.

Potential windows of opportunity

Established community members or organizations, such as local healthcare professionals, municipality employees, and social workers have a unique opportunity to understand older adults' circumstances, recognize their needs and refer them to local support. Some public or private institutions and voluntary organizations who come into direct contacts with the elderly population can offer a potential window of opportunity as well. Additionally, programs that target older adults, or address community participation or social engagement could expand their services to include the provision of information pamphlets about risk factors and identification methods of loneliness and social isolation to participants.

Background and Context

Human beings are social species. Social ties with families, friends and communities are critical for our health and well-being (3-5). However, as people age, their social connections and interactions are likely to decline due to life-changing events in later life such as loss of mobility (6). Decreased social relationships can lead to isolation and loneliness, which is strongly linked to poor health outcomes (7-10).

What is social isolation and loneliness?

Although the terms "social isolation" and "loneliness" are often used interchangeably in the literature, they are distinct concepts (13). Social isolation is an objective measure of the number of social contacts that a person has, whereas loneliness is a subjective feeling about the gap between the actual amount of social contacts that an individual has and their ideal levels of social relationships (14).

What is social isolation?

Social Isolation is an objective state that refers to the quantity of social relationships a person has with family, friends, groups, the community and society (11, 12).

What is loneliness?

Loneliness is a subjective and negative experience that addresses difference between the quantity and quality of relationships and contacts we wish for and those we actually have (11, 12).

Loneliness is often categorized into emotional loneliness and social loneliness. Emotional loneliness describes the absence of a significant figure or a close emotional attachment (e.g., a partner or best friend), and social loneliness indicates the absence of a wider group of social networks (e.g., friends, neighbors and colleagues) (15). While a person with a large number of social contacts may feel lonely, those who are objectively socially isolated may not experience the negative feeling of loneliness. Moreover, a person may experience loneliness and isolation at the same time (see, e.g., 11, 13, 16, 17) Due to the similar causes and consequences of the two conditions, this report focuses on both social isolation and loneliness.

The negative impact of social isolation and loneliness on health

Anyone can experience isolation and loneliness, and this condition can occur at any stage of life (18). However, older people are more susceptible to it (see, e.g., 6, 19, 20, 21). Social isolation and loneliness are strongly linked with a number of negative health consequences (17, 22-26). Previous research has demonstrated that having unsatisfactory or a low quantity of social connections is as harmful to our health as smoking 15 cigarettes a day (7, 27). The Swiss Health Survey (SHS) 2012 indicates that the Swiss who often experiences social isolation tend to suffer physical health conditions, such as back pain and gastrointestinal disorders (28). A study analyzing the SHS 2012 dataset suggests that loneliness negatively correlates to physical and mental health as well as healthy lifestyle (29). Furthermore, social isolation and loneliness are associated with increased mortality, increased susceptibility to dementia and Alzheimer's disease (8-10, 30-32), as well as greater likelihood of cognitive decline (26, 33, 34). Lonely or socially isolated elderly have increased chances of engaging in unhealthy be-

haviors such as drinking too much, being physically inactive, or smoking (35, 36). Some individuals feel isolated and lonely because of their caregiving role (21). Caregivers, family members in particular, often have difficulty in adjusting to their life change into a caring role and have limited time to participate in social activities (21, 44). Changes in social life may lead to loneliness and social isolation that further affects caregivers' health (21, 44). In addition to the above-mentioned negative health effects, other impacts of social isolation and loneliness are summarized in Table 1.

Table 1: Impact of loneliness and social isolation on health

Socially isolated older adults in comparison to the more socially connected are at greater risk for:	Loneliness amongst the elderly population is associated with:
• Mental health problems such as depression (33) • Lower resistance to infection (37-39) • Poor self-rated physical health (38) • Decreased health-related quality of life of older people (40) • Increased emergency admission to hospital and delayed discharges (20)	• Increased risk of high blood pressure (41) • Increased risk of the onset of disability among older males living alone (42) • Increased risk of developing coronary heart disease and stroke (43)

Source: Author's compilation based on literature (20, 33, 37-43)

Because of their adverse impact on the health of older people, social isolation and loneliness can influence the health care system (21). Firstly, chronic conditions associated with this issue, such as anxiety and depression, are usually linked to long-term treatment as well as greater utilisation of health services, which place a heavy burden on the health care system (21, 44). Moreover, studies indicate that some lonely individuals are prone to visit primary care providers more frequently than they need to, simply for the purpose of social contacts rather than medical needs (21, 45). These additional doctor visits increase healthcare utilization, and place extra stress on health service providers as well as healthcare resources (21, 45). Since healthcare resources and budgets are limited, investing in preventive interventions for older adults who are at most risk may reduce their visits to physicians due to loneliness.

Understanding what leads to social isolation and loneliness

In order to identify older adults who are at most risk of or are experiencing social isolation and loneliness, it is important to understand the reasons why people are lonely or isolated. There are many risk factors for loneliness and isolation during the life course. Some involve circumstances at the individual level, whereas others are part of a wider community or societal level (see Table 2).

Table 2: Types of risk factors for loneliness and social isolation

Individual Factors	Community Factors	Societal Factors
Socioeconomic characteristics • Older age • Gender (older men) • Partnership status (single) • Ethnicity (minority) • Migrant status • Fewer educational opportunities in the past • Unemployment • Low income (pension) • Sexual orientation (e.g., LGBTQI) • Access to technology, internet and social media (can have positive or negative effects) *Health status* • Limited mobility • Physical disability • Depression • Dementia • Hereditary factors • Sight/hearing loss *Personal characteristics* • Less confident • Less personal resilience • Sudden changes in behavior (e.g., drinking more) *Life events* • Retirement • Bereavement, deaths of close friends • Being a caregiver/carer • Moving to a new region *Skills* • Lack of social networking skills • Lack of investigative skills	• Lack of good quality green and public spaces • Lack of public transport • Poor location of home • Fewer amentities and services • Higher level of crime • Local economic conditions (e.g., high unemployment rate)	• Economic context (e.g., budget cuts to public sector) • Inadequate public transport policies • Demographic factors (e.g., more people live longer or alone) • Limited pension system • Under-developed national housing planning • Influence of mass/social media (e.g., media attitudes towards excessive drinking)

Source: Adapted from literature (17, 46, 48)

Note: Some risk factors may not be relevant for Switzerland, such as “Lack of good quality green and public spaces”, “Level of crime” and “National housing planning”.

At the personal level, being older is strongly associated with loneliness (48). This is often connected with other factors, such as a lower income, or poor physical or mental health status (46). In general, both females and males can feel lonely or isolated, however in the UK, for example, men are more prone to isolation than women (46). On the other hand, results from Switzerland show that elderly females with lower education and restricted personal resources are also at great risk of isolation (47). Furthermore, caregivers and people with a migration background are particularly susceptible to loneliness and social isolation (46, 47). With regard to partnership, being married and living with a partner reduces the extent of loneliness (48).

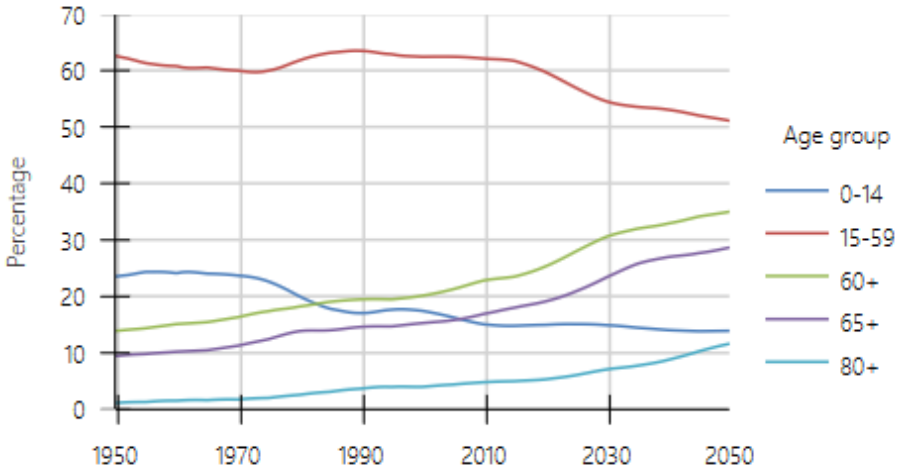
At the community level, evidence from the UK shows that poor physical infrastructure and limited availability of public facilities are important factors associated with social isolation and loneliness (18, 46, 48). People living in a rural or deprived urban area without access to public transport in the UK can be particularly at risk (46, 48). When extended to the society level, demographic changes such as the rise in the number of people living longer and living alone, are likely to lead to isolation and loneliness (46, 48).

As risk factors and their interactions may differ from person to person, the extent of their feelings of loneliness or social isolation can also be different, i.e., some may suffer more severe loneliness/isolation than others (48). As a result, loneliness and isolation are complex issues to address. Understanding risk factors can help us recognize loneliness around us. When we speculate that an older family member, friend or neighbor might be lonely, we may consider some circumstances, for example, whether they have been suffering from a chronic disease, or whether they live alone, etc. (2). These risk factors are loneliness indicators, and they can play an important role in the detection of loneliness and social isolation.

