FCSS

Positive social ties and vulnerable populations

fcss
family & community
support services

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.'"[2] 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.[3] 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,[4] 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.

calgary.ca | contact 311

THE CITY OF
CALGARY
COMMUNITY &
NEIGHBOURHOOD SERVICES

Onward/ By 2020, Calgary will continue to be a vibrant, safe, healthy and socially inclusive city. Communities will continue to be resilient, complete and connected.

2014-0154

Positive social ties and vulnerable populations

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

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.[5] For vulnerable seniors, social isolation is associated with poor general health,[6] including:

• Increased risk of chronic disease.[7]
• Disability or chronic disease.[8]
• Reduced self-care.[9]
• Decreased immunity[10] and slow wound healing.[11]
• Premature death.[12]
• Poorer sleep efficiency and fatigue.[13]
• Abuse.[14]

• Stress.[15]
• Loneliness,[16] depression and other mental illnesses[17] and suicide.[18]
• Poor nutrition.[19]
• Psychosomatic illness.[20]
• Reduced well-being.[21]
• Quality of life.[22]

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.

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.

Positive social ties and vulnerable populations

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.[23] 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."[24]

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.[25] 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),[26] including adequate income, food security, appropriate and affordable housing, and transportation.[27] 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.[28] 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.[29] 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.[30] 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.[31] 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.

Positive social ties and vulnerable populations

• 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.[35]

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.[36] 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.[37]

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.[38] 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,[39] identified similar positive outcomes, with social integration chief among them.[40]

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[41] although, as noted by Kunz, they are unlikely to result in sustained positive social ties.[42] 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."[43]

English as a Second Language (ESL) training

Clearly, fluency in the English language is crucial to social and economic integration in Canada.[44] 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.[45]

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."[46]

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."[47]

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.[48] 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.[50]

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.[51]

A more recent, qualitative Canadian study[52] 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.[53]

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.[54] 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,[55] and social support, all of which can dramatically improve positive parenting skills, family functioning, and child outcomes.[56]

Unfortunately, there has emerged a body of research showing families that need social support the most are least likely to receive it.[57] 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.[58] 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.[59]

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.[60] 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.[61]

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.[62] 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;[63] and, ideally, the support must come from a preferred individual with whom one has a trusting and intimate relationship.[64]

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.[65] Similar problems have been observed in Australia,[66] 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.

Positive social ties and vulnerable populations

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.[67] Social support has been identified as one of the most protective factors against child abuse and neglect.[68] Social support improves at-risk parents' parenting skills and knowledge,[69] supports positive home and family environments,[70] and reduces parents' punitive attitudes.[71]

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.[72] Also, some older research indicates abusive mothers reported negative relationships with family members.[73] 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.[74]

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.[75] 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.[76]

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.[77]

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.[79]

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.[80]

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."[81]

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.[82] 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.[83]

- 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.[84]

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.[85] A recent study suggests direct and complex mediating and moderating interactions between social support, type and severity of abuse, and physical and mental health.[86]

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.[87]

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

Positive social ties and vulnerable populations

to re-establish or strengthen personal support networks that may have been weakened or lost as a result of their abusive relationship."[88]

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.[89] 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.[90]

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.[91] People with intellectual disabilities experience more physical health problems, challenging behaviours, mental illness, and low income than the general population.[92] Each of these issues, along with cognitive skills and certain personality characteristics, may contribute to social isolation.[93]

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.[94] 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.[95]

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*).

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

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.[96]

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.[97] In addition, living in a community and having neighbours does not guarantee contact with neighbours.[98] 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."[99] 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.[101] However, physical, social, and financial barriers can prevent adults with disabilities from participating in social networks.[102]

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[103] and arthritis,[104] 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.[105] 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.[106]

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,[107] and older men may be more at risk than women as they tend to have smaller social networks.[108] 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.[109]

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.[110]

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.[111]

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.[112]

Comprehensive reviews of the research conclude there is little evidence of effectiveness for most of the interventions that target social isolation among seniors.[113] 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."[114] In the most recent comprehensive review of the evidence on the effectiveness of such interventions, completed by Dickens, et al.,[115] 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).[118]

Positive social ties and vulnerable populations

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.[119]

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.[120]

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[121] 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.[122] 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.[123] 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.[124]

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.[125]

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,[126] 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.[127]

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.[128] 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.[129] 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[130] or, depending on their immigration status, for fear of problems with immigration authorities.[131] They may also be unable to communicate problems due to language barriers.[132] 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.[133]

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.[134] 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.[135]

Community outdoor gardening may also be an effective engagement tool, especially for former agrarians who feel estranged in an urban environment.[136] 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.[137]

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.[138]

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.[139] Researchers acknowledge

Positive social ties and vulnerable populations

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.[140]

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.[142] 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.[143]

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.[145]

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.[146] 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.

Positive social ties and vulnerable populations

1 Policy Research Initiative. 2005. *Social Capital: A Tool for Public Policy.* Social Capital Briefing Note. (Ottawa, ON: Policy Research Initiative).

2 Policy Research Initiative. 2005. *Social Capital: A Tool for Public Policy.* Social Capital Briefing Note. (Ottawa, ON: Policy Research Initiative).

3 Putnam, R. 2000. *Bowling Alone: the Collapse and Revival of American Community* (New York: Simon and Schuster).

4 See, for example, Bourdieu, P. 1986. "The Forms of Capital." In J.G. Richardson (Ed.), *Handbook of Theory and Research for the Sociology of Education.* (New York, NY: Greenwood Press).

