FCSS

Positive social ties and vulnerable populations

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1. The issue

A wide range of research illustrates the ways in which the availability and use of various social ties make a difference to individual well-being. Whether it is a question of parenting, educational attainment, immigrant integration, labour market entry, or aging well in retirement, when we know people to turn to for resources, support, and connections it helps us to "get by" or "get ahead."[1] As noted by the Government of Canada's Policy Research Initiative, "people with extensive social connections linking them to people with diverse resources tend to be more 'hired, housed, healthy, and happy.'"[1] On the other hand, people who are socially isolated – that is, lacking in connections that can help them in one way or another – are at high risk of health problems, poverty, and social exclusion.

At risk of oversimplification, "positive social ties" is shorthand for various forms of social capital, an idea conceptualized many years ago but pulled into the public realm and popularized (and, arguably, simplified) by Putnam in 2000.[2] For purposes of this discussion, the simple version works well. In essence, there are two kinds of social capital: bonding and bridging.

Bonding social capital is typified by relations within a homogeneous group: strong ties among people who share similar backgrounds, such as members of an ethnocultural group, members of an extended family or, less optimally, members of a criminal gang. Bridging social capital is about connections outside one's own tight group, weaker connections with a broader range of people who are useful in linking people to external assets. Bridging social capital has often been associated with assisting people in obtaining employment and increasing income,[3] although it is certainly used for many different purposes.

Like other forms of capital, social capital is morally neutral. It is what one does with it that matters.

Social capital has particular components and implications from a community development perspective. In this research brief, the focus is on identifying ways of preventing the social isolation and, by extension, the social exclusion, of members of vulnerable population groups by increasing their positive social ties.

Immigrants, families, people with disabilities, and seniors are more likely than the general population to lack positive social ties and, for this reason, to be at risk of social exclusion. (Children and youth can also be socially isolated, but this population is addressed in *Research Brief 1, Positive child and youth development.)* The risk of social isolation also appears to be high among low-income people in general and, possibly, young, unattached adults but, outside of the context of neighbourhood and spatially concentrated poverty, this is not a subject of recent research. In addition, Aboriginal people may be more likely to lack bridging social capital. (Aboriginal issues are addressed in a separate research brief.)

Not all people in each of these groups are at risk of social isolation; rather, some people within these groups face particular challenges in developing or maintaining sufficient connections or the right type of connections they need to get by or get ahead. In all cases, however, vulnerable members of these groups need these connections to be socially included and to participate in all aspects of society.

Identifying the sorts of community-based programs and initiatives most effective for each group is a daunting exercise because the causes and consequences of

Introduction to FCSS research brief

This research brief is one of a series provided for FCSS-funded organizations and others in the field of preventive social services focused on enhancing social inclusion. It provides research-based information/statistics on the issue, risk and protective factors, and guidance on programming, but is not intended to serve as a comprehensive program development toolkit.

The 2020 version of the Positive social ties and vulnerable populations research brief is organized into the same three sections as the 2014 version:

1. The issue
2. Risk and protective factors
3. What works

Each section begins with the context from the 2014 version and is followed by a 2020 update. The 2020 updates provide more recent statistics and curated lists of resources/links readers can access for more detailed information on each topic.

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social isolation and positive social ties vary among the at-risk groups. There is very little research-based evidence supporting any sorts of community-level interventions to increase positive social ties. While there are tens of thousands of articles discussing social isolation, social capital, and social support in the published and grey literature bases, only a very few describe interventions or practices that have been evaluated in any way; fewer still describe interventions or practices that have been experimentally or quasi-experimentally evaluated. Unless an evaluation uses a control or comparison group, particularly in the absence of a strong research base supporting a particular model or approach, there is always the possibility the results were due to factors other than the intervention. As stressed throughout this research brief, most of the interventions described are, at best, promising and, in some cases, merely suggestions for consideration.

FIGURE 1: POSITIVE SOCIAL TIES OUTCOMES

Domain	Desired outcomes
Positive social ties/ bonding social capital	• Increased number of individuals who provide social support (e.g., people to socialize with, to turn to with problems, to exchange affection). • Increased number of individuals who provide support with daily living (e.g., provide rides, assist with errands/chores, care for children/parents/spouses). • Increased number of positive role models. • Increased social participation (e.g., increased number of volunteer hours, increased frequency of participation in organizations and associations).
Bridging social capital	• Increased number of individuals who provide useful connections in life, with the type of connections depending on the vulnerable group (e.g., for recent immigrants and low-income, unemployed people, job contacts, people who could lend money, people from other ethnocultural groups).

2020 update

City of Calgary Community Profiles, available at calgary.ca/communities, provide demographic, economic and housing information for each community and comparison data for Calgary as a whole.

- Social capital:
  - Studies show people with more social capital have better health, higher income, better quality employment and that immigrants with higher social capital are better integrated in the labour market.[4]
  - A study found that immigrant women who had friends in Canada prior to their arrival earned about $7,000 more than those who did not have friends prior to arrival. For men the difference was $10,000.[5]
  - For immigrants who made friends in Canada six months after admission to the country, incomes grew faster than for immigrants who did not make friends within the first six months.[5]
  - A survey comparing the social capital of the general population with that of people with disabilities and high support needs found that people with disabilities had lower levels of most components of social capital.[6]
- Living alone:
  - In Canada in 2016, 14 per cent of the population 15 and older, or 4.0 million people, lived alone. This number has more than doubled over the past 35 years.[7]
  - Between 1981 and 2016, the number of people living alone has grown fastest among people 35 to 64 years old. Growth has been faster among men than women and among those who are separated or divorced. The share of seniors living alone decreased slightly over the same time period.[7]
  - Most young adults living alone in 2017 intended to partner or have a child in the future, indicating that they consider living alone to be a temporary arrangement.[7]
  - While there are many more people living alone, they may still have close connections with loved ones.[7]
- In a 2019 study, only 14 per cent of Canadians describe the current state of their social lives as "very good," while 33 per cent said they are uncertain that they have family members or friends they could count on to provide financial assistance in an emergency.[8]
- In a 2019 study, respondents were grouped into five categories based on their degree of loneliness and isolation:

  23% – Desolate

  10% – Lonely, but not isolated

  15% – Isolated, but not lonely

  31% – Moderately connected

  22% – Cherished

Overall, the research points towards low perceptions of social support and connectedness among Canadians.[9]

2. What needs to be prevented: Social isolation

Most of the research on social isolation focuses on seniors and the relationships between isolation and health. (For a thorough and up-to-date summary see [10].) For vulnerable seniors, social isolation is associated with poor general health,[11] including:

- Increased risk of chronic disease[12]
- Disability or chronic disease[11]
- Reduced self-care[13]
- Decreased immunity[14] and slow wound healing[14]
- Premature death[11]
- Poorer sleep efficiency and fatigue[12]
- Abuse[15]
- Stress[12]
- Loneliness,[16] depression and other mental illnesses[17] and suicide[18]
- Poor nutrition[14]
- Psychosomatic illness[19]
- Reduced well-being[11]
- Quality of life[11]

Other groups at risk generally experience social isolation differently, with different consequences. For vulnerable immigrants, social isolation is associated with unemployment or under-employment, poverty, and settlement and integration challenges and, for some groups of refugees, mental health challenges. Depending on the nature of the disability and personal circumstances, social isolation experienced by people with disabilities can be associated with challenges ranging from poverty, to health problems, to loneliness. For at-risk parents, social isolation is associated with poverty, poor health, poor parenting, and, in some cases, child abuse. What is common among all people who suffer from social isolation is the risk of social exclusion on multiple dimensions. Preventing social isolation is one aspect of a broader social inclusion strategy.

