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A Community-Based Participatory Critique of Social Isolation Intervention Research for Community-Dwelling Older Adults

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Abstract

This article examines the dialogue that occurred within the structure of a Research-to-Practice Consensus Workshop that critiqued academic research priorities regarding social isolation among community-dwelling older adults and identified practice-based suggestions for a social isolation research agenda. The investigators adapted the scientific consensus workshop model to include expert practitioners and researchers in a discussion of the current state and future directions of social isolation intervention research. The group's critique resulted in several key recommendations for future research including the need for a social isolation measure with specific capacity to identify isolated older adults during a community crisis. This study

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demonstrates that the Research-to-Practice Consensus Workshop model can be used successfully to identify priority areas for research that have implications for community practice, construct an evidence base more relevant for community application, strengthen existing community–researcher partnerships, and build agency and practitioner capacity to take part in community-based participatory research.

Keywords

research-to-practice; social isolation; consensus workshop

In this paper, we present a case study analysis of an application of the Research-to-Practice Consensus Workshop model (Sabir et al., 2006) developed by investigators from the Cornell Institute for Translational Research on Aging (CITRA). The Consensus Workshop model is designed to foster a community-based participatory critique of academic research priorities, study design, and empirical findings in an area of research critical to community practice and social service. In this case, the model was applied to the critical topic of social isolation among community-dwelling older adults. The goal of the workshop was to identify practice-based suggestions for a research agenda to prevent and treat social isolation among community-dwelling elderly adults.

Social isolation is recognized as a high priority area for research and intervention among older adults (Berkman & Glass, 2000). A variety of deleterious physical and psychological health outcomes in older adults are associated with social isolation, which has been defined as physical separation from other people or as perceived social isolation, even if others are present (Andersson, 1998; Cattan, White, Bond, & Learmouth, 2005; Wegner, Davies, Shahtahmasebi, & Scott, 1996). With prevalence estimates reaching as high as 20% (Findlay, 2003), social isolation places a growing number of older adults worldwide at increased risk for hypertension, coronary disease, and stroke (Barefoot et al., 2001; Tomaka, Thompson, & Palacios, 2006), elder abuse (Cohen, 2006), depression, and suicide (Hawton & Harriss, 2006; Labisi, 2006). Older adults who have lost spouses and friends and key social roles such as employment, those caring for an older spouse or parent, the disabled, and the poor are at higher risk for social isolation (Walker & Herbitter, 2005). In addition, members of the baby boomer cohort may be at increased risk for social isolation as they age because of a high rate of divorce, declining rate of remarriage, and a relaively low rate of fertility (Easterlin, 1987; Easterlin, Macdonald, & Macunovich, 1990; Macunovich, Easterlin, Schaeffer, & Crimmins, 1995).

Although research has extensively documented the causes of social isolation and the negative outcomes associated with it, few evidence-based interventions have successfully reduced isolation among community-dwelling older adults (Findlay, 2003). Two systematic reviews of the literature concur that there have been relatively few empirically sound evaluations of social isolation interventions (Cattan et al., 2005; Findlay, 2003). This lack of an evidence base for effective intervention strategies motivated CITRA to convene a community event—a consensus workshop of expert researchers and expert practitioners—to discuss the current state and future directions of intervention research on this topic. In the

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spirit of community participatory research (e.g., Israel, Schultz, Parker, & Becker, 1998), the goal was to bring together researchers and community practitioners with diverse skills, expertise, and experience to codevelop an agenda for intervention research on social isolation. Events that foster community practitioner–researcher dialogue on research priorities are critical to assuring the effective translation and implementation of evidence-based research findings into real-world settings (Office of Behavioral and Social Sciences Research, 2007).

The CITRA Consensus Workshop Model

CITRA, an Edward R. Roybal Center funded by the National Institute on Aging, is a research partnership that involves social gerontologists, geriatricians, and geropsychiatric researchers from Cornell University and its Weill Cornell Medical College. The researchers are allied to New York City agencies serving older people through the Council of Senior Centers and Services (CSCS), an organization linking nearly 270 agencies and centers delivering direct service to over 300,000 older New Yorkers. The aim of CITRA is to facilitate the rapid translation of evidence-based research findings into practice that benefit older people. CITRA aims to accomplish this goal by establishing high-quality research programs practical enough to benefit the community, engaging community practitioners as coinvestigators, educating researchers about the techniques of translational research, and disseminating evidence-based findings to community practitioners (the subject of this article). Drawing on our previous experience working with agencies serving older people (e.g., Pillemer, Suitor, & Wethington, 2003) and with community-university partnerships (Dunifon, Duttweiler, Pillemer, Tobias, & Trochim, 2004), CITRA has built a partnership infrastructure that university researchers and community practitioners can access to develop research programs based on community research partnership principles (e.g., Giachello, Arrom, Davis, Sayad, Ramirez, Nandi, et al., 2003; Metzler et al., 2003; Schultz, Israel, Parker, Lockett, Hill, & Wills, 2001).