5 For a thorough and up-to-date summary, see Nicholson, N.R. 2012. "A review of social isolation: An important but underassessed condition in older adults." *Journal of Primary Prevention,* 33(2-3), 137-152.

6 Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Working Together for Seniors: A Toolkit to Promote Seniors' Social Integration in Community Services, Programs and Policies.* Retrieved November 15, 2012 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf.

7 Cacioppo, J.T.; Hawkley, L.C. 2003. "Social isolation and health, with an emphasis on underlying mechanisms." *Perspectives in Biology and Medicine,* 46(3), S39–S52.

8 Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Working Together for Seniors: A Toolkit to Promote Seniors' Social Integration in Community Services, Programs and Policies.* Retrieved November 15, 2013 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf

9 Kobayashi, K.M.; Cloutier-Fisher, D.; Roth, M. 2009. "Making meaningful connections: A profile of social isolation and health among older adults in small town and small city, British Columbia." *Journal of Aging and Health.* 21(2), 374-397.

10 Keefe, J.; Andrew, M.; Fancey, P.; Hall, M. 2006. Final Report: A Profile of Social Isolation in Canada. (Halifax, NS: Working Group on Social Isolation, Centre on Aging Nova Scotia).

11 Keefe, J.; Andrew, M.; Fancey, P.; Hall, M. 2006. Final Report: A Profile of Social Isolation in Canada. (Halifax, NS: Working Group on Social Isolation, Centre on Aging Nova Scotia).

12 Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Working Together for Seniors: A Toolkit to Promote Seniors' Social Integration in Community Services, Programs and Policies.* Retrieved November 15, 2012 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf.

13 Cacioppo, J.T.; Hawkley, L.C. 2003. "Social isolation and health, with an emphasis on underlying mechanisms." *Perspectives in Biology and Medicine,* 46(3), S39–S52.

14 Barker, N. N.; Himchak, M. V. 2006. "Environmental issues affecting elder abuse victims in their reception of community based services." *Journal of Gerontological Social Work,* 48 (1/2), 233-255.

15 Cacioppo, J.T.; Hawkley, L.C. 2003. "Social isolation and health, with an emphasis on underlying mechanisms." *Perspectives in Biology and Medicine,* 46(3), S39–S52.

16 Pinquart, M.; Sorensen, S. 2001. "Influences on loneliness in older adults: A meta-analysis." *Basic and Applied Social Psychology,* 23(4), 245- 266.

17 Wenger, G.C.; Burholt, V. 2003. "Changes in levels of social isolation and loneliness among older people in a rural area: A twenty-year longitudinal study." *Canadian Journal on Aging.* 23 (2), 115 – 127.

18 Findlay, R.; Cartwright, C. 2002. *Social Isolation & Older People: A Literature Review.* Report for the Seniors Interest Branch & Ministerial Advisory Council on Older People. (Brisbane, AU: University of Queensland, Australasian Centre on Ageing, Univeristy of Queensland).

19 Keefe, J.; Andrew, M.; Fancey, P.; Hall, M. 2006. Final Report: A Profile of Social Isolation in Canada. (Halifax, NS: Working Group on Social Isolation, Centre on Aging Nova Scotia).

20 Andersson, L. 1998. "Loneliness research and interventions: A review of the literature." *Aging and Mental Health,* 2(4), 264–74.

21 Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Working Together for Seniors: A Toolkit to Promote Seniors' Social Integration in Community Services, Programs and Policies.* Retrieved November 15, 2012 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf.

22 Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Working Together for Seniors: A Toolkit to Promote Seniors' Social Integration in Community Services, Programs and Policies.* Retrieved November 15, 2012 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf.

23 Houle, R.; Schellenberg, G. 2010. *New Immigrants' Assessments of Their Life in Canada.* Statistics Canada Catalogue No. 11F0019M No. 322. (Ottawa, ON: Minister of Industry).

24 Kunz, J.L. 2003. "Social capital: A key dimension of immigrant integration." *Canadian Issues,* April, 33-34.

25 See, for example, Citizenship and Immigration Canada. 2006. *Consultations on the Settlement and Language Training Needs of Newcomers.* Available at http://www.cic.gc.ca/english/resources/publications/settlement/coia-summary.asp. Access Alliance Multicultural Community Health Centre. 2002. *Advancing Knowledge, Informing Directions: An Assessment of Immigrant and Refugee Needs in Toronto.* (Toronto: Access Alliance); Reitz, J. G. 1995. *A Review of the Literature on Aspects of Ethno-Racial Access, Utilization and Delivery of Social Services.* (Toronto: Multicultural Coalition for Access to Family Services and the Ontario Ministry of Community and Social Services).

26 See http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare.asp, accessed December 21, 2012.

27 See, for example, Raphael, D. (Ed.) 2004. *Social Determinants of Health: Canadian Perspectives.* (Toronto: Canadian Scholars Press); Renaud, J.; et al. 2001. "Ils sont maintenant d'ici!, Les dix premières anneés au Québec des immigrants, admis en 1989." *Les Cahiers du Gres,* 2(1), 29-40.

28 See, for example, Simich, L.; Mawani, F.; Wu, F; Noor, A. 2004. *Meanings of Social Support, Coping, and Help-seeking Strategies Among Immigrants and Refugees in Toronto.* CERIS Working Paper No. 31. (Joint Centre of Excellence for Research on Immigration and Settlement – Toronto).