Evidence on lonliness and social isolation in Switzerland

The Swiss population is ageing at a rapid pace (49, 50) and Switzerland has one of the highest proportions of older people and one of the longest life expectancies in the world (49). The proportion of older people aged 65 and over is estimated to increase from 18.8% in 2019 to 23.4% in 2030 and 28.6% in 2050, as shown in figure 1 (111). This demographic trend is, on the one hand, a consequence of the decline in fertility rates, and on the other hand, influenced by substantial medical progress in improving health and reducing all-cause mortality (50). It is estimated that by 2025, there will be more people over 65 years than under the age of 20 (51). As the number of older people in Switzerland is growing and people are living longer, social isolation and loneliness in older age is also increasing. According to the SHS, approximately 24.7% of people aged 65 and older felt sometimes or often lonely in 2007 (52). This rate was found to reach one third in 2012 and slightly increase in 2017 (52).

Figure 1: Population by age group between 1950 and 2050 in Switzerland



Source: image from: Profiles of Ageing 2019, UN (111)

A report from 2016 has demonstrated that in canton Zurich the extent of social intergration is likely to drop as people age (108). Especially individuals over 75 years, who have little social cohesion, have the greatest risk of becoming isolated or lonely (108). A recent study from 2019 (110), based on the 2012 SHS data, has found that while frequent feelings of loneliness rise slightly with age, social isolation increases greatly with age. In addition, less than 4% of the youngest survey participants (15-24 years) had very low to low levels of social integration, whereas roughly 12% of those aged 65 and older were in the same condition. With respect to gender difference, the number of socially isolated women is slightly higher than that of men. Social isolation and loneliness are a social need that is frequently addressed in the Swiss primary care services, according to the 2019 International Health Policy Survey (117). It demonstrates that a relatively large proportion of physicians surveyed in Switzerland stated that they often or usually (in 50% to 100% of all cases) had patients who turned to their doctors for various social needs (117). Social isolation and loneliness account for 34.2% of the social needs, which is the second most frequently rasied social concern in Switzerland (117).

What can we do to address social isolation and loneliness?

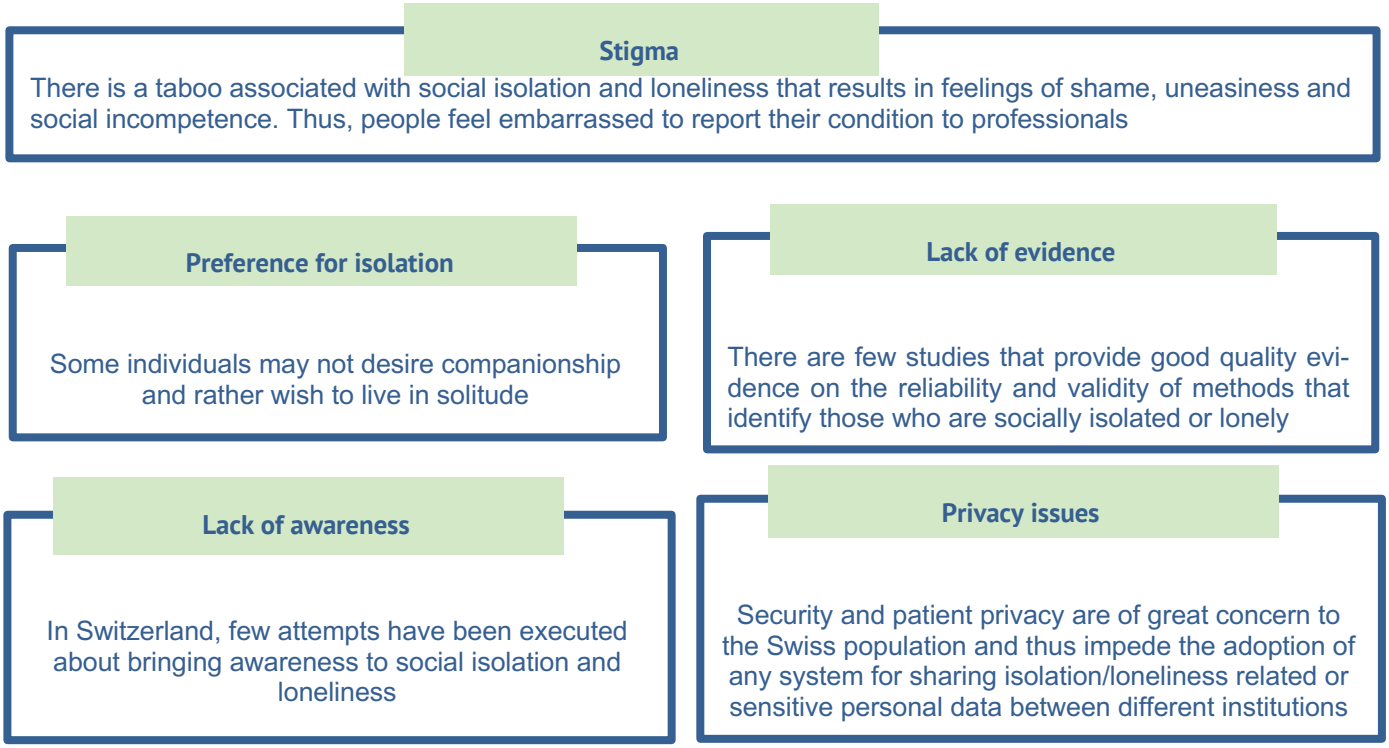
Existing literature suggests that there is a positive association between quality of life and social participation; for instance, an increase in social participation is associated with better health amongst the elderly (see, e.g., 54, 55, 56). In order to improve the quality of life of the lonely or isolated older adults, the first step is to identify and reach them. However, these individuals are difficult to find. Like other vulnerable populations, they tend to be invisible (21).

This policy brief seeks to explore different strategies to identify social isolation and loneliness, outline the challenges associated with identifying socially isolated and lonely older adults in Switerland, and recommend three approaches to identify these individuals. Furthermore, the policy brief discusses possible obstacles and windows of opportunity related to the recommended approaches.

The Challenge

Recognizing individuals in our community who are socially isolated and lonely is key to allocating the appropriate interventions in a timely manner and thus avoiding the negative health and well-being outcomes associated with the conditions. However, this might be more challenging than expected. Challenges can be divided into five key areas: stigma, preference for isolation, lack of evidence, lack of awareness and privacy issues. This section delineates the major challenges in detail.

Figure 2: Overview of challenges in identifying lonely and socially isolated older adults



Stigma

Most western societies have long promoted rugged individualism as well as independent living and placed less importance on strengthening personal relationships (57). Over-reliance on others is thus viewed as an undesirable characteristic. There is a taboo about social isolation and loneliness that leads people to associate it with shame, uneasiness and social incompetence (58). One might deny the feeling of loneliness or avoid speaking with others about it (21, 59). Another issue is that people who acknowledge their feelings of loneliness feel embarrassed to report their condition to professionals (11, 60).

In Switzerland, the stigma that is associated with social isolation and loneliness is a major factor for why it is so difficult to identify those in most need (61). Not being able to admit to feeling lonely can induce psychological distress and lower self-esteem, which ultimately worsens their isolated state (62). Research has shown that stigma is related to health inequalities and worsens existing health conditions (62). Thus, outreach to the elderly can be limited, less

successful, and less efficient due to the reluctance of lonely individuals to identify themselves (63).

Preference for isolation

One might argue that a lack of social ties may lead to feelings of loneliness. However, some individuals may not desire companionship and rather wish to live in solitude. There are certain individuals who prefer to spend their time alone. In terms of living arrangements, one study found that individuals who lost a spouse may find themselves preferring to continue to live alone (64). When interviews were conducted with various older adults, it was revealed that some respondents would rather be alone and did not want to be involved within a community as they perceived that members of such communities would be 'cliquey' or 'nosy' (65). Therefore, it is a presumption to assume that all individuals that are seemingly experiencing social isolation or loneliness wish to be contacted.

Lack of evidence on how to identify the socially isolated or lonely

There is an abundance of research that primarily focuses on the health outcomes or the interventions and management of social isolation and loneliness, however there are few studies that provide good quality evidence on the reliability and validity of methods that identify those who are socially isolated or lonely. This could be due to the complexity of how these concepts or conditions are measured. Both are multifaceted in their predisposing factors as well as in the nature of the way they are responded to: subjectively and individually (66). To date, there is no single best method to measure, examine and ultimately identify socially isolated and lonely individuals.

Lack of awareness of the problem

Awareness campaigns have been proven to lead to an increase in openness, a decrease in perceptions of discrimination and often pave the way towards de-stigmatization, support, prevention as well as early intervention and applied research (67). In Switzerland, few attempts have been executed about bringing awareness to social isolation and loneliness. An example of a comparable awareness campaign launched in January 2016 was "Alter hat Potenzial" (Old age has potential) (68). The campaign attempted to change "societal perspectives" on the deficit-oriented image of older adults, to address prejudices and to introduce forms of voluntary social engagement beyond retirement (68). However, the primary focus of the campaign was towards labor market perspectives of the 50+ age group with little or contradictory focus on social isolation (68). A petition was submitted to the Swiss parliament in May 2019 that aimed to convey the concerns of healthcare professionals and organizations about the growing issue of social isolation and loneliness among the older adult population in Switzerland. The petition, however, was rejected by the federal council based on their belief that certain organizations such as Prosenectute and the Red Cross already exist to deal with the issue (69).

Privacy issues

The value of rich data or medical records to medical practices, patient and policy makers is substantial (70). Information about an individual's determinants for experiencing social isolation and loneliness can be obtained through various outlets. Such outlets may include, but are not limited to, GP practices, home visit nurses, municipal registries or community centers. Partnerships between different repositories of data entry can expedite early identification and provision of services and support for those experiencing social isolation and loneliness. However, security and patient privacy are of great concern to the Swiss population and thus impede the adoption of any system for sharing isolation/loneliness related or personal data between different institutions (71).