2020 update

Recent publications on the consequences of low social capital and social isolation include:

Mental health

- Cognitive Function in Older Adults: Findings From the Chinese Longitudinal Healthy Longevity Survey[20]
- Loneliness in the General Population: Prevalence, Determinants and Relations to Mental Health[21]
- Social Determinants of Immigrant Women's Mental Health[22]
- The Effects of Loneliness and Coping Style on Academic Adjustment Among College Freshmen[23]
- Social Support, Social Conflict and Immigrant Women's Mental Health in a Canadian Context: A Scoping Review[24]

Physical health

(included for informational purposes only as FCSS focuses on social outcomes).

- A Systematic Review of Loneliness and Smoking: Small Effects, Big Implications[25]
- A Systematic Review of the Relationships Between Social Capital and Socioeconomic Inequalities in Health: A Contribution to Understanding the Psychosocial Pathway of Health Inequalities[26]
- Discrimination and Sleep Difficulties During Adolescence: The Mediating Role of Loneliness and Perceived Stress[27]
- Is Loneliness Associated with Malnutrition in Older People?[28]
- Loneliness and Acute Stress Reactivity: A Systematic Review of Psychophysiological Studies[29]
- Loneliness and Sleep Quality: Dyadic Effects and Stress Effects[30]
- Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review[31]

Both physical and mental health

- An Overview of Systematic Reviews on the Public Health Consequences of Social Isolation and Loneliness[32]
- Loneliness and Health in Older Adults: A Mini-Review and Synthesis[33]
- Tackling a Silent Beast: Strategies for Reducing Loneliness and Social Isolation[34]
- The Growing Problem of Loneliness[35]
- Who's at Risk and What Can Be Done About It? A Review of the Literature on the Social Isolation of Different Groups of Seniors[36]
- Social Isolation of Seniors: A Focus on New Immigrant and Refugee Seniors in Canada[37]

Employment and poverty

- Inequalities in Social Capital and Their Longitudinal Effects on the Labour Market Entry[38]
- Social Isolation and Its Relationship to Multidimensional Poverty[39]
- Food Insecurity and Mental Illness: Disproportionate Impacts in the Context of Perceived Stress and Social Isolation[40]

3. What works to increase positive social ties for vulnerable members of at-risk groups

The "right" intervention to prevent social isolation and increase positive social ties often depends on the reasons why people lack positive social ties and the intended purpose of those connections. For instance:

- A newcomer to Canada may need connections in the world of work to secure employment or connections in the community to learn about Canadian systems and customs.
- A single mother may need connections to help her manage the demands of parenting and work or connections to provide emotional support in overcoming an addiction.
- An elderly widower may need connections with people who will pick up his groceries or social connections to prevent the myriad health problems associated with isolation among older people.

While some interventions may have benefits for multiple groups, the type of intervention and why it might be effective can vary among groups.

3.1 Vulnerable immigrants

Research indicates the immigrants who are most vulnerable to social exclusion are:

- Recent newcomers.
- Refugees.
- Those who face language and/or cultural barriers.
- Those who have low income and are unable to obtain employment that is commensurate with their credentials.
- Stay-at-home parents or seniors.
- Those who belong to ethnocultural communities with few members in Calgary.

Most vulnerable immigrants meet several of these criteria.

It should be cautioned from the outset that the creation of positive social ties is not a panacea for the integration of immigrants. Even immigrants who have strong social networks may find themselves unable to achieve their potential due to other systemic barriers. However, recent evidence suggests a strong link between robust social networks, immigrants' social and economic outcomes, and immigrants' perceptions of their life in Canada.[41] It is widely agreed both bonding and bridging social capital are essential to a successful integration process. As summarized by Kunz, " it is through networks that immigrants expand their social and economic opportunities in the receiving country."[42]

Upon arrival, immigrants' needs include employment; housing; a welcoming community; an environment where children can be safe, healthy, and well-educated; social contacts; accurate information about and access to health, social and educational services; and, for many, English-language training[43] (see for example [44,45]). Research shows refugees and refugee claimants often experience significant problems in obtaining the basic determinants of health (an escalating problem due to cuts to the Interim Federal Health Program in June 2012),[46] including adequate income, food security, appropriate and affordable housing, and transportation.[47,48] This is in part due to many refugees' inability to obtain ESL training, employment opportunities, legal services, affordable childcare, sufficient settlement services, various educational and other supports for children and youth, and other supports and services that help newcomers along the road to self-reliance and a reasonable quality of life.

Friends and relatives are key sources of support to help immigrants with settlement challenges.[49] For the most part, new immigrants seek out members of their own ethnocultural groups to help them settle in Canada. Indeed, Statistics Canada reports that the most frequent reason reported by immigrants for choosing to immigrate to Canada is joining or accompanying family or friends[50] (see also [51-54]) In this sense, most new immigrants are not entirely socially isolated, but there remain many newcomers, especially those who are refugees, who have very few or no local contacts upon arrival, and who settle in places where few members of their own ethnocultural community live. In conjunction with the myriad language and cultural barriers encountered and the hardships experienced by many refugees, lack of social ties places some newcomers at high risk of long-term social exclusion.

Studies indicate that strong within-group networks (bonding social capital) help newcomers to find housing, access essential services, and address basic needs. Informal networks and social support are especially important to the adjustment, acculturation, and mental health of immigrants and refugees.[55,56] Canadian research shows that recent immigrants with low levels of social support had higher odds of reporting mental disorders than those who had been here longer and/or had high levels of social support.[57] Both bonding and bridging social capital help newcomers to find jobs, but bridging social capital may be more important to success in the labour market. (See *Research Brief 3, Individual and family economic self-sufficiency*)

It appears no evidence-based best or promising practices have been identified by studies or evaluations. However, qualitative research indicates the following types of programs and initiatives may be helpful in increasing positive social ties.