The Research-to-Practice Consensus Workshop model (Sabir et al., 2006), developed by CITRA, promotes a fundamental aim of community-based participatory research (CBPR): focusing the joint attention of practitioners and researchers on the empirical evidence base in specific areas. The topic of each consensus workshop is determined by pressing needs identified by the community collaborators. In a concept mapping study conducted to assess research priorities in New York City, representatives from community agencies identified social isolation among community-dwelling older adults as a critical problem to be addressed in the coming years (CITRA, 2004).

This article examines the researcher–practitioner dialogue that occurred within the structure of the CITRA Consensus Workshop Model (Sabir et al., 2006), focusing on (a) practitioner critiques of academic research priorities, study design, and empirical findings and (b) practice-based suggestions for future research on the topic of social isolation. Research recommendations identified by group consensus as having the highest priority are discussed as well as implications for developing community–researcher partnerships using CBPR or similar approaches (Israel, Eng, Schultz, & Parker, 2005; Minkler & Wallerstein, 2003).

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Components of the CITRA Consensus Workshop on Social Isolation

The six major steps in the CITRA Consensus Workshop Model are reviewed in detail elsewhere (Sabir et al., 2006) and are summarized briefly in Table 1. As a first step, the topic of social isolation was selected by members of CITRA's Community Advisory Committee from a group-generated list of urgent problems facing New York City older adults, using concept mapping methodology (Kane & Trochim, 2006). Three academic research experts from the fields of psychology, sociology, and public health were selected for this forum (Step 2) and included an expert on informal and formal helping networks of older adults, an expert on measurement of perceived social support, and an expert on social isolation among older caregivers. Three community practitioner experts were also selected for participation in the consensus workshop and included a senior policy analyst and principal author of a report highlighting the growing problem of social isolation among older people in New York City, the executive director of a community organization serving the blind and visually impaired, and a social worker with more than 10 years experience working with community-based case management agencies serving older people.

Using Cattan's recent review of social isolation and loneliness prevention among older adults and four other reviews of research on social integration and social relationships (Berkman & Glass, 2000; Cattan et al., 2005; Cohen, 2004; Cohen, Underwood, & Gottlieb, 2000; Pillemer, Moen, Wethington, & Glasgow, 2000), CITRA produced a nontechnical review of the literature on social isolation interventions among community-dwelling older adults (Step 3). All the reviews indicated that, overall, there are only a small number of randomized-controlled trial intervention studies addressing social isolation and integration among older community-dwelling adults and that the outcomes of these trials have been disappointing. Thus although the plethora of community programs to reduce social isolation suggests that many people believe that programs can work, there is relatively little hard evidence from the methodologically strongest studies that existing programs are efficacious. We summarized the findings from 14 existing randomized controlled efficacy studies for the purposes of the group discussion.

The 14 studies were selected by Cattan and colleagues (2005) in their review as the most scientifically rigorous. We maintained Cattan and colleagues' (2005) categorization of the social isolation interventions as group peer support, one-to-one support, and service provision. Targeted outcomes in the interventions included the reduction of social isolation, alienation, and loneliness and the increase of social activity level, network size, formal and informal support, and social integration. Populations targeted included older men and women who were living alone, physically inactive, impaired, or frail. Two studies targeted caregivers of older adults.

Table 2 summarizes Cattan's major findings from the research on social isolation interventions. Effective interventions shared several characteristics: (a) They were group interventions; (b) They targeted specific groups, such as women, caregivers, the widowed, the physically inactive, or people with mild mental health problems; (c) They used experimental samples that were representative of the larger target group; (d) They enabled some level of participant or facilitator control or input; and (e) They were developed and

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conducted within an existing community service organization. In addition, many group intervention studies recruited from within neighborhoods and existing communities to help insure that group members continued to meet after the intervention ended. Group interventions that included discussions of negative emotions demonstrated continued and increasing effectiveness at 1- and 2-year follow-ups.