Recommendations to identify socially isolated and lonely older adults in Switzerland

In this section, we first provide a summary of available methods outlined in the literature, and subsequently we recommend strategies that are likely to be feasible in Switzerland.

Although a wide variety of identification approaches for loneliness and social isolation have been used in intervention research, there is little information about their costs and effectiveness (1). The combination of two or more identification strategies might be more effective than public facing methods alone, but the drawback is that they require more time and resources (1, 2). When applying any of these approaches, it is important to adjust them to the context and population (2). Building on the four types of strategies (see Table 3) and taking account of the demographic trend, community capacity, and availability of social and health care services, we make three recommendations for identifying lonely older adults in Switzerland.

By reviewing and analyzing findings of the abundant literature about loneliness and social isolation among older people, we highlight two papers that comprehensively studied the identification strategies. One paper is a recent systematic review, which aimed to review methods used for identifying and recruiting individuals who are over the age of 50 and at risk of social isolation and loneliness into intervention studies (1). It has demonstrated that the most common approaches of identification included public facing methods such as mass media, information sessions, self-referrals as well as referrals by recognized agencies (1). These results are in line with the findings of a report from the Campaign to End Loneliness[2] (CEL) and in the UK (2). Goodman and colleagues conducted a meta-review and interviews with representatives of service providers and councils for older people, in order to explore the current understandings of and identification techniques for loneliness. All identification strategies described in the loneliness report (2) as well as in the systematic review (1) are categorized into four categories and displayed in Table 3.

[2] The Campaign to End Loneliness (CEL) has been running since 2011 across the UK and it was the first organisation dedicated to combating loneliness in the UK. The CEL is hosted by Independent Age and funded by the Big Lottery Fund. Through campaigning, research and learning opportunities, they inspire and support authorities, organisations as well as individuals who want to combat and prevent loneliness. They aim to end loneliness by ensuring that: "People most at risk of loneliness are reached and supported; Services and activities are more effective at addressing loneliness; a wider range of loneliness services and activities are developed" (More information is available at: https://www.campaigntoendloneliness.org/).

Table 3: Strategies to identify lonely or socially isolated older people

Types of strategies	Description
Public facing (print media and mass media)	Information flyers, leaflets, brochures, booklets, posters, local newspaper or advertisement in magazines; radio and TV programs; online advertisements, blogs, Facebook, Twitter, etc.
Referring older adults to social support programs	Referrals from various agencies or organizations, such as communities social service staff, GP practices, staff in hospitals and nursing homes, churches, senior centers, charity organizations, housing authority and food banks; Referrals from friends or acquaintances; Self-referrals and cross-referrals
Combined strategies	For example, online advertisements and flyers posted to local households, brochures in grocery stores, churches and senior centers
Using existing data	Data sources such as population registration data, local authority data, etc. By analyzing population data for risk factors, we can determine regions with highest level of loneliness and isolation

Sources: Author's compilation based on literature (1, 2)

Recommendation 1: Enlist personnel in the community in the process to identify at-risk older adults

- Healthcare professionals, public servants or other trusted community members, should be trained in assessing the risk of social isolation and loneliness
- Assessment tools can include short surveys or guided conversations
- Trained personnel refer the affected or at-risk older people to social support programs
- Use social prescribing schemes (also known as community referral) to help people to navigate possible offers and venues

It is recommended that trusted persons or professionals within the community be selected and trained to conduct the initial assessment of loneliness and social isolation. Enlisting them in assessing whether someone is at risk of or experiencing isolation or loneliness is the first step in identifying the at-risk elderly. This is because they have the leverage of accessing and building good relationships with difficult to reach groups of individuals who are most vulnerable of becoming or being socially isolated and lonely (75). The trained staff (see Table 4) may include, but are not limited to, healthcare professionals, municipality staff, social workers, or even postal service workers (12, 59, 76, 77). An example of how to enlist professionals in the community in the identification process can be found in Appendix II B.

These trained workers or professionals can measure levels of loneliness and social isolation with a range of established methods (78) (see Table 5). For instance, loneliness can be measured using a short survey such as the revised UCLA loneliness scale (36, 79). Loneliness can also be assessed through the use of guided conversations. A guided conversation is a relatively unstructured engagement with an older adult in which their social situation, needs and wishes are explored. This is then followed by discussions on how to achieve those wishes in order to improve their current circumstances (12).

Social isolation is easier to measure than loneliness due to its objective assessment of social contacts (65). In the primary care settings, the physician may arrange a print-out version of a measuring instrument, such as a questionnaire (75). They can give the questionnaire to patients, who can fill it out at home and return it upon the next visit for further discussion (75).

Public health professionals can decide upon a mechanism of assessment to adopt and instigate its use throughout the community (75). Once an individual is perceived to have, or be at risk of social isolation or loneliness, the professional can then refer the individual to an array of interventions that may involve a customized treatment plan by a case manager or simply by, for example, social prescribing. Social prescribing[3] provides affected individuals with access

[3] Two examples of how social prescribing works in practice are presented in text boxes, i.e., the Loneliness Project in Mannheim, Germany and the Claremont's Social Prescribing Project in the UK. To the best of the authors' knowledge, the social prescribing service has not yet been applied to tackle social Isolation and loneliness among older Swiss. However, prescribing for social counselling, which is similar to social prescribing that refers individuals for non-medical activities and services, is adopted by a few Swiss primary care practices. In Appendix II C, the project on social counseling run by the Bern University of Applied Science may shed light on how social prescribing could be used in Switzerland to reduce social isolation and loneliness.

to social, physical and therapeutic activities, which includes directing these individuals to social groups of interest, life skills and educational courses, and self-help groups, etc. (12, 57, 73). The approach of social prescribing could also be applicable to Switzerland, as indicated by a Swiss article (109). The authors suggest that if an elderly patient cannot specify any reference person as emergency contact in a regular medical registration form, then the family doctor would infer that this patient could probably be at risk of isolation. After a brief conversation with the patient, the physician can recommend a few social networking activities (109). Once this at-risk patient gives consent, the physician can make a referral (109). Social prescribing empowers older people to make their own decisions whether they should join social activities or have more social contacts. It ensures that those who wish to be alone or isolated feel respected but not obliged to make social interactions. Furthermore, it is important to point out that this type of social prescribing requires physicians to know social support services that are available within a limited area, such as home visit services provided by the Swiss Red Cross, group courses organised by Pro Senectute and voluntary services offered by local churches (109). It may prove to be difficult for an agency to assess, identify and manage a case single-handedly (75). By creating co-operative networks and working in partnership, different agencies can share and disemminate knowledge and experiences, support each other, reach out to more affected individuals as well as cross-refer identified individuals (2, 99).

Social Prescribing

Social prescribing and similar approaches have been used in the National Health Service (NHS) in England for many years. Social prescribing is sometimes referred to as *community referral* (116). The Social Prescribing Network defines it as follows: "A means of enabling GPs and other frontline healthcare professionals to refer patients to a Link Worker to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalized solutions, i.e. 'coproduce' their 'social prescription', so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and well-being often using services provided by the voluntary and community sector" (72, 73, 116).

In the UK, the Health Education England (HEE) and the National Health Service (NHS) England provide regional training courses and an e-learning platform to individuals who wish to participate in a social prescribing scheme. They also offer further education and training to members of existing Social Prescribing schemes

Seeing that early interventions have been proven to reduce the negative health outcomes associated with social isolation and loneliness, such as depression and falls, it would be advisable for insurance companies to reimburse for the assessments conducted in the identification process (75). Communities, which work with hospitals and primary care centers, may incorporate an assessment strategy into their plans of care, and will eventually benefit from a healthier older population (75).

Other community members such as volunteers, friends/relatives or neighbors may as well play an important part in identifying socially isolated or lonely older adults. In Switzerland, there are some programs to enhance social cohesion within neighborhoods. For instance, the Pro Senectute Vaud has since 2019 launched a project "Compagnie des Voisins"[4] (The Company of Neighbors) to forge strong social ties between older and younger residents living in the same

[4] For further information about the Compagnie des Voisins, see https://compagniedesvoisins.ch/.

community. By simply putting stickers of "Compagnie des Voisins" on their letter boxes, individuals can indicate their availability to organize activities that are inclusive of their neighbors or to help out. Anyone who wishes to participate in the project can purchase a kit of stickers for five francs. The program "Compagnie des Voisins" is a variation of the sucessful initiave "Quartiers Solidaires"[5] (Community Solidarity) launched by Pro Senectute Vaud in 2002, which has already been established in 23 municipalities in the canton. Both the "Compagnie des Voisins" and "Quartiers Solidaires" projects aim to facilitate older people's social contacts and build social cohesion within communities. In these community-based programs, it is possible to spread knowledge of loneliness and its negative effects on health through educational programs, campaigns etc. This way more people may become engaged in identifying and supporting isolated or lonely older adults in the same community.

Table 4: Description of personnel who could be enlisted in the identification of at-risk individuals

Categories	**Examples**
Non-physician healthcare providers	Nurses or assistants at primary care centers, home carers, employees at residential homes, physiotherapists, etc.
Physicians	Primary care practitioners, clinicians in hospitals, etc.
Public servants	Social workers, municipality employees, police officers, etc.
Trusted community members	Postal workers, pharmacists and hearing aid specialists, church staff, librarians, volunteers, neighbors, friends/relatives, houskeeprs, café employees, hairdressers, bus drivers, etc.