Programs and initiatives that may be helpful in increasing positive social ties

Initiatives to facilitate informal social support systems

Puyat, among others, recommends programs or interventions that aim to strengthen immigrants' informal support system, in addition to the existing social and settlement services, to improve newcomers' social networks. Other Canadian research on Sudanese refugees concluded that peer group interventions promoting strong

families may help recent refugees to re-create social support networks.

Hernandez-Plaza, et al., draw on other research and recommend social support interventions supplement the provision of formal social support by professionals with efforts to help newcomers to develop bridging social capital featuring reciprocity within informal support networks. Although there appears to be no research on the effectiveness of these strategies, they recommend:

- Social mediation (sometimes referred to as "cultural brokering") provided by individuals who are members of the target ethnocultural group.
- Using volunteers to provide information about the receiving society (employment and housing opportunities, relationships with natives, cultural norms and values), instrumental assistance in diverse tasks (language learning, legal procedures, direct help to find a job or a house), material support (temporary accommodation, food, clothing), emotional support and opportunities for social participation.
- Identification of key members of the community, such as individuals who are members of immigrants' associations and grass-roots organizations, religious leaders, business owners, and established immigrants, who can provide multiple types of support. Professionals can serve as specialized consultants or counsellors, with the purpose of increasing, promoting and improving the quality of non-facilitated support transactions.
- Mutual aid groups, particularly:
  - Support groups of fixed duration featuring six to 12 people, closed membership, and expert leaders.
  - Self-help groups, featuring face-to-face interaction, shared responsibility, exchange of multiple resources (emotional support, material aid, information, instrumental assistance), and reciprocity.
- Community interventions, in which a professional helps community members to identify issues that cannot always be addressed individually (e.g., employment, housing) and to support community members to develop and implement strategies to meet those needs.[58]

There is soft evidence that women's groups initially formed for one purpose, such as cooking or neo-natal support, can also serve as an excellent vehicle for ESL instruction. In addition, informal ESL instruction groups, such as English conversation clubs, can also serve other purposes, such as providing parenting instruction or support, health care and, of course, inter-personal support and the facilitation of broader connections, especially when such groups include members of different ethnocultural groups.[59-63] Research also shows gendered networks of immigrant women often extend beyond the role of social support. In addition, they facilitate both immigrant women's employment, and social and employment connections for other family members.[64]

Host programs

Host programs match newcomers (or newcomer families) with a volunteer who is either Canadian-born or a permanent resident. In Canada (excluding Quebec), immigrant-serving organizations are contracted by Citizenship and Immigration Canada (CIC) to recruit, select, and train volunteer hosts, match hosts with newcomers based on shared interests, and monitor progress.

As described by CIC, the role of volunteers is to ease the cultural shock newcomers experience following relocation. Volunteers may assist newcomers in day-to-day activities, such as banking, shopping, budgeting, using the transit system, accessing other public services, registering for school, learning about income tax, getting a driver's licence, and so on. More importantly, volunteers may introduce newcomers to their network of friends and family through social activities.

It does not appear that the CIC Host Program has been subject to rigorous evaluation. However, a 2004 evaluation based on surveys of and interviews with participants and stakeholders revealed positive impacts of the Host Program, most notably by increasing social support and friendships and by expanding newcomers' social networks, primarily through connections with the hosts' social networks. A number of focus group participants noted the Host Program helped to reduce their feelings of stress and isolation by providing emotional support and friendship.[65] This suggests the Host Program does help to facilitate the social and economic integration of newcomers through the formation of a social network between newcomers and their receiving communities. Participants in a small, qualitative evaluation of the Host Program in Prince Edward Island, where bonding social capital among the local population is very strong and serves to exclude both in-migrants and immigrants,[66] identified similar positive outcomes, with social integration chief among them.[67]

Settlement programs

For many adult newcomers, NGOs and settlement agencies are their first point of contact in building relationships and developing social networks. Programs such as the CIC-funded Immigrant Settlement and Adaptation Program (ISAP) and Language Instruction for Newcomers to Canada (LINC) help to forge the beginnings of other relationships[68] (see also [69]), although, as noted by Kunz, they are unlikely to result in sustained positive social ties.[70] These programs can, however, help immigrant parents to begin to develop networks with other parents and professionals via their children's schools, as discussed below. Adult immigrants who come to Canada as post-secondary students "are perceived as having an easier time developing social networks because university students tend to be more open to learning about new cultures."[68]

English as a Second Language (ESL) training

Clearly, fluency in the English language is crucial to social and economic integration in Canada.[71] Learning a new language, especially during adulthood, can be a long-term process. Families in which no adult speaks English well may experience barriers in communicating with health and other service organizations and agencies that are not prepared to function in a variety of languages. Linguistic isolation among immigrants and their families is not a new phenomenon, but it continues to challenge many newcomers.[72]

Time and finances are barriers to ESL education for both male and female immigrants, but immigrant women face additional challenges. Men who enter Canada are more likely to have done so as "principal applicants" on the point system, which credits their level of proficiency in an official language. Therefore, they are much more likely to be proficient in English than

women who enter as spouses or dependents of principal applicants.

Along with the benefits of speaking English for the women themselves, the ability of immigrant mothers to communicate in English is important to the development of social ties for immigrant families: "[T]o the extent their language proficiency is limited, so too will their abilities be in contributing to meeting their families' needs in the fundamental areas of health, education and financial security."[73]

Employment

For both men and women, employment can be both the incubator and the result of positive social ties, although risks of working exclusively with members of one's own ethnocultural group must be taken into account. A qualitative study of immigrant women in Montreal found working "also enabled the women to develop a convivial rapport with other immigrants or people from the 'host society' even though strong ties were rarely established."[69]

Volunteering

It has been suggested that membership in ethno-culturally-based voluntary organizations can increase bonding social capital within individual ethnocultural communities, and that membership in more general types of voluntary associations can foster bridging social capital, beyond the ethnocultural community.[74] There is some evidence that, in Canada, immigrants are more likely to engage in volunteering in ethnocultural associations and religious organizations than in general voluntary associations, although it cannot be inferred that such involvement increases only bonding social capital.[75]

A survey of immigrants conducted in 2000 found immigrants identified three main benefits of volunteering:

1. Enhancing skills related to entry into the Canadian labour market.
2. Developing managerial skills.
3. Building substantive knowledge.[76]

A more recent, qualitative Canadian study[77] found that chief among all reasons identified by immigrants for volunteering within a religious congregation was making social connections within and outside the congregation. Other reasons identified were to satisfy religious beliefs and to further employment skills or professional connections. This same study found that study participants reported volunteering did, in fact, help those with unrecognized educational credentials and lack of Canadian work experience to obtain employment.[77]

3.2 Vulnerable families

Families most vulnerable to social exclusion include those that experience:

- Chronic low income.
- Are led by teen parents or low-income lone parents.
- Have few social supports.
- Experience high household mobility and/or homelessness.
- Experience family dysfunction and/or parents use poor parenting practices.
- Experience or have experienced domestic abuse.
- In some cases, have a child with a disability.