29 Statistics Canada. 2003. *Longitudinal Survey of Immigrants to Canada: Process, Progress and Prospects.* Statistics Canada Catalogue No. 89-611. (Ottawa, ON: Minister of Industry). See also Hou, F. 2005. *Summary of: The Initial Destinations and Redistribution of Canada's Major Immigrant Groups: Changes over the Past Two Decades.* Statistics Canada Catalogue No. 11F0019MIF(255). (Ottawa, ON: Minister of Industry); McDonald, J. 2003. "Location choice of new immigrants to Canada: the role of ethnic networks." In C. Beach, A. Green & J. Reitz, J. (Eds.) *Canadian Immigration Policy for the 21st Century.* (Montreal, QU: McGill-Queen's University Press); Simich, L. 2003. "Negotiating boundaries of refugee resettlement: A study of settlement patterns and social support." *Canadian Review of Sociology and Anthropology,* 40(5), 575-591.

30 See, for example, Simich, L.; Hamilton, H.; Baya, B.K. 2006. "Mental distress, economic hardship and expectations of life in Canada among Sudanese newcomers." *Transcultural Psychiatry,* 43(3), 418-444; Simich, L.; et al. 2005. "Providing social support for immigrants and refugees in Canada: challenges and directions." *Journal of Immigrant Health,* 7(4), 259-268.

31 Puyat, J.H. "Is the influence of social support on mental health the same for immigrants and non-immigrants?" *Journal of Immigrant and Minority Health,* published online June 19, 2012.

32 Puyat, J.H. "Is the influence of social support on mental health the same for immigrants and non-immigrants?" *Journal of Immigrant and Minority Health,* published online June 19, 2012.

33 Simich, L.; Este, D.; Hamilton, H. 2010. "Meanings of home and mental well-being among Sudanese refugees in Canada." *Ethnicity and Health,* 15(2), 199-212, p. 210.

34 Hernandez-Plaza S, Alonso-Morillejo E, Pozo-Munoz C. 2006. "Social support interventions in migrant populations." *British Journal of Social Work,* 36(7), 1151–69.

35 Hernandez-Plaza S, Alonso-Morillejo E, Pozo-Munoz C. 2006. "Social support interventions in migrant populations." *British Journal of Social Work,* 36(7), 1151–69.

36 Cherfas, L. 2006. "Negotiating Access and Culture: Organizational Reponses to the Healthcare Needs of Refugees and Asylum Seekers living with HIV in the UK." *Refugee Studies Centre Working Paper No. 33.* Oxford University; Fassil, Y. 2005. *Working Together to Improve HIV and Sexual Health Services for BME Communities in North West London: Final Report.* (London, North West London Strategic Health Authority); Matthews, J.; Ritsema, S. 2003. "Addressing the reproductive health needs of conflict-affected young people." *Forced Migration Review,* 19, 6–8; Khamphakdy-Brown, S.; et al. 2006. "The Empowerment Program: An Application of an Outreach Program for Refugee and Immigrant Women." *Journal of Mental Health Counseling.* 28(1), 38-47; Behnia, B. 2003. "Refugees Convoy of Social Support." *International Journal of Mental Health,* 32(4), 6-19.

37 Dobowolsky, A.; Tastsoglou, E. 2008. "Women, gender, and networks." *Our Diverse Cities,* 5, 80-83. (Metropolis Project, Atlantic Region).

38 Citizenship and Immigration Canada. 2004. *Evaluation of the Host Program.* Retrieved November 24, 2013 from http://www.cic.gc.ca/english/resources/evaluation/host-program/section3.asp.

39 See, for example, Wright, T. 2009. "Who is an Islander?" *The Charlottetown Guardian,* August 22, 2009.

Positive social ties and vulnerable populations

40 Baldacchino, G.; et al. 2009. The Host Program and Immigrant Retention on Prince Edward Island. (University of Prince Edward Island and Prince Edward Island Association for Newcomers to Canada). Retrieved October 14, 2012 from http://www.peianc.com/sitefiles/File/reports/Host-Program-Study-Report-October-8-2009.pdf.

41 Quaicoe, L. "The role of education in developing and maintaining social networks of immigrants." *Our Diverse Cities,* 5, 77-79, p.78. (Metropolis Project, Atlantic Region). See also Rose, D.; Carrasco, P.; Charboneau, J. 1998. *The Role of "Weak Ties" in the Settlement Experiences of Immigrant Women with Young Children: The Case of Central Americans in Montréal.* CERIS Working Paper Series No. 4 (Joint Centre of Excellence for Research on Immigration and Settlement-Toronto).

42 Kunz, J.L. 2006. "Orienting newcomers to Canadian society: Social capital and settlement." In Policy Research Initiative, *Social Capital in Action: Thematic Policy Studies.* (Ottawa, ON: Government of Canada, Policy Research Initiative).

43 Quaicoe, L. 2008. "The role of education in developing and maintaining social networks of immigrants." *Our Diverse Cities,* 5, 77-79. (Metropolis Project, Atlantic Region).

44 See, for example, Hou, F. 2001. "Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: a 10 year study." *Social Science and Medicine,* 53, 1321-1334.

45 Hernandez, D.J. 2004. "Demographic change and the life circumstances of immigrant families." *The Future of Children,* 14(2), 17-49, p. 31.

46 Kilbride, K.M.; et al. 2008. *Reclaiming Voice: Challenges and Opportunities for Immigrant Women Learning English.* CERIS Working Paper Series. No. 72. (Joint Centre of Excellence for Research on Immigration and Settlement-Toronto), p. 7.