Sources: Author's compilation based on literature (12, 59, 76, 77)

[5] For further information about the Quartiers Solidaires, see https://www.quartiers-solidaires.ch/.

Table 4: Common measures of social isolation and loneliness

Measures	Description
Loneliness	
Revised UCLA Loneliness Scale	20-item and shortened 4-item scale designed to measure subjective feelings of loneliness. Each statement is rated from 1 (never) to 4 (often) or 1 (hardly ever) to 3 (often), depending on the version.
De Jong Gierveld Loneliness Scale	11-item and shortened 6-item scale designed to measure overall, emotional and social loneliness. Some statements are framed positively and some negatively; each is scored on a five or three step response from "Yes!" to "No!" to indicate level of agreement with each statement.
Single question metrics	Questions containing "do you feel lonely?" and "do you feel isolated?" are used in various national surveys in the UK.
CEL Scake	Statements include "I am content with my friendships and relationships", "I have enough people I feel comfortable asking for help at any time" and "My relationships are as satisfying as I would want them to be".
Social Isolation	
Duke Social Support Index (DSSI-10)	The revised 10-item scale assesses social support. It contains two subscales, social interaction and subjective social satisfaction, with higher score indicating more social support.
Lubben social Network scale-6 (LSNS-6)	The 6-item scale measures the size of the active social network among community-dwelling older adults on a six-point Likert scale. Total scores range from 0 to 30, with higher scores indicating larger social networks. The validated LSNS-6 has established a cut-off point of 12 for best overall sensitivity (29, 30) and he scale has been widely used in elderly populations (31).
Social Disconnectedness	8-item scale
Revised Social Support Questionnaire (SSQ6)	The 6-item instrument assesses perceived availability and satisfaction of social support. For each item, respondents indicate the perceived number of people that they have available to provide support, and rate their satisfaction with the support on a 6-point scale.

Source: Adapted from a diagram included in a review (78)

"Social Prescribing" Example 1

MAG1- Mannheim gegen Einsamkeit (Loneliness Project in Mannheim, Germany)

This loneliness project was initialized in 2015 by a few social workers, physicians, representatives of residence homes and geriatric outpatient rehabilitation institutes in Mannheim, Germany. The goal of this project is to jointly tackle loneliness among older people aged 60+, and improve social support as well as social contacts. The project is mainly (75%) financed by the Ministry for Social Affairs and Integration of Baden-Württemberg.

The MAG1 project has built a network ("vitaconnect") for a wide variety of organizations that are relevant for elderly population. This includes but not is limited to family doctor practices, counselling centers, long-term care support centers, hospitals and outpatient rehabilitation centers. Residents in Mannheim are encouraged to volunteer in the MAG1 project. Professionals from "vitaconnect" provides educational programs to volunteers, who receive a certificate after their successful completion of the education program. An expense allowance is provided to volunteers for their work. If a physician, social worker or caregiver from the "vitaconnect" recognizes that an older adult is lonely and needs help, someone from "vitaconnect" and visit this identified lonely person. Once the lonely elderly individual agrees to receive help, "vitaconnect" brings this person into contact with a volunteer. The volunteer supports the elderly individual in everyday life, until this person does

"Social Prescribing" Example 2

Claremont's Social Prescribing Project (Isling, London)

The Claremont Social Prescribing Project, funded by a local charity (Islington Giving), has been running since 2012. It targets isolated, often vulnerable Islington residents aged 55+ and connects them with social, physical and therapeutic activities within a community setting. Claremont's Social Prescribing Manager reaches out to agencies or organizations that have direct contact with older people as referring partners, e.g., GP surgeries, health professionals, housing providers and voluntary sector service. The referring partners "prescribe" Claremont's 6-week introductory program and refer the elderly to a Claremont's Social Prescribing Manager. Self-referrals are also allowed. After receiving referrals, the Social Prescription Manager conducts an assessment interview at Claremont using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to evaluate participants' level of physical health, psychological well-being and suitability to function in a group. Participants receive a personalized program and timetable for an initial three weeks. Participants are required to provide informed consent to allow their GP or other referrers to track their progress. After six weeks, they have another interview and WEMWBS assessment. After six weeks' free classes, participants sign up for a membership with subsidized fees if they wish to carry on with the classes. After three months, a follow-up

Recommendation 2: Build strong databases using assessment tools and use existing data to create heat maps

- By assessing loneliness and social isolation, trained personnel provide an information base
- Isolation/loneliness data can be shared between trained personnel and agencies providing social support activities
- Analysis of existing data allows for development of loneliness maps/heat maps

Build strong data bases

As mentioned in recommendation one, enlisting personnel that come into contact with the older population in their everyday fields of practice is the first step in identifying lonely or at-risk individuals. They serve as gatekeepers and allow for the dissemination of information to the appropriate establishments that ultimately provide potential intervention strategies.

Identification at an early stage can lead to the prevention of adverse health effects and it helps in the mitigation of the condition (75). Trained personnel, health professionals in particular, may integrate assessment tools and strategies described in recommendation one into their daily fields of practice. For instance, when a new patient registers in a family practice, physician assistants have the unique opportunity to provide a loneliness assessment form in the standard registration procedure. It is vital to conduct an assessment not only to aid in the diagnosis of social isolation and loneliness but also to serve as a baseline measure. Primary measures of social isolation and loneliness can provide an information base, which can help in comparing and monitoring the progress or effectiveness of any interventional activities adopted by the individual. These measures also serve as data entries and this information can be retrieved by interventional organizations.

As there is a wide scope of trained personnel, they may have various expertise and skills, which enable them to broaden their view of risks of loneliness and social isolation amongst older people, as well as extend the boundaries of the search to those who are most vulnerable, so that no one is left behind. This also allows for multiple points of data entry and collection that can be shared with adjunct organizations in the delivery of subsequent interventions (2). This data can be stored in a central repository, to which the trained personnel and other agencies can access. The data may comprise information about individual risk levels, referrers, local social prescribing schemes as well as provision of services and support (85). It can be used to map existing local social networks and services, to facilitate different agencies or sectors to design, implement and evaluate interventions and to help them better understand whether existing services have met individual needs. Since this data may contain sensitive personal information, data sharing across different organisations or agencies must be handled with caution in order to protect privacy.

Use existing data (register, census and survey data)

Another way to identify individuals at risk, or those who already are lonely or isolated is to analyze existing data (see, e.g., 66, 86). Risk factors associated with social isolation and loneliness are well documented (87-89). By analysing data, it is possible to predict the prevalence of risks for the individuals as well as their residential areas, and highlight the areas of the greatest need, for example, on a "heat map" (see Appendix III). Data sources may range from population registration data at the local authorities to national census data or representative survey data. Age UK, for example, has used data from the English Longitudinal Study of Ageing (ELSA) to map the relative risk of loneliness among people aged 65 and older across different neighborhoods in England (84). The risk factors include age, marital status, self-reported health status and household size (84). The Office for National Statistics (ONS) applied the ELSA data to the 2011 Census Microdata to estimate prevalence of loneliness among residents aged 65 and over by area in England.

Loneliness maps / Heat Maps

Loneliness "heat map" can link loneliness with risk prevalence, and in the UK there is vast evidence about it (66). A loneliness heat map identifies geographic areas of high risk for loneliness and allows local community leaders, for example, to identify local hotspots that have a lack of venues or services for lonely or socially isolated individuals (84). In addition, heat maps can inform discussions and workshops with local partners and engage them in more concrete ways with the issue of loneliness in the community (84).

There are a few indicators for loneliness in Switzerland, but there is not enough evidence about their validity and reliability. Besides, data is not avaialbe in every region and the costs of collecting reliable data that covers many regions of Switzerland can be very high. Therefore, it may make sense to adopt heat maps for small regional areas of Switzerland, such as Geneva city, where there are likely to be representative communities and lots of data for creating an effective heat map. The heat maps could provide an opportunity for areas with higher levels of social isolation and loneliness and less resources to learn from areas with lower levels of the problem and more services for older people. Furthermore, when developing heat maps, data need to be anonymized and exclude personally identifying information.

Recommendation 3: Use campaigns to raise awareness and reduce stigma attached to social isolation and loneliness

- Awareness campaigns can be used to increase the understanding of and reduce stigma about loneliness and social isolation, among the public and trained personnel who come into direct contact with the elderly
- Awareness campaigns can be conducted via various channels such as mass media or public events

Previous studies show that awareness campaigns[6] are an acknowledged and important approach to raising awareness and reducing stigma around loneliness (91, 92); they are "central to success in tackling loneliness, are efforts to improve awareness of the issue" (86, 91). Campaigns have been used in different countries to mitigate loneliness and social isolation. For example, the Loneliness Campaign North Yorkshire that ran between early 2019 and December 2020 (112) and the Be More Us campaign launched by the UK charity Campaign to End Loneliness in 2018 (113) to tackle loneliness of all age groups. In 2016, the National Association of Area Agencies on Aging (n4a), along with the AARP Foundation, launched a national public education campaign to increase awareness of the problem of social isolation and loneliness and the associated negative health consequences amongst older Americans (114). These campaigns raise awareness in local communities and of the general public, particularly among those who may be in direct contact with lonely or isolated elderly (91). It is also of great importance to increase awareness among the older people themselves (86). The aims of campains can be achieved in a number of ways. Often awareness raising activities and information are introduced to the public through (mass) media campaigns, such as leaflets, television, radio, social media, public relations, special events, or speeches (90).