The predominant characteristics of the interventions found to be ineffective are that they involved indirect contact between the participant and others, such as contact through the internet, or they were one-to-one interventions conducted in participants' homes. It should be noted, however, that Cattan and colleagues qualify the blanket categorization of one-on-one interventions as ineffective. They suggest that measurement may be an issue with the measures employed not sufficiently sensitive to subtle changes in outcomes. Furthermore, it is possible that the design of these programs can be enhanced. Thus it is possible that with better design and measurement of outcomes, one-on-one interventions might show greater effects.

Practitioner Critique of Intervention Research to Reduce Social Isolation

In spring 2006, CITRA convened the research and practice experts and an invited researcher and practitioner audience to discuss the topic and arrive at recommendations for the future research agenda (Step 4). The invited practitioners represented the five boroughs of New York City and the range of available elder services including senior centers and residential facilities. The discussion was taped and transcribed and the comments were organized into three categories: practitioner–researcher differences in research priorities, critique of study designs, and practitioner suggestions for future research on social isolation. The following is an overview of practitioner responses, followed by a more detailed discussion of the five highest prioritized practitioner recommendations for research.

Differences in Research Priorities

The differences in priorities between researchers and community practitioners can often be traced to differences in the specific subpopulation of interest. The studies selected for the research review suggest that the most rigorous research has focused primarily on ambulatory older adults who are well enough to attend community programs as opposed to homebound older adults. In contrast, practitioners' comments reflected their primary concern for frail older adults who are likely to be homebound and perceived to be at higher risk of social isolation. For example, although research has focused much attention on group interventions, practitioners raised potential research questions around barriers facing homebound older adults including payment for transportation to group meetings and accommodating wheelchairs during various legs of journeys and at entry and exit points. They also proposed potential research questions around the range of psychiatric disabilities some older people experience, such as paranoia, that may contribute to social isolation.

Critiques of Study Design

Practitioners in the consensus workshop were highly suspicious of the main finding from the CITRA research review that group interventions have consistently demonstrated

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effectiveness, whereas one-to-one interventions have not. Practitioners affirmed the main reasons for the effectiveness of groups, for example, that participants were recruited from a single community to help insure continuing relationships. However, practitioners emphasized that the one-to-one interventions presented in the research review were secondary medical interventions involving brief visits from nurses working within the constraints of the health care system. They argued that secondary medical interventions could not be expected to affect social isolation as much as more person-centered and therapeutic interventions with intentional relationship-building components that are typical of practitioners' efforts with the homebound. Furthermore, the practitioners identified relationship building as the critical component of effective social isolation interventions, whether conducted in a one-to-one or group format. Practitioners were convinced that one-to-one interventions are not only appropriate in many circumstances but also effective in reducing social isolation and thus need to be subjected to further evaluation. Practitioners emphasized situations in which one-to-one direct contact or indirect contact interventions are most appropriate—for example, when older adults, such as self-neglectors, are unwilling to participate in groups or when an older adult is physically disabled and homebound.

Furthermore, in terms of group interventions, practitioners perceived researchers' conceptualization of community as too narrow. In addition to the traditional geographically bound areas, practitioners suggested the use of an expanded concept of community in future research designs—for example, one that includes those who gather regularly around a disability such as blindness. Practitioners indicated that these groups come to rely on the places they gather as their community.

A final set of criticisms of study design centered on the nature of the interventions. Researchers tend to abstract a single component of a larger problem and develop an intervention specialized enough to answer relatively narrow and specific research questions. This approach is appropriate for research, which seeks to understand component variables. Practitioners, on the other hand, enter into an individual's home life and regularly see that older adults' problems are embedded in or highly interconnected with other problems. Many components must be addressed simultaneously if improvement in circumstances is to occur. Thus practitioners perceived existing research designs as overly simplistic. Believing that effective intervention requires a multicomponent response, they strongly encouraged efficacy studies of multicomponent trials.