47 Rose, D.; Carrasco, P.; Charboneau, J. 1998. *The Role of "Weak Ties" in the Settlement Experiences of Immigrant Women with Young Children: The Case of Central Americans in Montréal.* CERIS Working Paper Series No. 4 (Joint Centre of Excellence for Research on Immigration and Settlement-Toronto).

48 See, for example, Halpern, D. 2005. *Social Capital.* (Cambridge, UK: Cambridge University Press).

49 Thomas, D. 2012. "Giving and volunteering among Canada's immigrants." *Canadian Social Trends,* 55-67.

50 Andersen, R.; Grabb, E.; Hwang, M. 2009. "Bridging and bonding: Ethnic background and voluntary association activity in Canada." *Canadian Ethnic Studies Journal,* 41(1-2), 47.

51 Scott, K.; Selbee, K.; Reed, P. 2006. Making Connections: *Social and Civic Engagement Among Canadian Immigrants.* (Ottawa, ON: Canadian Council on Social Development. Retrieved August 24, 2010 from http://www.ccsd.ca/pubs/2006/makingconnections/makingconnections.pdf.

52 Handy, F.; Greenspan, I. 2009. "Immigrant volunteering: A stepping stone to integration?" *Nonprofit and Voluntary Sector Quarterly,* 38, 956-982.

53 Handy, F.; Greenspan, I. 2009. "Immigrant volunteering: A stepping stone to integration?" *Nonprofit and Voluntary Sector Quarterly,* 38, 956-982.

54 See, for example, Olds, D.L. 2008. "Preventing child maltreatment and crime with prenatal and infancy support of parents: The Nurse-Family Partnership." *Journal of Scandinavian Studies in Criminology and Crime Prevention,* 9(S1), 2-24; Donovan, E.F. 2007. "Intensive home visiting is associated with decreased risk of infant death." *Pediatrics,* 119(6), 1145-1151; Dumont, K.; et al. 2008. "Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect." *Child Abuse & Neglect,* 32(3), 295-315; Balaji, A.B.; et al. 2007. "Social support networks and maternal mental health and well-being." *Journal of Women's Health,* 16(10), 1386–1396; Martinez-Schallmoser, L.; Telleen, S.; Macmullen, N.J. 2003. "The effect of social support and acculturation on postpartum depression in Mexican American women." *Journal of Transcultural Nursing,* 14(4), 329-338; Kotchick, B.A.; Dorsey, S.; Heller, L. 2005. "Predictors of parenting among African American single mothers: Personal and contextual factors." *Journal of Marriage and Family,* 67, 448–460; Ceballo, R.; McLoyd, V.C. 2002. "Social support and parenting in poor, dangerous neighborhoods." *Child Development,* 73(4), 1310–1321; Coble, H.M., Gantt, D.L.; Mallinckrodt, B. 1996. "Attachment, social competency, and the capacity to use social support." In G. R. Pierce, B. R. Sarason, & I. G. Sarason (Eds.), *Handbook of Social Support and the Family.* Plenum Series on Stress and Coping. (New York, NY: Plenum); Aronowitz, T.; Morrison-Beedy, D. 2004. "Resilience to risk-taking behavior in impoverished African American girls: The role of mother-daughter connectedness." *Research in Nursing and Health,* 27(1), 29-39; McCreary, L.L.; Dancy, B.L. 2004. "Dimensions of family functioning: Perspectives of low-income African American single-parent families." *Journal of Marriage and Family,* 66(3), 690-701. Cited in Black, K.; Lobo, M. 2008. "A conceptual review of family resiliency factors." *Journal of Family Nursing,* 14(1), 33-55.

[55] See, for example, Ryan, R.M.; Kalil, A.; Leininger, L. 2009. "Low-income mothers' private safety nets and children's socioemotional well-being." *Journal of Marriage and Family,* 71, 278-297; Brown, J.B.; Lichter, D.T. 2009. "Poverty, welfare, and the livelihood strategies of nonmetropolitan single mothers." *Rural Sociology,* 69(2), 282-301; Harknett, K. 2006. "The relationship between private safety nets and economic outcomes among single mothers." *Journal of Marriage and Family,* 68(1), 172-191; Brewster, K.L.; Padavic, I. 2002. "No more kin care? Change in black mothers' reliance on relatives for child care, 1977-94." *Gender & Society,* 16(4), 546-563.

[56] See, for example, Olds, D.L. 2008. "Preventing child maltreatment and crime with prenatal and infancy support of parents: The Nurse-Family Partnership." *Journal of Scandinavian Studies in Criminology and Crime Prevention,* 9(S1), 2-24; Donovan, E.F. 2007. "Intensive home visiting is associated with decreased risk of infant death." *Pediatrics,* 119(6), 1145-1151; Olds, D.L.; et al. 2007. "Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial, *Pediatrics,* 120, 832-845. Olds,D., et al. 1997. "Long term effect of home visitation on maternal life course and child abuse and neglect." *Journal of the American Medical Association,* 278(8), 637-643; Aronowitz, T.; Morrison-Beedy, D. 2004. "Resilience to risk-taking behavior in impoverished African American girls: The role of mother-daughter connectedness." *Research in Nursing and Health,* 27(1), 29-39; McCreary, L.L.; Dancy, B.L. 2004. "Dimensions of family functioning: Perspectives of low-income African American single-parent families." *Journal of Marriage and Family,* 66(3), 690-701. Cited in Black, K.; Lobo, M. 2008. "A conceptual review of family resiliency factors." *Journal of Family Nursing,* 14(1), 33-55; Staveteig, S.; Wigton, A. 2005. *Racial and ethnic disparities: Key findings from the national survey of America's families.* (Washington, DC: Urban Institute). Cited in Black, K.; Lobo, M. 2008. "A conceptual review of family resiliency factors." *Journal of Family Nursing,* 14(1), 33-55; Comer, E.; Fraser, M. 1998. "Evaluation of six family-support programs: Are they effective?" *Families in Society: The Journal of Contemporary Human Service,* March/April 1998, 134-148.