Campaigns' goals

The major goals of awareness campaigns are to:

- Increase awareness about the issue of social isolation and loneliness amongst the elderly Swiss population and reduce stigma
- Enable trained personnel and the public to better understand and respond to loneliness and social isolation
- Encourage trained personnel and the public to help identify lonely or isolated elderly and help them improve social connections

Campaigns to reduce stigma

Research suggests that many people perceive and experience loneliness and social isolation as stigmatizing (66, 93). The stigma can be a barrier for older people to seek help or reveal their feelings (93). It might be helpful to launch campaigns to improve individuals' understanding and views about loneliness and social isolation in order to destigmatize and normalize these conditions. Just as we understand pain or hunger as an inherent or biological trait (66, 94), and happiness or sadness as a natural emotion (95), we must understand that it is normal to feel lonely or socially isolated (66).

Awareness campaigns can help reduce the stigma around loneliness and isolation so that older adults who need help can self-identify and feel more comfortable to talk about their feelings and seek social support. It can also encourage people to identify lonely elderly in their family or neighborhood. As a result, the campaign may lead to societal change (85). One effective

[6] Awareness raising campaigns are defined as organized communication activities, which aim at creating awareness on particular topics (health, environment, education), behavioral change among the general population and to improve the focus on better outcomes (better health, greater environmental protection, reduced early school leaving) (90).

campaign in destigmatization is, for example, the Defeat Depression Campaign running between 1991 and 1996 in the UK. It significantly changed public and medical attitudes about depression. It educated the public about possible symptoms and potential treatments, through newspapers, magazines, radio and television programs and other media activities (96, 97). With respect to loneliness, there are also campaigns launched to reduce stigma. For example, an ongoing campaign "#LetsTalkLoneliness" was launched in June 2019 by the UK government to help tackle the stigma around loneliness and encourage people to talk about it (95).

Campaigns targeting the trained personnel

Trained personnel as mentioned in recommendation one, will be of great assistance in awareness raising campaigns, as some of them are engaging in events and activities to assist older people. Trainings can be provided to professionals working in community through events and dissemination of information on the issue, about how to assess and identify older adults who are at risk of or experiencing loneliness and social isolation (98), and how to refer them to available social services (91). The municipality, social workers, Pro Senectute and Red Cross Switzerland could work together in getting service providers such as doctors, nurses, pharmacists and other people that are in contact with older adults to come to information events and provide them with short training sessions. In the Campaign to End Loneliness in the UK, service providers were inspired to discover new approaches to reaching the most isolated people (98). In addition, using loneliness heat maps to identify neighborhoods with at-risk individuals as well as gaps in the provision of existing social support has been found to be very effective in engaging with commissioners, community providers in dialogue around loneliness and social isolation, making it easier to identify affected individuals (99).

Campaigns targeting the public

Awareness raising campaigns can be launched to help the public learn about risk factors of loneliness and social isolation, identify at-risk seniors in local communities and connect with them.

Different channels can be used to spread messages. Media campaigns may be effective, given most people watch news, listen to the radio, read newspapers or magazines, and are on social media. Research shows that media coverage gives great success to a campaign as it reaches the majority of the population and the issue will be disseminated (98). The media campaigns should flag the loneliness issue among the elderly and how the society can help them reconnect. A media campaign could be done in various ways, such as having columns in the newspapers around the specific issue, having a radio segment, television adverts or a short segment on a talk show.

Face-to-face campaigns can be launched in local community or shopping centers with the assistance of community workers and volunteers. They can be trained by seniors' organizations about the signs of an at-risk older adult. They can inform community members through a short conversation and/or giving out pamphlets about how to identify signs of loneliness and social isolation, guidance on how to refer a lonely older adult to community centers, and available social activities for lonely people, etc. Signs such as poor health and having difficulty in communicating or mobilizing could be easily recognized by neighbors or relatives of the senior people who are at risk (100). Anyone who recognizes them could refer them to the community workers for support.

Internet and social media have become an important channel for dissemination of information (101, 102), as seen with the "Angelina Jolie effect", where she shared her issue on breast cancer screening. It led to an increase in testing for gene mutation (101). Spreading knowledge of social isolation and loneliness among the public through these channels enables people to be aware of the issue, be part of the change and help in identifying at-risk older people. This can be accomplished by engaging well-respected people within the country, celebrities and well-known athletes to share their thoughts, views, experience and information about loneliness and social isolation. For instance, Oprah Winfrey, in partnership with Dr. Sanjay Gupta and Skype, organized a campaign to fight loneliness and increase face-to-face interaction in the US in 2014. They brought stars to engage in the campagin and encouraged people to reach out to others by just saying “hello” (113).

Furthermore, posters at train stations or bus stops could be of use to highlight the importance of tackling the issue of isolation and loneliness. As many people travel with public transport in Switzerland, they may learn about the issue from well-designed posters. It is important that posters should neither worsen the images of the elderly nor stigmatize those who want to be lonely or isolated. In addition to posters, providing preventive counselling sessions and directly sending letters to older people may increase the chance of reaching them and encouraging them to seek for help.

Awareness campaigns can help people recognize and understand the issue of social isolation and loneliness, and enable them to be better equipped with knowledge to identify at-risk and affected individuals. By setting up networks for existing programs and making programs available and accessible for vulnerable individuals, a campaign would give room for individuals who are at risk of or experiencing loneliness and isolation to open up and seek help, making it easier for them to be identified (103). Awareness raising is not a one-time-only action, and it should be strengthened over several years via different channels and best practice. One possible way to promote sustainability of campaign programs is to launch sensibilization campaigns in schools. For instance, invite senior citizens to read books to school children or organize other inter-generation programs at community centers. To ensure the effectiveness of a campaign, it is vital to use positive language and positive images of older people to improve social integration and participation. Moreover, successful campaigns require large financial investments and administrative efforts. Impact evaluations should therefore be undertaken to assess the effects and efficacy of awareness campaigns.

Implementation considerations and key points of recommendations

Recommendation 1. Enlist personnel in the community in the identification process		
Healthcare professionals	**Physicians**: As an increase in age is directly related to the increase of various medical conditions, older adults typically make more visits to family practices, immunization centres and hospitals. Physicians can therefore make a quick assessment of social isolation and loneliness as a part of the admission process, just as they routinely measure the blood pressure (57).	**Nurses**: Social isolation is an official diagnosis that nurses are presumably aware of and should assess for in their everyday practice (Nicholson, 2012). Visiting community nurses offer a profound opportunity in reaching homebound individuals who are most at risk of social isolation and loneliness. This is of great value as homebound individuals may lack the resources or knowledge to actively seek help otherwise (75).
Public servants	Public servants, such as social workers, municipality employees, and the police offer a safe and secure environment when reaching out to individuals at their home. They can collect information related to the level of social isolation and loneliness of the residents as well as provide safety advice and information (12).	
Trusted community members	Initiatives can be carried out to train trusted members of the labour force within a community that are more likely to come into contact with older adults. The skills attained will be to gain insight on social isolation and loneliness as a condition that leads to negative health outcomes, to recognise the signs of the condition and to initiate the first outreach to the at-risk individuals. These trained staff may include church staff, postal workers, pharmacists, hairdressers, community centre staff, café employees, bus drivers, and many more (12, 76, 77).	

Recommendation 2. Build strong strong databases using assessment tools and use existing data to create heat maps		
Group	**Proposed responsibilities**	**Data sharing**
Researchers	Critically analyze the literature that exist on social isolation and loneliness; Report on evidence-driven methods to find lonely and socially isolated older adults; Use available data to map areas with older adults that are at risk of becoming socially isolated and lonely.	Share the information with other organizations
Municipality employees	Assist with data to be able to map areas with more at-risk older people; Educate service providers in identifying the socially isolated and lonely within the communities.	Assist with data sharing and mapping
Pro Senectute	The first point of contact in most cantons and communities with regard to old-age issue; Give support to older people by offering services that support the older people, relatives and the caregivers; Act as gatekeepers in communities and assist in methods to identify socially isolated and lonely individuals.	Share information on what they have done and how they identified older people in their organization
Red Cross Switzerland	Has a goal on healthy ageing and has developed age friendly environments in which the young and the older adults interact; Created sustainable and equitable systems to provide long-term community care for individuals that may need long-term assistance.	Share information on how they identified the affected individuals
Spitex & religious groups or churches	They can help identify lonely and socially isolated individuals that they work with and offer activities in which they can become involved.	Share information of the at-risk individuals they meet

Recommendation 3. Key elements of awareness raising campaigns in Loneliness	
Goals	• Increase the trained workers' and the public's awareness about the issue of social isolation and loneliness amongst older adults and reduce stigma; • Encourage the trained workers and the public to help identify lonely or isolated elderly to improve social connections; • Enable the trained workers and the public to better understand and response to loneliness and social isolation.
Target audience	Trained workers from Recommendation one and the general public.
Main message	Anyone can experience loneliness or social isolation and it is okay to talk about it.
Communication channels	Media, posters, social media and internet, face-to-face campaigns, etc.
Awareness raising activities	Invite trained workers to information events and provide them with short training sessions; Use loneliness heat maps; Spread information and knowledge though columns in the newspapers talking about the issue, having a short radio segment, television adverts or a short segment at a talk; Distributing pamphlets or having face-to-face conversations about signs of an at-risk elderly, etc.

Summary

This policy brief has collected evidence from academic and grey literature on approaches to identifying older adults who are at risk of or experiencing loneliness and social isolation, and presents methods that could be suitable for the Swiss context.