Most vulnerable families meet several of these criteria.

The helpful effects of positive social ties and social support, both informal and formal, for at-risk families are well documented (see for example [78-84,85]). Much of this research has focused on low-income immigrant, single, young, and/or new mothers, as these mothers tend to be at highest risk of isolation. All parents (and all individuals) benefit from positive social support systems but, for low-income, isolated families, high-quality support systems can serve as a private safety net that provides supplementary income, housing, and instrumental supports, such as childcare and transportation,[86-89] and social support, all of which can dramatically improve positive parenting skills, family functioning, and child outcomes (see for example [78,79,90-92]).

Unfortunately, there has emerged a body of research showing families that need social support the most are least likely to receive it.[93-96] Most recently, Offer's large study using data from the U.S. Welfare, Children, and Families Study found that, regardless of income level, mothers who suffer from "psychological distress" and mothers in poor physical health reported lower levels of support than their healthier counterparts. Interpersonal violence was also associated with lower levels of support, but this was driven mainly by poor health.[97] Harkett's large study using data from the U.S. Fragile Families and Child Well-being Study and the Welfare, Children and Families Study in the U.S. reported that low-income mothers reported lower levels of perceived social support than other mothers.[98]

The reasons for this problem appear to be as follows: as has been documented in many studies over the past several decades, the social networks of low-income, lone-mother families may simply be unable to provide the types and extent of support they require because the families' needs are so high and members of the support networks are themselves impoverished and vulnerable.

A more complex reason, and the focus of recent studies, relates to reciprocity in social networks. Studies indicate people tend to construct social networks based on what others will bring to the relationship, so individuals who are considered a burden or a drain on others' resources, or perceived to be incompetent or unreliable, are often excluded.[94,99,100] Both Offer and Harkett conclude families with few resources and many encumbrances are often unable to reciprocate in social support networks, so others are less willing to help them, which further contributes to their social isolation.[97,98]

Older research indicates reciprocity is also important to the recipient of the support: in order to be perceived as helpful, the cost to the recipient of returning the favour must not be excessive.[101] Two other characteristics influence the extent to which the support is perceived to be helpful: it must match the needs and expectations of the recipient;[102,79] and, ideally, the support must come from a preferred individual with whom one has a trusting and intimate relationship.[8]

A considerable body of literature has emerged from the welfare-to-work policies in the U.S. and their effects on

women and mothers, in this context relating to reciprocity burdens arising from instrumental and social supports provided to women who are forced into the workforce. In addition to the time burdens imposed by employment and parenting, these mothers now have to "repay" care to those who have assisted them by providing childcare, transportation, and other services, which has actually led some mothers to reject instrumental and social support, contributing to social isolation.[105-107] Similar problems have been observed in Australia1[108] where welfare reform has followed a similar pattern to Canada, suggesting that social isolation among low-income families could increase in this country as well.

It is widely agreed prevention strategies should focus on helping families to build a network of reliable supports on whom they can rely for assistance and advice, but there is limited evidence about effective strategies for doing so.

Promising practices to increase the positive social ties of isolated, vulnerable families

Parenting and social supports

Research indicates mothers with strong networks of positive social support from friends and extended family are more effective parents than those without such supports.[109,110] Social support has been identified as one of the most protective factors against child abuse and neglect.[111] Social support improves at-risk parents' parenting skills and knowledge,[112] supports positive home and family environments,[113] and reduces parents' punitive attitudes.[114]

However, the parents most at risk of perpetrating abuse may receive the least amount of useful support. Research indicates abusive mothers have fewer friends in their social support networks, less contact with friends, and report a lower quality of support received from friends than non-abusive mothers.[115] Also, some older research indicates abusive mothers reported negative relationships with family members.[116] This may be because parenting styles tend to be transmitted along generational lines (see *Research Brief 2, Positive parenting and family functioning*), and adult survivors of abuse may not enjoy healthy relationships with their own parents. In addition, support from a grandparent who was an abusive parent may not be welcomed. Likewise, social support from other parents with poor parenting skills may not result in improvements in parenting practices. Rather, modeling of good parenting practices by a positive role model, with support and encouragement for the parent from the role model to repeatedly practice new parenting techniques, is more likely to result in changes in parenting practices.[117,78,118,119]

In addition, if friends or family members engage in negative interactions with the mother, generate conflict, or demand significant time or energy from the mother, they can actually contribute to maternal stress and depression – both linked with poor parenting – rather than support the mother's well-being or her parenting practices.[94,120] This is why the research emphasizes the need for "positive" social ties, which are more predictive of maternal health and well-being, not simply social ties in general.[81]

One approach, supported by research, is evidence-based parenting programs (See *Research Brief 2, Positive parenting and family functioning*).

Community and school engagement

Some qualitative research suggests a successful approach to addressing the needs of vulnerable families is to involve parents in their children's academic life. Interaction in the school has been found to improve bonding and bridging social capital, thereby reducing risk factors for children.[121]

Although little recent research has appeared on this subject over the past few years, older studies show that, in addition to the well-documented benefits of parental involvement in school to children's learning, family and community involvement in schools increases the support and services received by families[78] and, when the school serves as a place where people can come together and be involved in decision making that affects their community, civic capacity and community development can be increased within the neighbourhood.[123,124]

Supporting families via the provision of on-site and linked support services, such as pre-school, parenting classes, English-language classes for parents, and family liaison services helps to engage parents in the school. It enhances the role of the school in the community as a facilitator of community development. It also helps the school earn the trust of parents and let them know it cares about where and how families live.[125]

Connections with their children's school appears to have additional benefits for vulnerable immigrant families, particularly mothers, as a means of increasing positive social ties beyond their own ethnocultural communities. As explained by Van Ngo, "… through school involvement, parents benefit from parent support networks and develop self-confidence and decision-making abilities. They are more likely to have positive attitudes toward schools and personnel, demonstrate greater willingness and ability to gather support in the community for school programs, and get more involved in community affairs. They are also more likely to enroll in other educational programs. For parents from ethnocultural communities, participation in the public school system also means empowerment, access to school decision-making structures, active citizenship, and overall integration into Canadian society."[126]

Social support interventions for victims of intimate partner violence (IPV)

Much has been written about social support and IPV in particular. Little is known about social support and male victims, with one Canadian study indicating social support has no buffering effect on men's psychological distress.[127] For women, however, repeated studies have reported:

- Positive social support can mitigate the harmful mental health effects associated with abuse and enhance women's well-being.[128-130]
- Women in abusive relationships have smaller social networks, with a recent study finding that, within these smaller networks, abused women provide more support than they receive.[131]