[57] Henly, J.R.; Danziger, S.K.; Offer, S. 2005. "The contribution of social support to the material well-being of low-income families." *Journal of Marriage and Family,* 67(1), 122-140; Domınguez, S.; Watkins, C. 2003. "Creating networks for survival and mobility: social capital among African-American and Latin-American low-income mothers." *Social Problems,* 50(1), 111-135; Howard, E.C. 2006. "The informal social support, well-being, and employment pathways of low-income mothers." In H. Yoshikawa, H.; T.S. Weisner; E.D. Lowe. (Eds.), *Making it Work: Low-Wage Employment, Family Life, and Child Development.* (New York, NY: Russell Sage Foundation), pp. 256-72.

[58] Offer, S. 2012. "Barriers to social support among low-income mothers." *International Journal of Sociology and Social Policy,* 32(3-4), 120-133.

[59] Harknett, K.S.; Hartnett, C.S. 2011. "Who lacks support and why? An examination of mothers' personal safety nets." *Journal of Marriage and Family,* 71, 861-875.

[60] Nelson, M.K. 2005. *The Social Economy of Single Motherhood: Raising Children in Rural America.* (New York, NY: Routledge); Hansen, K.V. 2005. *Not-So-Nuclear Families: Class, Gender, and Networks of Care.* (New Brunswick, NJ: Rutgers University Press); Domınguez, S.; Watkins, C. 2003. "Creating networks for survival and mobility: social capital among African-American and Latin-American low-income mothers." *Social Problems,* 50(1), 111-135;

[61] Offer, S. 2012. "Barriers to social support among low-income mothers." *International Journal of Sociology and Social Policy,* 32(3-4), 120-133; Harknett, K.S.; Hartnett, C.S. 2011. "Who lacks support and why? An examination of mothers' personal safety nets." *Journal of Marriage and Family,* 71, 861-875.

[62] Belle, D. 1982. *Lives in stress: Women and depression.* (Beverly Hills, CA: Sage). Cited in Logsdon, M.C.; Davis, D.W. 2003. "Social and professional support for pregnant and parenting women." *Maternal and Child Nursing,* 28(6), 371-376.

[63] Levitt, M.J. 1991. "Attachment and close relationships: A life span perspective." In J.L. Gewirtz & W.F. Kurtines (Eds.), *Intersections with Attachment.* (Hillsdale, NJ: Earlbaum); Logsdon, M.C.; McBride, A.B. 1989. "Help after childbirth...Do women get what they need?" *Kentucky Nurse,* 37, 14-15. Both cited in Logsdon, M.C.; Davis, D.W. 2003. "Social and professional support for pregnant and parenting women." *Maternal and Child Nursing,* 28(6), 371-376.

[64] Logsdon, M.C. 2000. "Social support for pregnant and postpartum women." Association of Women's Health, Obstetric, & Neonatal Nursing Symposium. Cited in Logsdon, M.C.; Davis, D.W. 2003. "Social and professional support for pregnant and parenting women." *Maternal and Child Nursing,* 28(6), 371-376.

[65] See, for example, Cook, K.E. 2012. "Social support in single parents' transition from welfare to work: analysis of qualitative findings." *International Journal of Social Welfare,* 21, 338-350; Strier, R.; Surkis, T.; Biran, D. 2008. "Neo-liberalism: Bottom-up counter-narratives." *International Social Work,* 51(4), 493–508; Roy, K.M.; Tubbs, C.Y.; Burton, L.M. 2004. "Don't have no time: Daily rhythms and the organization of time for low-income families." *Family Relations,* 53(2), 168–178.

[66] Saunders, P. 2002. "Mutual obligation, participation and popularity: Social security reform in Australia." *Journal of Social Policy,* 31(1), 21–28

Positive social ties and vulnerable populations

67 Burchinal, M.R.; Follmer, A.; Bryant, D.M. 1996. "The relations of maternal social support and family structure with maternal responsiveness and child outcomes among African American families." *Developmental Psychology,* 32, 1073–83; Taylor, R.D.; Casten, R.; Flickinger, S.M. 1993. "Influence of kinship social support on the parenting experiences and psychosocial adjustment of African-American adolescents." *Developmental Psychology,* 29, 382–88.

68 See, for example, Stith, S.M.; et al. 2009. "Risk factors in child maltreatment: A meta-analytic review of the literature." *Aggression and Violent Behavior,* 14, 13–29.

69 See, for example, Green, B.L.; Furrer, C.J.; McAllister, C. 2007. "How do relationships support parenting? Effects of attachment style and social support on parenting behavior in an at-risk population." *American Journal of Community Psychology,* 40, 96-108.

70 See, for example, Cochran, M.; Niegro, S. 1995. "Parenting and social networks. In M. H. Bornstein (Ed.), *Handbook of parenting. Status and social conditions of parenting,* Vol. 3. (Mahwah, NJ: Erlbaum), pp. 393-418.