Practice-Based Suggestions for the Social Isolation Research Agenda

In addition to the suggestions identified above, which include research on transportation barriers, psychiatric disabilities, varying types of communities, and multicomponent and person-centered interventions, practitioners and researchers in the consensus workshop generated an extensive list of suggestions for future research on social isolation among community-dwelling older adults. These suggestions were prioritized by a group voting procedure in which participants placed dots beside their three highest priority suggestions. The highest priority items were further discussed at a follow-up roundtable meeting involving a volunteer subset of the original participants (Step 5). As summarized in Table 3,

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in order of priority, the top five areas of needed research suggested by the group are as follows:

Priority 1: The need to understand and increase service utilization by older adults who do not currently accept services even when services are free

Practitioners sometimes perceive a need for services in cases when services are not accepted. This invites an investigation of cohort differences among older adults in service utilization, among other possibilities. Adults 75 years and older may view many forms of health care as a luxury, only to be used to relieve pain or extreme discomfort (Ettinger, 1993), whereas adults aged 65 or younger may be more informed about health and prefer alternative models (Mitchell, 1993). Some older adults may choose activities that maintain a youthful self-image and avoid those services that contradict such an image, whereas others may seek to maintain independence and control over their own affairs for a long as possible (Quine & Carter, 2006). Practitioners inquired about existing bodies of literature that may be drawn on to understand and overcome service resistance. Potential research questions include (a) What is relevant and acceptable to the coming populations of older adults whose lifestyles may be different than that of current older adult cohorts? (b) What is the demographic makeup of the socially isolated older adult population? (c) In what ways and to what extent do immigrant populations experience cultural barriers to service utilization?

Priority 2: Development of a social isolation measure with specific emphasis on identifying isolated older adults during a community crisis

The primary research question here is: What are the essential elements of a sufficient social isolation instrument? A working list, generated by the group, of essential elements of a comprehensive instrument for measuring social isolation among community-dwelling older adults would include (a) subjective, objective, cognitive, and affective aspects of social isolation, (b) degree and duration of isolation, (c) a comprehensive list of symptoms of isolation, and (d) cause of social isolation (self or circumstantially imposed). The measure also would need to be easily used in clinical settings, and most importantly, would identify those at greatest risk of isola tion during a community crisis. It was suggested that such a tool should be specifically normed on older persons.

Priority 3: Evaluate one-to-one direct contact or indirect contact interventions discussed in the Critiques of Study Design section above

Practitioners emphasized the need to evaluate the impact of the intentional relationship-building interventions they conduct. The appropriateness of randomized controlled designs in these evaluations was considered given that such designs are expensive, difficult to complete, and sometimes difficult to conduct in a manner consistent with research and practitioner ethics. Practitioners inquired about other types of scientific methodologies that may be used in the evaluation of these social services.

Priority 4: Efficacy studies of multicomponent interventions

Practitioners recognized that older adults often suffer multiple challenges that may contribute to the overall condition of social isolation including depression, limited mobility,

having outlived friends or spouses, cultural and language barriers, and lower knowledge of services. Addressing one challenge without attention to others may fail to resolve the problem of social isolation when attention to several may succeed.

Priority 5: Research that reflects respect for continuing self-determination in older adulthood

Practitioners were well aware of the balance between extending service as far as possible and older adults' right to refuse services even as they called for research to increase service utilization. Practitioners also asked for research on the impact of unwanted changes that are often imposed on older adults by adult children who mean well by their actions and for intervention research on how to help older adults cope with changes that are imposed on them. Examples they suggested included strategies for determining the proper timing for relocating to a different home, clarifying the pros and cons of relocating, or anticipating pending changes. Finally, in regard to continuing self-determination, practitioners asked for increased research emphasis on the value of experiencing reciprocity in social relationships throughout the later years of life rather than increased dependency.

In summary, the practitioner critique of intervention research to reduce social isolation and the suggestions for future research that emerged from the dialogue demonstrate that although researchers and practitioners may differ somewhat in research priorities, working together they can generate intervention designs that are more relevant to the daily work of practitioners in elder service agencies. Interventions that yield evidence more applicable to community practice are necessary to ensure effective research translations (Office of Behavioral and Social Sciences Research, 2007). The critique also indicates that practitioners would like to see investigations of what they believe from experience to be promising interventions for social isolation, for example, those that evaluate person-centered and intentional relationship building between practitioner and client. They would like to see study designs that capture more elusive communities, a social isolation measure that identifies older adults most vulnerable during a community crisis, and evidence-based strategies for protecting the experience of self-determination through old age.