At least two studies have found that higher social support was related to decreased abuse and higher quality of life at multiple points in time.[132] A recent study suggests direct and complex mediating and moderating interactions between social support, type and severity of abuse, and physical and mental health.[132]

A recent Canadian study found social conflict (tension, discord, and/or stress) within support networks, arising when friends or family members minimize the abuse or blame the victim or side with the abuser. In this study, social conflict was found to diminish the positive impact of social support on health, at least among women who had left their abusive partners.[133]

There is still much to be learned about how, why, and under what circumstances social support assists victims of IPV, but leading researchers in the field conclude "…emphasizing involvement in supportive networks, such as group therapy or support groups, or directly involving individuals to whom women feel closest in clinical intervention may greatly benefit women's overall mental health and well-being. Clinicians may also work closely with women to re-establish or strengthen personal support networks that may have been weakened or lost as a result of their abusive relationship."[132]

However, the research provides little guidance about the best ways to improve abused women's social support networks. Two types of interventions have been evaluated: peer support groups and, in one study, a shelter-based intervention to help women increase their social support networks. The limited, mostly qualitative, and dated research on support groups is primarily descriptive or reflects feedback from participants. A 1993 evaluation completed by Tutty, et al. reported improvements in self-esteem, sense of belonging, locus of control, and overall stress, among those participants who could be located at the six months' follow-up period.[134] A 2005 experimental evaluation of an eight-week, shelter-based group, facilitated by a nurse, reported decreased psychological distress and higher feelings of social support among participants at the end of the group, but there was no longitudinal follow-up.[135]

3.3 Vulnerable people with disabilities

Social isolation experienced by people with disabilities is a very complex issue and seemingly impossible to quantify. Not all people with disabilities experience isolation, and the causes and consequences of isolation vary among types of disabilities and personal circumstances and attributes. Tens of thousands of articles discussing social capital and positive social ties among some people with particular disabilities appear in the academic and grey literature bases. Earlier research, and a good deal of current popular literature, identifies social isolation as a problem for people with disabilities as a whole. However, people with disabilities are a highly diverse group. That being said, causes of isolation, common to many people with any type of disability, include barriers to employment, transportation challenges and discrimination.

The following subsections provide brief summaries of the social isolation/social support research on people with intellectual disabilities and physical disabilities.

3.3.1 People with intellectual disabilities

Much has been written about social isolation experienced by people with intellectual disabilities, whose social networks have been reported to often be restricted and to primarily consist of family members, health care staff, and other people with intellectual disabilities.[136-138] People with intellectual disabilities experience more physical health problems, challenging behaviours, mental illness, and low income than the general population.[139-141] Each of these issues, along with cognitive skills and certain personality characteristics, may contribute to social isolation.[139,142]

Only a few studies have investigated the nature, scope, and prevalence of the problem. A recent research review concluded adults with intellectual disabilities have a social network of an average of 3.1 people – one of whom is usually a professional support worker. It further concluded the leisure activities of adults with intellectual disabilities are mostly solitary and passive in nature.[143] Although there are many descriptive articles, there appear to be fewer than a dozen quantitative and qualitative studies on the environmental factors that influence community participation among adults with intellectual disabilities. The focus of these studies is social service provision, with little discussion of social supports or social ties.[144]

What may work to increase positive social ties for people with intellectual disabilities

There appears to be no experimental and virtually no qualitative research on best or promising practices or interventions to prevent or reduce social isolation for adults with intellectual disabilities, other than employment programs (see *Research Brief 3 Individual and family economic self-sufficiency*).

Pairing people with disabilities with community volunteers

A comprehensive literature search revealed only one evaluation of a program targeting social isolation for adults with intellectual disabilities. A qualitative evaluation, completed in 2006, of the Best Buddies program in the U.S., where people with intellectual disabilities are paired with college students, found that both college students and participants reported their lives had been enhanced by participation. Sustained effects on social ties or social supports, however, were not described.[145]

What does not appear to work

Research on the social integration of adults with intellectual disabilities has shown being physically integrated and engaged in a wide range of activities does not necessarily increase social support.[146] In addition, living in a community and having neighbours does not guarantee contact with neighbours.[147,148] As summarized by Chadsey, "It is quite clear… that having the opportunity to interact with others who do not have disabilities will rarely result in social relationships forming."[149] Drawing primarily on program descriptions, Chadsey suggests including the following factors in programs and interventions may help adults with intellectual disabilities to expand their networks of friends and contacts (assuming mental health issues have been addressed):

- Matching with others who have similar interests and other personal variables (e.g., religion, values, personality).
- Frequent interactions, with sufficient time available for socializing, over at least a few months.
- Ensuring people with disabilities are engaged in roles that are valued and equal in status to those of people without disabilities.[100]

3.3.2 People with physical disabilities

Not all adults with physical disabilities are socially isolated. At least one study has shown that overall, adults with physical disabilities have larger social networks than is sometimes reported in the mainstream literature. These networks usually include relationships with people with and without disabilities.[146] However, physical, social, and financial barriers can prevent adults with disabilities from participating in social networks.[150]

The vast majority of the literature on physical disabilities and social isolation focuses on children, youth, young adults (see *Research Brief 1, Positive child and youth development*), and seniors. For seniors, most of the literature is descriptive. Evidence-based interventions are discussed in the following section. Of the research relating to adults who are not seniors, most studies appear to be specific to individuals with a particular disability, such as epilepsy[151] and arthritis,[152] with social support mediating psychological distress, which influences physical well-being and perceptions of well-being.

What may work to increase positive social ties for people with physical disabilities

Social media

The only somewhat promising practice to increase social support and social ties for people with physical disabilities that emerges in the research is use of the internet.[153,154] However, a recent research synthesis identified 6,762 studies, six of which met the criteria for inclusion (studies using an experimental, quasi-experimental, or pre-experimental design) in the synthesis. The researchers conclude many of the positive outcomes described in the literature are either unfounded or premature, but there are indications future studies may reveal internet interventions may have multiple benefits. This may or may not include increased social support and social ties for adults with physical disabilities.[155]

3.4 Vulnerable seniors

The risk of social isolation increases with age; social isolation is most common among seniors aged 75 years or more, although younger seniors can also experience isolation,[17] and older men may be more at risk than women as they tend to have smaller social networks.[156] Although they are sometimes conflated in the literature relating to seniors, it is important to distinguish social isolation from loneliness. Loneliness may stem from loss of, or lack of, long-time intimate contacts. Some people with an extensive social base and community connections are still lonely. This can be very difficult to prevent or address through programming or other forms of intervention.[157]

In addition to age, the most common risk factors for social isolation among seniors include living alone, having low income, being single, experiencing loss, experiencing language and cultural barriers, and having transportation difficulties. Although disability is also a risk factor for social isolation, it is rarely addressed as a discrete issue in the research on seniors' social isolation, presumably because the prevalence of disability is so high in this age group and inextricably intertwined with most of the other risk factors.