Based on the literature, there are several challenges to face during the process of identification. These barriers include stigma, preference for loneliness, lack of evidence on how to identify socially isolated older adults, lack of awareness and privacy issues. It is dfficult to recognize the affected and at-risk old people, because:

- There is a taboo about social isolation and loneliness that leads people to associate it with shame, uneasiness and social incompetence. The stigma is a major obstacle in identifying those in most need in Switzerland;
- Some individuals have a preference for solitude. They may not desire frequent social contact or engage in certain social activities. Therefore, it is reasonable to assume that not all people who are seemingly lonely or isolated wish to be contacted;
- There is limited good quality evidence on the reliability and validity of methods that identify those who are socially isolated or lonely;
- In Switzerland, few efforts have been made to bring awareness to social isolation and loneliness;
- Security and patient privacy are an important concern in Switzerland, thus they may impede the adoption of any system for sharing sensitive or personal data between different institutions.

By evaluating existing literature, we have found a variety of identification methods, including public facing methods such as mass media, information sessions, and referrals by oneself or by agencies as well as other individuals, combined strategies and using population data. Based on the findings and taking the challenges into account, this policy brief summarizes three separate and complementary recommendations:

1. Enlist personnel who often come into contact with older adults to identify the lonely or isolated elderly with questionnaires and refer them to community activities that improve social networking.
2. Use existing data to create heat maps that demonstrate variations of the prevalence of loneliness in different neighborhoods.
3. Undertake awareness campaigns to increase the trained workers' and the public's awareness about social isolation and loneliness, and reduce stigma. Encourage the lonely and isolated older people to self-identify themselves and self-disclose their problems, as well as encourage the general public to help identify the target population.

Acknowledgements

We would like to sincerely thank Kathryn Dawson-Townsend, Russul Glass, Nyasha Chigariro for their import and helpful support concerning the literature review and preparation of this Policy Brief. We are also highly thankful to Tanya Kasper Wicki and Lorena Wyss for her suggestions on the policy brief.

We wish to extend our sincere thanks to Dr. Martin Hošek for bringing up the idea of social counseling. We would like to show our greatest appreciation to René Rüegg for providing information about social counseling in Switzerland. We would also like to express our gratitude to all the stakeholders who have provided helpful feedback on the recommendations presented in this policy brief.

References

[1] Ige J, Gibbons L, Bray I, Gray S. Methods of identifying and recruiting older people at risk of social isolation and loneliness: a mixed methods review. BMC medical research methodology. 2019;19(1):181.

[2] Goodman A, Adams A, Swift H. Hidden citizens: How can we identify the most lonely older adults. 2015.

[3] Eisenberger NI. Social ties and health: a social neuroscience perspective. Current Opinion in Neurobiology. 2013;23(3):407-13.

[4] Kawachi I, Berkman LF. Social ties and mental health. Journal of Urban health. 2001;78(3):458-67.

[5] Umberson D, Karas Montez J. Social relationships and health: A flashpoint for health policy. Journal of health and social behavior. 2010;51(1_suppl):S54-S66.

[6] Windle K, Francis J, Coomber C. Preventing loneliness and social isolation: interventions and outcomes: Social Care Institute for Excellence London; 2011.

[7] Coyle CE, Dugan E. Social isolation, loneliness and health among older adults. Journal of aging and health. 2012;24(8):1346-63.

[8] O'Súilleabháin PS, Gallagher S, Steptoe A. Loneliness, living alone, and all-cause mortality: The role of emotional and social loneliness in the elderly during 19 years of follow-up. Psychosomatic medicine. 2019;81(6):521.

[9] Pantell M, Rehkopf D, Jutte D, Syme SL, Balmes J, Adler N. Social isolation: a predictor of mortality comparable to traditional clinical risk factors. American journal of public health. 2013;103(11):2056-62.

[10] Teguo MT, Simo-Tabue N, Stoykova R, Meillon C, Cogne M, Amiéva H, et al. Feelings of loneliness and living alone as predictors of mortality in the elderly: the PAQUID study. Psychosomatic medicine. 2016;78(8):904-9.

[11] de Jong Gierveld J, Van Tilburg T, Dykstra PA. Loneliness and social isolation. Cambridge handbook of personal relationships. 2006:485-500.

[12] Jopling K. Promising approaches to reducing loneliness and isolation in later life. London: Age UK. 2015.

[13] Collins E. Preventing social isolation and loneliness in older people: Institute for Research and Innovation in Social Services; 2014.

[14] Perlman D, Peplau L. Toward a social psychology of loneliness. In S. duck & R. Gilmour (Eds.), personal relationships in disorder (pp. 31–56). 1981.

[15] Weiss RS. Loneliness: The experience of emotional and social isolation. 1973.

[16] Association LG. Combating loneliness: a guide for local authorities. 2016.

[17] Erosh. Erosh good practice guide: Addressing Loneliness and Social Isolation in Older People 2018 [Available from: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Good-practice-loneliness-and-social-isolation-final-May-18-pdf.pdf].

[18] Durcan D, Bell R. Reducing Social Isolation across the Lifecourse. Public Health England: London, UK. 2015.

[19] Griffin J. The lonely society?: Mental Health Foundation. 2010.

[20] Landeiro F, Leal J, Gray A. The impact of social isolation on delayed hospital discharges of older hip fracture patients and associated costs. Osteoporosis international. 2016;27(2):737-45.

[21] Palmarini N, Wu R, Zinck S, Lesser E. Loneliness and the aging population, how businesses and governments can address a looming crisis. IBM. 2017.
[22] Cattan M, White M, Bond J, Learmouth A. Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. Ageing & Society. 2005;25(1):41-67.
[23] Dickens AP, Richards SH, Greaves CJ, Campbell JL. Interventions targeting social isolation in older people: a systematic review. BMC public health. 2011;11(1):647.
[24] Golden J, Conroy RM, Bruce I, Denihan A, Greene E, Kirby M, et al. Loneliness, social support networks, mood and wellbeing in community - dwelling elderly. International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences. 2009;24(7):694-700.
[25] Luanaigh CÓ, Lawlor BA. Loneliness and the health of older people. International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences. 2008;23(12):1213-21.
[26] Patel RS, Wardle K, Parikh RJ. Loneliness: the present and the future. Age and ageing. 2019;48(4):476-7.
[27] Holt-Lunstad J. The potential public health relevance of social isolation and loneliness: Prevalence, epidemiology, and risk factors. Public Policy & Aging Report. 2017;27(4):127-30.
[28] Wettstein A, Dyntar D, Kälin M, editors. Gesundheitsrisiko Vereinsamung im Alter. Swiss Medical Forum; 2014: EMH Media.
[29] Richard A, Rohrmann S, Vandeleur CL, Schmid M, Barth J, Eichholzer M. Loneliness is adversely associated with physical and mental health and lifestyle factors: Results from a Swiss national survey. PloS one. 2017;12(7):e0181442.
[30] Fratiglioni L, Wang H-X, Ericsson K, Maytan M, Winblad B. Influence of social network on occurrence of dementia: a community-based longitudinal study. The lancet. 2000;355(9212):1315-9.
[31] Valtorta N, Hanratty B. Loneliness, isolation and the health of older adults: do we need a new research agenda? Journal of the Royal Society of Medicine. 2012;105(12):518-22.
[32] Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. Loneliness and risk of Alzheimer disease. Archives of general psychiatry. 2007;64(2):234-40.
[33] Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. Annals of the New York Academy of Sciences. 2011;1231(1):17.
[34] James BD, Wilson RS, Barnes LL, Bennett DA. Late-life social activity and cognitive decline in old age. Journal of the International Neuropsychological Society: JINS. 2011;17(6):998.
[35] Age UK. Safeguarding the convoy: a call to action from the Campaign to End Loneliness. 2011.
[36] Shankar A, McMunn A, Banks J, Steptoe A. Loneliness, social isolation, and behavioral and biological health indicators in older adults. Health Psychology. 2011;30(4):377.
[37] Cohen S, Doyle WJ, Skoner DP, Rabin BS, Gwaltney JM. Social ties and susceptibility to the common cold. Jama. 1997;277(24):1940-4.
[38] Cornwell EY, Waite LJ. Social disconnectedness, perceived isolation, and health among older adults. Journal of health and social behavior. 2009;50(1):31-48.