Lessons Learned From Applying the Research-to-Practice Consensus Conference Model

The consensus conference model constitutes an ideal vehicle for facilitating colearning by both practitioners and researchers, a feature that is prominent in programs designed to promote community-based participatory research. Practitioners gain knowledge in the areas of research design and interpretation of research findings, whereas researchers gain insight into community and practice contexts that can deepen the relevance of their research and lead to the generation of better-informed hypotheses. The model thereby builds research capacity in a bidirectional manner. Other potential dividends include the formation of new practitioner–researcher partnerships. After convening a consensus conference workshop on the topic of chronic pain among older New York City residents, practitioners and researchers joined together to form an interdisciplinary group of professionals from diverse backgrounds including nursing, social work, medicine, and directors of senior service

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agencies. The group seeks to improve the quality of life for the diverse range of older New Yorkers with pain through research, education, program development, collaboration, and advocacy and promote and enhance accessibility to pain programs and encourage practices that reduce and prevent pain throughout the lifespan (see www.citra.org). Finally, the consensus workshop model adheres to another community-based participatory research principle—the dissemination of research findings to diverse practitioner audiences using language that is understandable to those not skilled in the conduct and interpretation of intervention research.

As we have applied and refined the consensus conference model (for a detailed description, including instructions for conducting the workshop, see http://www.citra.org/reviews.php), we have encountered a number of limitations of the model that warrant consideration. The limitations center on (a) turning practitioner recommendations into scientifically sound research that is responsive to practice concerns and (b) bridging gaps between scientific research priorities and practitioner priorities.

The recommendations generated by practitioners in this workshop have not necessarily been established by scientific testing. Researchers, moreover, are difficult to recruit for studies that evaluate existing practice programs because funding is difficult to acquire for such studies. Outlets for scientific publication are also limited. Practitioners are often not sufficiently trained in evaluation research nor do they have funding to pursue evaluation of practice programs. Thus recommendations generated by practitioners for scientific interventions will tend to be underutilized unless pathways are found to fund high-quality evaluation research on them. CITRA has developed a pilot studies program (Wethington et al., 2007) that is designed to connect researchers to community partners to conduct research responsive to agency and community needs. The pilot studies program, however, is designed to develop evidence-based programs based on new scientific research, not to evaluate established programs.

Replications of the consensus conference model have made us keenly aware of the differing perspectives of researchers and practitioners on what constitutes high-priority as well as high-quality research. CITRA has chosen to focus on presenting findings from randomized controlled trials (RCTs), when they are available, to educate practitioners about the scientific gold standard for research. (A focus on RCTs also has acquainted many practitioners with findings about the potential negative impacts of some interventions.) Yet several issues of critical interest to practitioners, such as encouraging utilization of community services by older people, have not been the subject of RCTs. Bridging the gap between research and practice on this topic would involve a major research effort. Finally, it is possible that our results would be augmented had different stakeholders (e.g., older adults) participated in the conference. Future research is needed to examine the ways in which increasing both the number and diversity of stakeholder groups can possibly enhance the depth and range of conference findings.

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Implications and Conclusion

The CITRA Consensus Workshop on interventions to counter social isolation among older people underscores the scarcity of evidence for effective interventions in this area and suggests that the broader effort to reduce social isolation may be improved by expanding the scope of the social isolation intervention research agenda in several ways. The differences uncovered between researchers and practitioners regarding intervention research priorities—for example, selection of target populations and neglect of relationship building in one-on-one interventions—are important discrepancies given the importance of translating intervention research to practice (Pillemer et al., 2003).

The reaction of practitioners to intervention studies involving ambulatory older adults is informative of the bridges that must be crossed to design interventions that meet practitioner needs. Researchers may tend to include ambulatory adults in intervention studies because ambulatory older adults are easier to access than the frail, less ambulatory older people who practitioners must serve. Nevertheless, there is scientific justification for focusing interventions on ambulatory adults. Preventive interventions targeting independent older adults at risk of social isolation will benefit a greater number of older adults in the long run than interventions targeting those who become extremely isolated. Our experience with the consensus conference suggests that patience, honest communication, and colearning will contribute to understanding the implications of these differences in perspective and overcoming them.

In addition, the limited evidence research base for the intentional relationship-building interventions among older adults recommended by practitioners suggests that colearning and dialogue opportunities between researchers and practitioners may result in creative intervention research if resources allow. Resources and capacity for community-relevant research could increase if practitioners themselves were encouraged by funders to evaluate programs that are believed to be promising. The practitioners' call for attention to relationship-building interventions also suggests that they may be interested in getting such training and contributing to research. Funders could be encouraged to take the lead in increasing community capacity for research by providing support for program evaluation in the programs that they fund. Progress can be facilitated by including representatives of governments and other funders in the audience for the consensus conference.