For seniors, preventing social isolation from occurring in the first place is especially important because few secondary and tertiary interventions appear to work. The primary means of preventing social isolation among seniors is to prevent it earlier in life through good health, communication skills, social skills, accessible services, feeling connected to and valued by others, having meaningful roles in society, and having access to transportation.[11,158]

By the age of 65, factors that protect against social isolation, at least in the non-immigrant population, include:

- Higher education.
- Higher income.
- Connections with younger friends and neighbours.
- Living in a socially-cohesive community.
- Having higher proportions of women and family within networks.
- Larger network size.

In addition, residing in a cohesive community may provide individuals with access to social resources, even when personal networks are lacking.[156]

For low-income seniors, taking steps to increase their income or decrease their expenses may indirectly prevent or reduce social isolation. For example, helping them obtain benefits or transfer payments to which they are entitled, but not receiving, or reducing housing or medical costs may free up the means to increase social engagement. The extensive body of literature on seniors' social isolation focuses on preventing social isolation to avoid the serious physical health, mental health, and quality of life problems socially isolated seniors often experience. For a thorough and up-to-date summary, see [10]

Comprehensive reviews of the research conclude there is little evidence of effectiveness for most of the interventions that target social isolation among seniors.[18,159-161] Findlay observed that "an enormous amount of public money, time and manpower may be wasted on interventions for which little evidence of their effectiveness is available."[159] In the most recent comprehensive review of the evidence on the effectiveness of such interventions, completed by Dickens, et al.,[162] only 32 out of 7,067 studies were deemed eligible for inclusion based on study design and methods. Many of these 32 studies were at medium-to-high risk of bias.

This review considered physical and mental health, along with social isolation outcomes, and included a few programs for adult caregivers of seniors. Dickens' review indicates there are not really any research-identified best practices in interventions to reduce seniors' social isolation. This review does suggest, however, that more effective interventions include:

- Interventions with a clear theoretical base.
- Group interventions.
- Interventions where participants are actively involved in the program rather than passive recipients (e.g., receiving a health or educational service).[160]

This is consistent with older research.[116] Interestingly, interventions that explicitly target socially-isolated seniors appear to be less effective than those with no explicit targeting.[117] In addition, older research suggests that, although information is an important component of interventions to increase social ties, simply providing advice and information is not effective.

Mixed findings on the effectiveness of interventions to increase seniors' positive social ties

Group interventions

Dickens' review found some activity-based group interventions appear to be at least somewhat effective in reducing social isolation; others do not. Group interventions with positive outcomes included:

1. A community-based psychosocial activity group, in which participants reported developing more new friendships at 12 months' follow-up.
2. A community-based activity group for socially disengaged seniors, in which participants increased their social interaction.

In the latter, however, the sample was small and the follow-up period was only six weeks. Likewise, seniors who read books to school children reported enduring increases in social ties and supports on several measures, although the sample of those who received follow-up may have been biased.

Group-based activity programs that had no effect included a physical activity program delivered at an inpatient geriatric rehabilitation facility and an activity program for people living in a seniors' apartment building.[162]

Likewise, the findings on support-based group interventions were also mixed. A discussion group for seniors with disabilities, a psychosocial group for women with breast cancer, and an educational friendship program for older women all resulted in increased social support. A cognitive behavioural therapy for nursing home residents did not increase their perceptions of social support, however, social support declined among those in the control group. Finally, a telephone-based therapy group that taught older people how to cope with their blindness resulted in more social activities and reduced levels of loneliness amongst participants.

On the other hand, several programs were found to be ineffective. These included a coping group intervention for people with chronic rheumatic disorders and a mental health counselling group for members of a senior citizens centre who showed evidence of depression, recent trauma or senility. In addition, a self-management group for single older women had some initial effects but they had disappeared at six months' follow-up, and a bereavement support group for widows living in the community increased social interaction and reduced depression, but the effects faded over time.[162]

Older research on support groups, which should be interpreted with caution as studies did not always include a control group, indicated that structured skills classes may be effective for lonely women seniors[163] and self-help groups (e.g., for bereaved spouses) of at least 20 weeks in duration appeared to be effective, whether led by professionals or trained peer facilitators.[164,165] Likewise, older research indicated that support groups (e.g., educational, friendship, discussion) can be effective provided they are at least five months in duration.

However, most of the research on support groups has been on groups for women; support groups may only be effective for people who already have the necessary social skills to join them. They may not work for the severely socially isolated.[159,166-168] Support groups for immigrant seniors are often mentioned in the literature but do not appear to have been evaluated. For example, the Illinois Refugee Social Services Cultural Adjustment Project, which provides opportunities for socializing, peer and professional advocacy, and links to services, states that it is effective, although no evidence is offered.[169]

Foster grandparenting

Only one grandparenting program evaluation met the standards for Dickens' review. Participants in a foster grandparent program for developmentally-disabled children reported increased new social ties relative to the control group at two years follow-up, although there were no differences in loneliness. This study is considered to be at high risk of bias, however, and the findings have limited generalizability due to a high attrition rate.

Internet training programs

Of the four studies meeting the criteria for inclusion in Dickens' review, one demonstrated effectiveness. An internet training program was implemented for seniors who were already part of a home visiting intervention, and who lived alone and had a chronic illness or disability. This program reported decreased loneliness at three years' follow-up, compared with a control group. Social isolation was not measured. This study was considered to be at high risk of bias. Two group internet training interventions and one one-on-one internet training intervention had no effect on social isolation.

A 2012 meta-analysis of six computer and internet training interventions intended to reduce loneliness and depression in older adults, concluded such programs may be effective in managing loneliness but had no effect on depression. As noted above, loneliness and social isolation are separate constructs. The meta-analysis, however, did suggest loneliness may have been reduced through increased social support.[170]

Home visitation

Of the three studies meeting the criteria for inclusion in Dickens' review, two demonstrated effectiveness. Participants who received home visits from a volunteer in conjunction with home nursing services, showed some evidence of improved social support at six weeks' follow-up. A visitation program for nursing home residents

reported increases in frequency and duration of visits and more time spent in active pursuits and planned activities, but only among those participants who had some control over the frequency, duration, and timing of the visits. There were no effects for those who received random visits. This study was considered to be at high risk of bias.

On the other hand, there were no changes in social networks, number of visitors, or phone calls per week among nursing home residents who participated in either a network-building or a relationship-oriented visiting program. This, despite participants' expressed desire for larger social networks. This study was also considered to be at high risk of bias.

It has been suggested in the literature, to be effective, home visits need to reflect some degree of reciprocity between the support giver and the support receiver. Also the two individuals should belong to the same generation, have common interests, and share a common cultural and social background. This has not been evaluated,[171] but is consistent with other research on social support and reciprocity.