71 McCurdy, K. 2005. "The influence of support and stress on maternal attitudes." *Child Abuse & Neglect,* 29, 251-268.

72 Bishop, S.J.; Leadbeater, B.J. 1999. "Maternal social support patterns and child maltreatment: Comparison of maltreating and nonmaltreating mothers." *American Journal of Orthopsychiatry,* 69(2), 172-181.

73 Corse, S.J.; Schmid, K.; Trickett, P.K. 1990. "Social network characteristics of mothers in abusing and non-abusing families and their relationships to parenting beliefs." *Journal of Community Psychology,* 18, 44-59.

74 See, for example, Kaminski, J.W.; Valle, L.A.; Filene, J.H.; Boyle, C.L. 2008. "A meta-analytic review of components associated with parent training program effectiveness." *Journal of Abnormal Child Psychology,* 36(4), 567-589; Lundahl, B.W.; Harris, N. 2006. *Delivering parent training to families at risk to abuse: Lessons from three meta-analyses.* (Columbus, OH: American Professional Society on the Abuse of Children); Lundahl, B.W.; Nimer, J.; Parsons, B. 2006. "Preventing child abuse: A meta-analysis of parent training programs." *Research on Social Work Practice,* 16, 251-62; Olds, D.L. 2008. "Preventing child maltreatment and crime with prenatal and infancy support of parents: The Nurse-Family Partnership." *Journal of Scandinavian Studies in Criminology and Crime Prevention,* 9(S1), 2-24.

75 Domínguez, S.; Watkins C. 2003. "Creating networks for survival and mobility: Social capital among African-American and Latin-American low-income mothers." *Social Problems,* 50, 111-135; 43; Brodsky A.E. 1999. "Making it: The components and process of resilience among urban, African-American, single mothers." *American Journal of Orthopsychiatry,* 9, 148-160.

76 See, for example, Balaji, A.B.; et al. 2007. "Social support networks and maternal mental health and well-being." *Journal of Women's Health,* 16(10), 1386–1396.

77 See, for example, Terrion, J.L. 2006. "Building Social Capital in Vulnerable Families: Success Markers of a School-Based Intervention Program." *Youth & Society,* 38(2), 155-176.

78 Dryfoos, J.G. 2000. *Evaluations of community schools: Findings to date.* ED450204. (Washington, DC: Coalition for Community Schools.) Retrieved November 5, 2012 from http://www.communityschools.org/assets/1/assetmanager/evaluation%20of%20community%20schools_joy_dryfoos.pdf.

79 Lewis, A.C. 1999. Communities working for better schools. (Chicago, IL: Cross City Campaign for Urban School Reform); Lewis, A.C.; Henderson, A. T. 1998. *Building Bridges: Across Schools and Communities, Across Streams of Funding.* (Chicago, IL: Cross City Campaign for Urban School Reform). Cited in Jordan, C., Orozco, E., Averett, A. 2002. *Emerging Issues in School, Family, and Community Connections.* (Austin, TX: National Center for Family and Community Connections with Schools, Southwest Educational Development Laboratory).

80 Bush Center in Child Development and Social Policy. 2003. *Portraits of four schools: Meeting the needs of immigrant students and their families.* (Newhaven, CT: Yale University, Bush Center in Child Development and Social Policy), p. 41.

81 Van Ngo, H. 2004. *Immigrant Children in Focus: A Map of Needs, Strategies and Resources.* (Calgary, AB: Coalition for Equal Access to Education).

82 Fortin, I.; et al. 2012. "Intimate partner violence and psychological distress among young couples: Analysis of the moderating effect of social support." *Journal of Family Violence,* 27(1), 63-73.

83 See, for example, Bosch, K.; Bergen, M.B. 2006. "The influence of supportive and nonsupportive persons in helping rural women in abusive partner relationships become free from abuse." *Journal of Family Violence,* 21, 311-320; Coker, A.L.; et al. 2003. "Social support reduces the impact of partner violence on health: Application of structural equation models." *Preventative Medicine,* 37, 259-267; Coker, A.L.; et al. 2002. "Social support protects against the negative effects of partner violence on mental health." *Journal of Women's Health and Gender-Based Medicine,* 11, 465-476.

Positive social ties and vulnerable populations

84 Katerndahl, D.; et al. 2012. "Differences in social network structure and support among women in violent relationships." *Journal of Interpersonal Violence,* published online before print December 21, 2012.

85 Beeble, M.L.; et al. 2009. "Main, mediating, and moderating effects of social support on the well-being of survivors of intimate partner violence across 2 years." *Journal of Consulting and Clinical Psychology,* 77(4), 718-729.

86 Beeble, M.L.; et al. 2009. "Main, mediating, and moderating effects of social support on the well-being of survivors of intimate partner violence across 2 years." *Journal of Consulting and Clinical Psychology,* 77(4), 718-729.

87 Guruge, S.; et al. 2012. "Rethinking social support and conflict: Lessons from a study of women who have separated from abusive partners." *Nursing Research and Practice,* published online before print, Article ID 738905.

88 Beeble, M.L.; et al. 2009. "Main, mediating, and moderating effects of social support on the well-being of survivors of intimate partner violence across 2 years." *Journal of Consulting and Clinical Psychology,* 77(4), 718-729.