[39] Pressman SD, Cohen S, Miller GE, Barkin A, Rabin BS, Treanor JJ. " Loneliness, social network size, and immune response to influenza vaccination in college freshman": Correction to Pressman et al.(2005). 2005.
[40] Hawton A, Green C, Dickens AP, Richards SH, Taylor RS, Edwards R, et al. The impact of social isolation on the health status and health-related quality of life of older people. Quality of Life Research. 2011;20(1):57-67.
[41] Hawkley LC, Thisted RA, Masi CM, Cacioppo JT. Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. Psychology and aging. 2010;25(1):132.
[42] Lund R, Nilsson CJ, Avlund K. Can the higher risk of disability onset among older people who live alone be alleviated by strong social relations? A longitudinal study of non-disabled men and women. Age and Ageing. 2010;39(3):319-26.
[43] Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. Heart. 2016;102(13):1009-16.
[44] Owens J, Sirois, F. 2019. Review of the impact of loneliness and social isolation on health and well-being and whether people who experience loneliness/social isolation have higher use of public services. [Available from: https://gov.wales/loneliness-and-use-public-services-literature-review].
[45] Gerst-Emerson K, Jayawardhana J. Loneliness as a public health issue: the impact of loneliness on health care utilization among older adults. American journal of public health. 2015;105(5):1013-9.
[46] Clarke D. Social Isolation in Bristol: Risks, Interventions and Recommendations Report. Bristol City Council; 2014.
[47] Dawson-Townsend K, Mantwill S, Boes S. Strengthening social participation of socially disadvantaged older people in Switzerland.
[48] Griffiths H. Social isolation and loneliness in the UK: With a focus on the use of technology to tackle these conditions. London: Future Cities Catapult; 2017.
[49] Bonk M. Policies on ageing and health: A selection of innovative models. Mandated by the Swiss Federal Office of Public Health. 2016.
[50] Office FS. Switzerland's population 2014 2015.
[51] Schweiz G. Gesundheitsförderung im Alter: Fakten und Zahlen. 2016.
[52] Federal Office of Statistics. Einsamkeitsgefühl in der ständigen Wohnbevölkerung ab 15 Jahren, nach Migrationsstatus und verschiedenen soziodemografischen Merkmalen. 2019. [Available from: https://www.bfs.admin.ch/bfs/en/home/news/whats-new.assetdetail.9186018.html].
[53] Affairs UNDoEaS. Profiles of Ageing 2017, Switzerland: United Nations Department of Economic and Social Affairs; 2017. [Available from: https://population.un.org/ProfilesOfAgeing2017/index.html].
[54] Cohen GD, Perlstein S, Chapline J, Kelly J, Firth KM, Simmens S. The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. The Gerontologist. 2006;46(6):726-34.
[55] Pitkala KH, Routasalo P, Kautiainen H, Tilvis RS. Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomized, controlled trial. Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences. 2009;64(7):792-800.

[56] Poscia A, Stojanovic J, La Milia DI, Duplaga M, Grysztar M, Moscato U, et al. Interventions targeting loneliness and social isolation among the older people: An update systematic review. Experimental gerontology. 2018;102:133-44.
[57] Lubben J. Addressing social isolation as a potent killer! Public Policy & Aging Report. 2017;27(4):136-8.
[58] Bohn C. Die soziale Dimension der Einsamkeit unter besonderer Berücksichtigung der Scham: Kovač; 2008.
[59] Luhmann M. Einsamkeit und soziale Isolation im hohen Alter: Implikationen für Forschung und Politik. 2019.
[60] Barney LJ, Griffiths KM, Jorm AF, Christensen H. Stigma about depression and its impact on help-seeking intentions. Australian & New Zealand Journal of Psychiatry. 2006;40(1):51-4.
[61] Einsamkeit in der Schweiz. swissinfo; [Available from: https://stories.swissinfo.ch/einsamkeit-in-der-schweiz#222943].
[62] Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. American journal of public health. 2013;103(5):813-21.
[63] Lewin S, Oxman AD, Lavis JN, Fretheim A, Marti SG, Munabi-Babigumira S. SUPPORT tools for evidence-informed policymaking in health 11: Finding and using evidence about local conditions. Health Research Policy and Systems. 2009;7(S1):S11.
[64] Newall NE, Chipperfield JG, Bailis DS. Predicting stability and change in loneliness in later life. Journal of Social and Personal Relationships. 2014;31(3):335-51.
[65] Wigfield A, Alden S. Assessing the effectiveness of social indices to measure the prevalence of social isolation in neighbourhoods: a qualitative sense check of an index in a northern English city. Social Indicators Research. 2018;140(3):1017-34.
[66] Steve B. The Missing Million: In Search of the Loneliest in our Community. Campaign to End Loneliness; 2016.
[67] Jorm AF, Christensen H, Griffiths KM. Changes in depression awareness and attitudes in Australia: the impact of beyondblue: the national depression initiative. Australian & New Zealand Journal of Psychiatry. 2006;40(1):42-6.
[68] Alter hat Potenzial Kanton Zug; 2016. [Available from: https://www.alter-hat-potenzial.ch/].
[69] Daniel F. Gegen die Einsamkeit. Soziale Isolation als gesellschaftliches Phänomen politisch angehen. 2019. [Available from: https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20193487].
[70] Teich JM. The benefits of sharing clinical information. Elsevier; 1998.
[71] Federal Data Protection and Information Commissioner; [Available from: https://www.edoeb.admin.ch/edoeb/en/home/data-protection/ueberblick/anliegen-des-datenschutzes--icons-.html].
[72] England N. Social prescribing: NHS England; [Available from: https://www.england.nhs.uk/personalisedcare/social-prescribing/].
[73] Thomson L, Camic PM, Chatterjee H. Social prescribing: a review of community referral schemes. 2015.
[74] England HE. Social Prescribing-Learning for Link Workers: Health Education England [Available from: https://www.e-lfh.org.uk/programmes/social-prescribing/].

[75] Nicholson NR. A review of social isolation: an important but underassessed condition in older adults. The journal of primary prevention. 2012;33(2-3):137-52.
[76] Freedman A, Nicolle J. Social isolation and loneliness: the new geriatric giants: Approach for primary care. Canadian Family Physician. 2020;66(3):176-82.
[77] Zoey P. In France, Elder Cares Comes With the Mail. 2019 October 9.
[78] Veazie S, Gilbert J, Winchell K, Paynter R, Guise J-M. Addressing social isolation to improve the health of older adults: a rapid review. 2019.
[79] Hughes ME, Waite LJ, Hawkley LC, Cacioppo JT. A short scale for measuring loneliness in large surveys: Results from two population-based studies. Research on aging. 2004;26(6):655-72.
[80] Besier W. MM. MAG1: Mannheim gegen Einsamkeit. 2017.
[81] MAG1 Mannheim gegen Einsamkeit [Available from: https://www.mageins.de/].
[82] Terwiel S, Wolff K. Vorbeugung und Bekämpfung von Einsamkeit und sozialer Isolation im hohen Alter. 2019.
[83] Claremont-Project. Claremont Project [Available from: https://www.claremont-project.org/join-us/].
[84] UK A. Loneliness maps: Age UK; [Available from: https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-maps/]. Age UK. Age UK's Loneliness Heat Map – Questions & Answers, London, Age UK.2016. [Available from: http://www.ageuk.org.uk/Documents/EN-GB/]. For-professionals/Research/Age_UK_Loneliness_Heat_Maps_FAQs.pdf
[85] Government H. A connected society: A strategy for tackling loneliness–laying the foundations for change. HM Government London; 2018.
[86] Association LG. Combating Loneliness: A guide for local authorities. 2016.
[87] Jones DA, Victor CR, Vetter NJ. The problem of loneliness in the elderly in the community: characteristics of those who are lonely and the factors related to loneliness. The Journal of the Royal College of General Practitioners. 1985;35(272):136-9.
[88] Machielse A. The heterogeneity of socially isolated older adults: A social isolation typology. Journal of Gerontological Social Work. 2015;58(4):338-56.
[89] Wenger GC, Davies R, Shahtahmasebi S, Scott A. Social isolation and loneliness in old age: review and model refinement. Ageing & Society. 1996;16(3):333-58.
[90] Masiuliene L. The key features of successful awareness raising campaigns. Brussels, Belgium: European Literacy Policy Network. 2015.
[91] Council S. Loneliness and Social Isolation in Solihull
[92] Gardiner C, Geldenhuys G, Gott M. Interventions to reduce social isolation and loneliness among older people: an integrative review. Health & social care in the community. 2018;26(2):147-57.
[93] Lau S, Gruen GE. The social stigma of loneliness: Effect of target person's and perceiver's sex. Personality and Social Psychology Bulletin. 1992;18(2):182-9.
[94] Cacioppo J. Connected Minds: Loneliness, Social Brains and the Need for Community. London: RSA Available at. 2010.
[95] LetsTalkLoneliness: UK Government. #LetsTalkLoneliness [Available from: https://letstalkloneliness.co.uk/about/].
[96] Hole K. Loneliness compendium: examples from research and practice. JRF/JRHT programme paper: Neighbourhood approaches to loneliness. 2011.

[97] Paykel E, Hart D, Priest R. Changes in public attitudes to depression during the Defeat Depression Campaign. The British Journal of Psychiatry. 1998;173(6):519-22.
[98] Cupitt S. KM, Ellis J., Dien-Johns R. The Campaign to End Loneliness: impact report. 2013.
[99] Age UK. Testing Promising Approaches to Reducing Loneliness: Results and Learnings of Age UK's Loneliness Pilot. 2016.
[100] Elder K, Retrum J. Framework for isolation in adults over 50: AARP Foundation/isolation Framework Project. San Diego CA: Research Works. 2012.
[101] Dean M. Celebrity health announcements and online health information seeking: An analysis of Angelina Jolie's preventative health decision. Health communication. 2016;31(6):752-61.
[102] Van de Belt TH, Engelen LJ, Berben SA, Teerenstra S, Samsom M, Schoonhoven L. Internet and social media for health-related information and communication in health care: preferences of the Dutch general population. Journal of medical Internet research. 2013;15(10):e220.
[103] Goodman A, Symons M. Evidence-based campaigning on loneliness in older age: an update from the Campaign to End Loneliness. Working with Older People. 2013.
[104] No one should have No one to turn to [press release]. Age UK2018.
[105] Schweiz G. Fokusthema «Soziale Teilhabe»: Gesundheitsförderung Schweiz; [Available from: https://gesundheitsfoerderung.ch/kantonale-aktionsprogramme/psychische-gesundheit/aeltere-menschen/fokusthemen/soziale-teilhabe.html].
[106] Geneva RC. Seniors d'ici et d'ailleurs Red Cross Geneva; [Available from: https://www.croix-rouge-ge.ch/?page=seniors-d-ici-et-d-ailleurs].
[107] Neukomm Sarah JG. Erreichbarkeit von sozial benachteiligten älteren Personen durch Angebote der Gesundheitsförderung und Prävention. Bundesamt für Gesundheit 2019.
[108] Hämmig, O. Soziale Beziehungen und Gesundheit im Kanton Zürich. 2016.
[109] Kessler, M., Steinmann, R. M. Gesundheitsförderung im Alter in der Hausarztpraxis. Primary Care. 2015; 15(7), 118-23.
[110] Hämmig, O. "Health risks associated with social isolation in general and in young, middle and old age." PLoS One. 2019; 14(7): e0219663.
[111] Profiles of Ageing 2019. UN. [Available from: https://population.un.org/ProfilesOfAgeing2019/index.html].
[112] Community First Yorkshire 2020. Be social, Be well: A Strategic Framework for Tackling Loneliness in North Yorkshire.
[113] #BeMoreUs (Campaign to End Loneliness) [Available from: https://bemoreus.org.uk/FAQs].
[114] Home for the Holidays Campaign: Addressing Social Isolation & Loneliness in Older Adults. [Available from: https://www.n4a.org/h4h2016].
[115] Gupta S. Just Say Hello: The Powerful New Way to Combat Loneliness. [Read more: http://www.oprah.com/health/just-say-hello-fight-loneliness/all#ixzz6c5IvzYum].2014.
[116] Polley, M., Fleming, J., Anfilogoff, T., Carpenter, A., Kimberlee, R., Bertotti, M., ...Wheatley, J. Making sense of social prescribing. (2017).