Intergenerational programs

Intergenerational programs were not included in Dickens' review, possibly because preventing or decreasing seniors' social isolation is not consistently identified among the objectives of such programs. Intergenerational programs bring together youth and older adults for a variety of reasons, but are generally intended to benefit both generations. As summarized by Kaplan, et al., studies have reported outcomes of programs as including, for youth, increased school attendance, improved social skills, and improved attitudes toward aging and seniors. For older adults, outcomes included improved memory, improved mobility, and an increased sense of social connectedness.[172]

Additional considerations for immigrant seniors

Many immigrant seniors are completely dependent on their families for all forms of social and economic support. A recent Canadian qualitative study suggests that, among immigrant senior women from non-European countries, social isolation may not be offset by living in a multigenerational family because these women are often confined to the home by childcare and household responsibilities and lack of their own spending money, along with language and transportation barriers.[173] This study also reported an unexpectedly high proportion of immigrant senior women from all cultural backgrounds, would prefer to live on their own than with their adult children and their families.[173] This included women with a culture tradition dictating elderly parents live in the children's home.

In addition to placing them at risk of social isolation, a high degree of dependency on family can place immigrant seniors at risk of abuse within the family. Reaching out to others for support may not be possible for seniors who have no contacts outside the family. Some immigrant seniors may be reluctant to discuss personal issues due to pride or cultural beliefs[174] or, depending on their immigration status, for fear of problems with immigration authorities.[175] They may also be unable to communicate problems due to language barriers.[14,176] The experience of receiving formal supports from government or community organizations may be unfamiliar to older immigrants and refugees, and they may be reluctant to use them.

Research shows the biggest barrier to immigrant seniors' use of social services is the belief that their children will fully support them, followed by distrust of government or the view that reliance on government for elder care is shameful. Members of some ethnocultural groups may be particularly uncomfortable seeking or receiving help from outsiders because, within their ethnocultural community, it is critical the family be viewed as capable of taking care of its own problems and needs.[175]

Although there is little or no hard evidence, ESL programs and community gardening programs have been identified as ways of reducing social isolation experienced by immigrant seniors.

Although they do not appear to have been evaluated, community-based English literacy programs for immigrant seniors are offered in some American cities and, based on participant feedback, claim to be effective. One example is the Bright Ideas ESL for Seniors program, developed in Illinois, which makes its curriculum publicly available.[169] Also, although it is unclear whether the program is still available, Manitoba offered the community-based *English for Seniors* program, which provided student supports, such as transportation and child care, and was reported to reduce isolation, build friendships, improve activity levels, improve knowledge of community resources and increase integration.[177]

Community outdoor gardening may also be an effective engagement tool, especially for former agrarians who feel estranged in an urban environment.[175,176] A qualitative evaluation of Edmonton's *Small Plot Intensive (SPIN)-Farming*, a commercial urban agricultural project started in 2007, reported, among many other positive outcomes, project participants reduced their social isolation through friendships and links to other social networks.[178]

3.5 Other promising initiatives and ideas for all vulnerable groups

Collective kitchens

Collective or community kitchens are community-based cooking programs where small groups of people pool their resources and cook in bulk. In Canada, collective kitchens are usually organized by a non-profit organization that provides professional or volunteer support to participants. Kitchens target sub-groups of people including women, people living in poverty, single mothers, new immigrants, people living with mental illness or disability, and, in Toronto, homeless men.

As described by Engler-Stringer, there are three general types of collective kitchens:

- Groups with an emphasis on education and social interaction composed most often of people living with mental illness or disability, new immigrants, or seniors.
- Groups with an emphasis on bulk cooking, composed most often of homeless or under-housed people and those with reduced mobility.
- Groups that balance bulk cooking and social and educational aspects, composed most often of single mothers.[179]

Research suggests collective kitchens may improve household food security (see *Brief 3, Individual and family economic self-sufficiency*). In addition, qualitative research, most of it completed in Canada and Australia, suggests collective kitchens may reduce social isolation and increase social supports.[179-183] Researchers acknowledge the need for experimental evaluations of collective kitchens to determine if, how, and for whom participation leads to measurable positive outcomes, although the challenges of conducting this sort of research with this sort of program are recognized.[184]

Based on what we know at present, with a view to reducing social isolation, it is suggested kitchens should be structured to bring together participants with similar life circumstances, and facilitate social interactions (e.g., breaks, communal meals that encourage socializing).

Peer support groups

Older, qualitative research suggests peer support groups help isolated women to cope with the overwhelming demands of their day-to-day lives in an atmosphere of mutual understanding and support provided by a group of peers.[185] There is soft evidence peer support delivered in an individual or group format, and delivered at a location such as a women's resource centre, is associated with expanded social networks. This, in turn, is associated with positive physical and mental health. This would apply for women in general and for others who are experiencing isolation and other life challenges.[134,186,187]

There appears to be no research on the effects of support groups in helping isolated women strengthen their broader social ties in ways that might improve their overall lot in life, socially or economically (i.e., bridging social capital). There appears to be no useful research, evidence-based or not, on social support groups for men or for other groups at risk of social isolation.

Access to public transportation and accessible transit

There appears to be no research directly linking access to public transportation and accessible transit with increased social ties. However, it may reasonably be inferred that – among people who do not have access to, or are unable to use, private vehicles due to limited finances, disabilities, functional limitations, or other factors – social isolation may be prevented through access to affordable and physically accessible forms of transportation. Access to transportation improves the ability to "get around" and participate in activities, attend meetings and appointments, attend work, complete errands, and visit with friends and family.

In Canada, members of households that do not own vehicles, households with teenagers, and low-income households use public transit most frequently, especially for non-work-related travel.[144] Recent immigrants are twice as likely to use public transit to commute to work in Calgary as Canadian-born persons are, even after controlling for demographic characteristics, income, commute distance and residential distance from the city centre.[189]

In Canada as a whole, only 5.5 per cent of seniors aged 65 to 74 years, 6.8 per cent of seniors aged 75 to 84 years, and 7.5 per cent of seniors aged 85 years or more use public transit as the main form of transportation. Among seniors, taxi or accessible transit is used as the main form of transportation most frequently by the oldest group of seniors (7.4 per cent). Seniors aged 85 years or more, however, are still more likely to drive their own vehicle (31.2 per cent) or to be a passenger in vehicle (40.6 per cent) than to use public transit or accessible transit. Those who drive themselves or are driven by others are by far the most likely to be regularly participating in social activities.[190] Statistics Canada reports elderly men (aged 75 years or more) seldom identify transportation problems as the reason for limited participation but, for elderly women, transportation problems are the second most common reason, after health problems, for not participating in more social, recreational, or group activities (24 per cent).