89 Tutty, L.M.; Bidgood, B.A.; Rothery, M.A. 1993. "Support groups for battered women: Research on their efficacy." *Journal of Family Violence,* 8(4), 325-343.

90 Constantino, R.; Kim, Y.; Crane, P.A. 2005. "Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study." *Issues in Mental Health Nursing,* 26, 575-590.

91 Dusseljee, J.C.E.; et al. 2011. "Participation in daytime activities among people with mild or moderate intellectual disability." *Journal of Intellectual Disability Research,* 55, 4-18; Bigby, C. 2008. "Known well by no-one: Trends in the informal social networks of middle-aged and older people with intellectual disability five years after moving to the community." *Journal of Intellectual and Developmental Disability,* 33(2); 148-157; Forrester-Jones R.; et al. 2006. "The social networks of people with intellectual disability living in the community 12 years after resettlement from long-stay hospitals." *Journal of Applied Research in Intellectual Disabilities,* 19, 285-95.

92 See, for example, Bigby, C. 2012. "Social inclusion and people with intellectual disability and challenging behaviour: A systematic review." *Journal of Intellectual and Developmental Disability,* 37(4), 360-374; De Winter, C.F.; Jansen, A.A.; Evenhuis, H.M. 2011. "Physical conditions and challenging behaviour in people with intellectual disability: A systematic review." *Journal of Intellectual Disability Research,* 55(7), 675-698; Hemmings, C.P.; et al. 2006. "Psychiatric symptoms and problem behaviours in people with intellectual disabilities." *Journal of Intellectual Disabilities Research,* 50(4), 269-276.

93 Bigby, C. 2012. "Social inclusion and people with intellectual disability and challenging behaviour: A systematic review." *Journal of Intellectual and Developmental Disability,* 37(4), 360-374; Lehmann, B.A.; et al. 2012. "Aging with an intellectual disability: The impact of personal resources on well-being." *Journal of Intellectual Disabilities Research,* early view, published online September 14, 2012.

94 Verdonschot, M.M.L.; et al. 2009. "Community participation of people with an intellectual disability: A review of empirical findings." *Journal of Intellectual Disability Research,* 53(4), 303-318.

95 Verdonschot, M.M.L.; et al. 2009. "Impact of environmental factors on community participation of persons with an intellectual disability: A systematic review." *Journal of Intellectual Disability Research,* 53(1), 54-64.

96 Hardman, M.L.; Clark, C.; Kliewer, C. 2006. "Promoting friendships through Best Buddies: A national survey of college program participants." *Mental Retardation,* 44(1), 56-63.

97 Lippold, T.; Burns, J. 2009. "Social support and intellectual disabilities: A comparison between social networks of adults with intellectual disability and those with physical disability." *Journal of Intellectual Disability Research,* 53(5), 463-173.

98 Dijker A.; et al. 2011. "Social integration of people with intellectual disability: Insights from a social-psychological research program." *Journal of Intellectual Disability Research,* 55(9), 885-894; Van Alphen, L.M.; et al. 2009. "The significance of neighbors: Views and experiences of people with intellectual disability on neighboring." *Journal of Intellectual Disability Research,* 53, 745-757.

99 Chadsey, J. 2007. "Adult social relationships." In S.L. Odom; et al. (Eds.) *Handbook of Developmental Disabilities.* (New York, NY: The Guilford Press), pp. 449-466.

100 Chadsey, J. 2007. "Adult social relationships." In S.L. Odom; et al. (Eds.) *Handbook of Developmental Disabilities.* (New York, NY: The Guilford Press).

101 Lippold, T.; Burns, J. 2009. "Social support and intellectual disabilities: A comparison between social networks of adults with intellectual disability and those with physical disability." *Journal of Intellectual Disability Research,* 53(5), 463-173.

102 See, for example, Butterfield, P. 2006. "Changing the disability climate: Promoting tolerance in the workplace." *American Association of Occupational Health Nurse,* 54, 129-134.

Positive social ties and vulnerable populations

103 See, for example, Elliot, J.O.; et al. 2011. "The impact of marriage and social support on persons with active epilepsy." *Epilepsy and Behavior,* 20(3), 533-538.

104 See, for example, Benka, J.; et al. 2012. "Social support and psychological distress in rheumatoid arthritis: A 4-year prospective study." *Disability and Rehabilitation,* 34(9), 754-761.

105 See, for example, Miller, S. 2008. "The effect of frequency and type of Internet use on perceived social support and sense of well-being in individuals with spinal cord injury." *Rehabilitation Counselling Bulletin,* 51(3), 148-158; Ritchie, H.; Blanck, P. 2003. "The promise of the Internet for disability: A study of on-line services and web site accessibility at Centers for Independent Living." *Behavioral Science Law,* 21(1), 5-22.

106 Cheatham, L. 2012. "Effects of Internet use on well-being among adults with physical disabilities: A review." *Disability and Rehabilitation: Assistive Technology,* 7(3), 181-188.

107 Wenger, G.C.; Burholt, V. 2003. "Changes in levels of social isolation and loneliness among older people in a rural area: A twenty-year longitudinal study." *Canadian Journal on Aging.* 23(2), 115-127.

108 Keating, N.; Swindle, J.; Foster, D. 2006. "The role of social capital in aging well." In Policy Research Initiative, *Social Capital in Action: Thematic Policy Studies.* (Ottawa, ON: Government of Canada, Policy Research Initiative).