[117] Pahud, Olivier. "Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich." Analyse des International Health Policy (IHP) Survey (2019).

Appendix I

Example: Social participation activity for older people in Switzerland

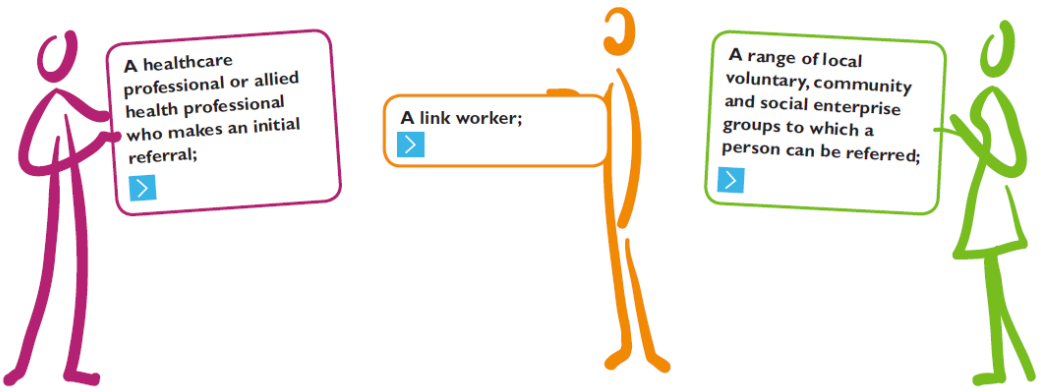
Seniors d'ici et d'ailleurs (Seniors Here and Elsewhere, Switzerland)

The "Seniors d'ici et d'ailleurs" (Seniors Here and Elsewhere) program, established by the Swiss Red Cross in 2000 in the canton of Geneva, aims to promote the integration of lonely and isolated people over the age of 55, with particular focus on immigrants. A variety of group activities take place regularly, including weekly French class and gymnastic class, monthly visit to swimming pools, workshops and/or information sessions. Other activities at special occasions such as Christmas are also provided. Participants can take part in the activities for free or pay a small amount of fees. Up to now this program has helped 120 people aged 55+ (106, 107).

Source: Red Cross of Geneva (https://www.croix-rouge-ge.ch/nos-activites/personnes-agees/activites-dintegration-pour-seniors-migrants)

Appendix II A

What are the key components of a social prescribing scheme?



Source: (116).

Appendix II B

Example: Enlist personnel in the community in the identification process in Recommendation 1

Hampshire County Council in partnership with local pharmacies (UK)

Hampshire County Council designed a questionnaire targeting people aged 65 and older, and aimed to find out if they were interested in hearing about local activities and how other locals could assist them with some everyday tasks. The council distributed the questionnaires to local pharmacies, where older customers were invited to complete the survey. Those who suggested that they wished to know about local activities or support were referred to Age Concern Hampshire (*Source*: Executive Summary of Goodman et al., 2015).

Appendix II C

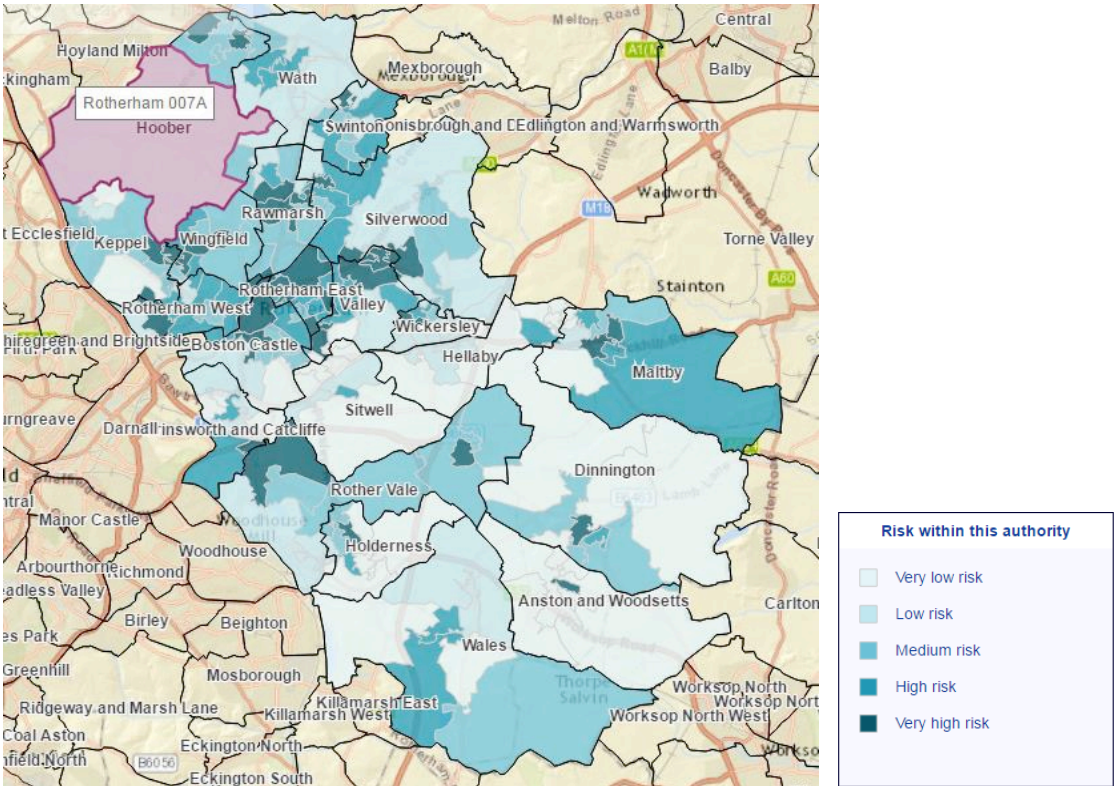
The following text outlines a project run by the Bern University of Applied Science (Berner Fachhochschule, BFH) in order to promote social counseling in primary care settings in Switzerland. This project may provide some valuable insights on how to integrate social prescribing for social isolation and loneliness in GP practices in Switzerland:

Social work in medical practices

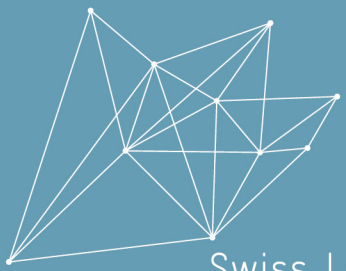
There are high rates of non-medical social concerns raised by patients during medical consultations. The frequently addressed problems include social isolation and loneliness, financial situation and domestic violence. Other social concerns are mainly concerning workplace insurance and pensions, family and partnership as well as diffuse social problems. The non-medical social concerns have caused extra stress to many primary care providers and they would like to have better access to and get more financial support for social programs. One solution is to introduce social counseling services in medical practices. Social counseling services are offered in two forms. One type is integrated social work in a medical practice, where a social worker is employed by the medical practice or an operating company. The social worker and the medical practice have common electronic patient records and appointments for counseling can be scheduled through the front desk. The other type of social counseling service is the external practice social work, i.e., a social worker works for one or several medical practice(s) on a basis of collaboration agreements. GPs provide patients with referral letters for social counseling. The referrals are similar to those for physiotherapy or for specialist care. Social counseling services in GP practices are currently not covered by the basic health insurance. Social workers who offer the counseling services are mainly paid by medical practices, charitable foundations, municipalities and cantons, and according to the Tarmed tariff chapter 02.04 for their work in psychiatric practices. Although only a few medical practices in Switzerland have adopted integrated or external social counseling services, interviews conducted by the BFH with five physicians from pioneering practices suggest that social counseling has a positive impact on both the GPs' work efficiency and the patients' social wellbeing. This is consistent with findings of international studies (*Source*: Rüegg R. 2021, Broschüre Soziale Arbeit in der Arztpraxis).

Appendix III

Age UK Loneliness Heat Map Case Study in Rotherham



Source: https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-maps/



Swiss Learning
Health System