Efforts to reduce the risk of social isolation in old age and its related negative physical and psychological health outcomes are justified both by anticipated demographic changes in the older population and by the need to enhance well-being in the later years. We have learned much about the causes and associated negative outcomes of social isolation but very little about how to prevent or reduce it. The overlooked suggestion from practitioners that intentional relationship building may be key to addressing this problem reflects the value of including practitioner experience in discussions of research agendas. This project suggests that the CITRA Consensus Workshops are a useful tool for bringing these two groups together to identify priority areas for research that have implications for community practice, constructing an evidence base more relevant for community application, strengthening existing community-researcher partnerships, and building agency and practitioner capacity

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to take part in community-based participatory research. Such workshops are a forum in which those building or engaged in community-researcher partnerships can take a broader perspective on the particular research area of mutual interest. First, such conferences are settings for effective dissemination of research findings to practice audiences. Second, the practitioner experts are enabled to increase research capacity in the community by promoting understanding of different approaches to doing research. Third, researchers can gain insight into community and practice contexts that can deepen the relevance of their research. Finally, bringing researchers and practitioners together on a regular basis to examine areas of research that have implications for community practice is an important evolution in translating research to practice.

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Table 1

Steps in the CITRA Consensus Workshop Model

Steps	Descriptions
1. Select workshop topic	CITRA practitioner community advisory committee selects topic based on practice relevance, whether research exists on the topic, the topic's compatibility with the CITRA priorities, and whether topic duplicates another very similar existing effort.
2. Select a panel of research and practice experts	CITRA identifies three scientific experts and three practice experts in the area of interest who are willing to participate in the consensus workshop process.
3. Develop an up-to-date, nontechnical translation of the literature	CITRA staff review the available scientific literature and prepare a written research review that sets out the practice-relevant research in a nontechnical way.
4. Convene workshop	A consensus workshop is organized and held to facilitate a community-based participatory critique of academic research priorities, study design, and empirical findings in the written research review.
5. Convene follow-up roundtable	Research recommendations from the workshop are prioritized, then further discussed and expanded upon at a follow-up roundtable meeting involving a subset of the original participants.
6. Disseminate research and practice recommendations	Dissemination activities are conducted as deemed appropriate to the topic.

Note: CITRA = Cornell Institute for Translational Research on Aging.

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Table 2

Summary of Major Research Findings on Social Isolation From Cattan et al. (2005)

Intervention	Characteristics	Effectiveness	Possible Adverse Outcomes
Group peer support	Targeted specific groups. Allowed participant input. Conducted within an existing community organization. Many recruited from within existing neighborhoods and communities. Often included discussions of negative emotions.	Consistently demonstrates effectiveness in reducing loneliness and depression and in increasing social contact and social activity level.	Potential to alter perceptions of existing support or to disrupt relations with family and friends.
One-to-one support and service provision	Involved indirect contact between the participant and others (e.g., through e-mail). One-to-one interventions conducted in participants' homes.	Consistently ineffective at reducing loneliness and social isolation.	Potential for embarrassment or shame in reporting that they are undervalued and isolated by their own family members.

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Table 3

Top Five Practice-Based Suggestions for a Social Isolation Research Agenda

Practitioner Priorities	Potential Research
Priority 1: The need to understand and increase service utilization by older adults who do not currently accept services even when services are free	Social demographic characteristics of the socially isolated older adult population
	Cultural barriers to service utilization among immigrants
	Service resistance by some homebound older adults, and strategies to overcome resistance
	Relevance and acceptability for more older adults
	Plans for the increasing number of older, single adults
Priority 2: Development of a social isolation measure with specific emphasis on identifying isolated older adults during a crisis	Measure subjective, objective, and cognitive aspects of isolation, degree and duration of isolation, multiple symptoms, and whether isolation is self- or circumstantially imposed
	Focus on highest risk
	Normalize on older adults
	Design for easy use in clinical settings
Priority 3: Evaluate one-to-one direct contact or indirect contact interventions	Compare person-centered, one-to-one social service programs to medical interventions
	Evaluate role of intentional relationship building in existing support interventions
	Study social support benefits of existing services, for example, meals on wheels
	Match interventions to different types of social isolation
	Determine when group interventions, one-to-one contact, and indirect contact are most appropriate
Priority 4: Efficacy studies of multicomponent interventions	Design interventions that address multiple aspects and causes of social isolation among older adults
Priority 5: Research that reflects respect for continuing self-determination in older adulthood	Design interventions that preserve dignity, that is, allow for support reciprocity
	Promote interventions with families who unintentionally isolate older relatives from friends and community