The City of Calgary has taken steps to meet the transportation needs of low-income and mobility-challenged citizens through policies and programs including the recently expanded low-income monthly transit pass, accessible C-Train stations, low floor buses, and accessible transportation in partnership with Calgary Handi-bus and private taxi companies. No recent research on the extent to which these services meet the needs of those who require them appears to be publicly available.

2020 update

The table is organized alphabetically by type of intervention. The links provide access to full-text resources as they are available. The table is a curated list of resources relevant to positive social ties for populations experiencing vulnerabilities; it's not a comprehensive catalogue of all research on each topic.

Best practice reviews

Listed at the top of each section are websites that provide Best Practice Reviews, when they are available. These are program-overviews and concise summaries of program research/evaluation. Many rate or rank programs using high-level categories like "model plus/model/promising." These sites provide examples of programs

that have a strong evidence base. To be included here, organizations that produce the best-practice review have to operate independently from private interests and have a clearly articulated process and quality control.

Additional information

Detailed information including best practice guidelines and toolkits, which focus on program implementation, as well as several types of research summaries are provided below the Best Practice Reviews. These summaries include literature reviews, which are narrative summaries of existing research on a specific topic, and systematic reviews, which use more rigorous methods to collect and assess studies and synthesize findings. Meta-analyses, which are also included, use a type of statistical analysis that combines the results of multiple similar scientific studies to determine whether the overall effect is positive or negative. In some sections, examples of new programs with strong published evaluation results are included. Resources included in this section come from peer-reviewed journal articles as well as well-documented grey literature including that from government agencies, best practice sites, and systematic review organizations (e.g. Cochrane Library, Campbell Collaboration) published since 2013.

What works by type of intervention

Type of intervention	Resources
Populations experiencing multiple vulnerabilities	**Best practice reviews** Social Programs That Work, Critical Time Intervention for People Diagnosed with Mental Illness[191] **Additional resources** Promoting Health and Well-being through Social Inclusion in Toronto: Synthesis of International and Local Evidence and Implications for Future Action[192] Exploring the Role of Community Engagement in Improving the Health of Disadvantaged Populations: A Systematic Review[193] Is Volunteering a Public Health Intervention? A Systematic Review and Meta-Analysis of the Health and Survival of Volunteers[194] Mental Health Impact of Social Capital Interventions: A Systematic Review[195] What Works in Inclusion Health: Overview of Effective Interventions for Marginalised and Excluded Populations[196]
Bullying	**Additional resources** Bullying Literature Review[197] Effectiveness of Anti-Bullying School Programs: A Meta-Analysis[198] Empathy and Involvement in Bullying in Children and Adolescents: A Systematic Review[199] Parenting Behavior and the Risk of Becoming a Victim and a Bully/Victim: A Meta-Analysis Study[200] The Effectiveness of School-Based Bullying Prevention Programs: A Systematic Review[201] Translating Research to Practice in Bullying Prevention[202]
People with disabilities	**Additional resources** Sport Intervention Programs (SIPs) to Improve Health and Social Inclusion in People with Intellectual Disabilities: A Systematic Review[203] Social Inclusion and Community Participation of Individuals with Intellectual/Developmental Disabilities[204] Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: A Comprehensive Review[205]
Loneliness	**Additional resources** Interventions Targeting Loneliness and Social Isolation Among the Older People: An Update Systematic Review[206] (Rating and summary available at link) Tackling a Silent Beast: Strategies for Reducing Loneliness and Social Isolation[34] Interventions to Address Social Connectedness and Loneliness for Older Adults: A Scoping Review[207]

Positive social ties and vulnerable populations

Youth	**Best practice reviews** Interventions to Improve the Labour Market Outcomes of Youth: A Systematic Review of Training, Entrepreneurship Promotion, Employment Services and Subsidized Employment Interventions[208] **Additional resources** The Psychology and Practice of Youth-Adult Partnership: Bridging Generations for Youth Development and Community Change[209] Routes to Homes: Transit and Social Support Intervention for Homeless Youth[210] School-Based Programs for Increasing Connectedness and Reducing Risk Behavior: A Systematic Review[211] Benefit-Cost Analysis of a Randomized Evaluation of Communities That Care: Monetizing Intervention Effects on the Initiation of Delinquency and Substance Use Through Grade 12[212] Interventions for Promoting Reintegration and Reducing Harmful Behaviour and Lifestyles in Street-Connected Children and Young People: A Systematic Review[213]
Families experiencing vulnerabilities	**Best practice reviews** The Triple P System[214] Child First[215]
Immigrants experiencing vulnerabilities	**Additional resources** Community-Based Interventions for Building Social Inclusion of Refugees and Asylum Seekers in Australia: A Systematic Review[216] Refugee Children: Mental Health and Effective Interventions[217] Refugees Connecting with a New Country through Community Food Gardening[218]
Seniors experiencing vulnerabilities	**Additional resources** Combatting Social Isolation and Increasing Social Participation of Older Adults Through the Use of Technology: A Systematic Review of Existing Evidence[219] Decreasing Loneliness and Social Isolation Among the Older People: Systematic Search and Narrative Review[220] National Seniors Council – Report on the Social Isolation of Seniors, 2013-2014[221] Reducing Loneliness Amongst Older People: A Systematic Search and Narrative Review[222] The Association Between Social Support and Physical Activity in Older Adults: A Systematic Review[223] Who's at Risk and What Can Be Done About It? A Review of the Literature on the Social Isolation of Different Groups of Seniors[224]

In this document:

- *"Evidence-based" means that a program or practice has been tested in a well-designed and methodologically sound experimental (randomized controlled trial (RCT)) or quasi-experimental study (and, ideally, multiple studies and replicated in more than one site), and has been shown to produce significant reductions in poor outcomes or associated risk factors or significant increases in positive outcomes or associated protective factors.*
- *"Best practices" refer to programs or components of programs or delivery methods that have been identified as effective (i.e., produce significant reductions in poor outcomes or associated risk factors or significant increases in positive outcomes or associated protective factors) by repeated methodologically sound studies using an experimental (RCT) or quasi-experimental design.*
- *"Promising practices" refer to programs or components of programs or delivery methods that have been identified as effective ("effective" as defined above) in at least one well-designed and methodologically sound study using at least a pre-post design with a large sample of participants that has been subject to peer review.*
- *"Prevention" means creating conditions or personal attributes that strengthen the healthy development, well-being, and safety of individuals across the lifespan and/or communities.*

  Prevention programs deter the onset of a problem, intervene at a very early stage in its development or mitigate risk factors/ strengthen protective factors. In the research-based risk and protection prevention paradigm, prevention occurs by reducing risk factors and increasing protective factors.
- *Risk and protective factors – A risk factor can be defined as a characteristic at the biological, psychological, family, community or cultural level that precedes and is associated with a higher likelihood of problem outcomes. Conversely, a protective factor can be defined as a characteristic at the biological, psychological, family, community or cultural level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor.*

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