109 See, for example, Van Baarsen, B.; et al. 2001. "Lonely but not alone: emotional isolation and social isolation as two distinct dimensions of loneliness in older people." *Educational and Psychological Measurement,* 61(1), 119-35. Cited in Findlay, R. 2003. "Interventions to reduce social isolation amongst older people: where is the evidence?" *Ageing & Society,* 23, 647-658.

110 Stevens, N.; van Tilburg, T. 2000. "Stimulating friendship in later life: A strategy for reducing loneliness among older women." Educational Gerontology, 26(1), 15–36; Federal/Provincial/Territorial Ministers Responsible for Seniors. 2007. *Report. Working together for seniors: A toolkit to promote seniors' social integration in community services, programs and policies.* Retrieved November 15, 2012 from http://www.health.alberta.ca/documents/Seniors-Toolkit-WorkingTogether-2007.pdf.

111 Keating, N.; Swindle, J.; Foster, D. 2006. "The role of social capital in aging well." In Policy Research Initiative, *Social Capital in Action: Thematic Policy Studies.* (Ottawa, ON: Government of Canada, Policy Research Initiative).

112 For a thorough and up-to-date summary, see Nicholson, N.R. 2012. "A review of social isolation: An important but underassessed condition in older adults." *Journal of Primary Prevention,* 33(2-3), 137-152.

113 Cattan, M.; White, M.; Bond, J.; Learmouth, A. 2005. "Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions." *Ageing & Society,* 25, 41-67; Findlay, R. 2003. "Interventions to reduce social isolation amongst older people: where is the evidence?" *Ageing & Society,* 23, 647-658; Findlay, R.; Cartwright, C. 2002. *Social Isolation & Older People: A Literature Review.* (University of Queensland, Brisbane: Australasian Centre on Ageing); Cattan, M.; White, M. 1998. "Developing evidence based health promotion for older people: a systematic review and survey of health promotion interventions targeting social isolation and loneliness among older people." *Internet Journal of Health Promotion,* 1998. Retrieved October 4, 2012 from http://rhpeo.net/ijhp-articles/1998/13/index.htm

114 Findlay, R. 2003. "Interventions to reduce social isolation amongst older people: where is the evidence?" *Ageing & Society,* 23, 647-658, p. 655.

115 Dickens, A.P.; et al. 2011. "Interventions targeting social isolation in older people: A systematic review." *BMC Public Health,* 11, 647-669.

116 Findlay, R.; Cartwright, C. 2002. *Social Isolation & Older People: A Literature Review.* Report for Seniors Interest Branch & Ministerial Advisory Council on Older People,. (Brisbane, AU: Queensland Government , The University of Queensland, Australasian Centre on Ageing).

117 Dickens, A.P.; et al. 2011. "Interventions targeting social isolation in older people: A systematic review." *BMC Public Health,* 11, 647-669.

118 Cattan, M.; White, M.; Bond, J.; Learmouth, A. 2005. "Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions." *Ageing & Society,* 25, 41-67.

119 Dickens, A.P.; et al. 2011. "Interventions targeting social isolation in older people: A systematic review." *BMC Public Health,* 11, 647-669.

120 Dickens, A.P.; et al. 2011. "Interventions targeting social isolation in older people: A systematic review." *BMC Public Health,* 11, 647-669.

121 Andersson, L. 1985. "Intervention against loneliness in a group of elderly women: an impact evaluation." *Social Science and Medicine,* 20(4), 355–64.

Positive social ties and vulnerable populations

[122] Caserta, M. S.; Lund, D. A. 1996. "Beyond bereavement support group meetings: Exploring outside social contacts among the members." *Death Studies,* 20, 6, 537-556. Cited in Cattan, M.; White, M.; Bond, J.; Learmouth, A. 2005. "Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions." *Ageing & Society,* 25, 41-67; Caserta, M.S.; Lund, D.A. 1993. "Intrapersonal resources and the effectiveness of self-help groups for bereaved older adults." *The Gerontologist,* 33(5), 619-29.

[123] Findlay, R. 2003. "Interventions to reduce social isolation amongst older people: Where is the evidence?" Ageing & Society, 23, 647-658; Killeen, C. 1998. "Loneliness: an epidemic in modern society." *Journal of Advanced Nursing,* 28(4), 762-770; Kremers, I.P.; Steverink, N.; Albersnagel, F.A.; Slaets, J.P. J. 2006. "Improved self-management ability and well-being in older women after a short group intervention." *Aging & Mental Health.* 10(5), 476-484; Medical Advisory Secretariat. 2008 *Aging in the Community.* (Toronto, ON: Ontario Medical Advisory Secretariat).

[124] http://clese.org/elder-programs

[125] Choi, M.; Kong, S.; Jung, D. 2012. "Computer and Internet interventions for loneliness and depression in older adults: A meta-analysis." *Healthcare Informatics Research,* 18(3). 191-198.

[126] Cattan, M.; Newell, C.; Bond, J.; White, M. 2003. "Alleviating social isolation and loneliness among older people." *International Journal of Mental Health Promotion,* 5(3), 20-30.

[127] Kaplan, M.; Liu, S.; Hannon, P. 2006. "Intergenerational engagement in retirement communities: A case study of a community capacity-building model." *Journal of Applied Gerontology,* 25(5), 406-426.

[128] Kilbride, K.M.; et al. 2010. *Speaking with Senior Immigrant Women and Sponsoring Families: A First-language Investigation of the Needs for Holistic Approaches to Service.* (CERIS – The Ontario Metropolis Centre, Ryerson University). Retrieved October 16, 2012 from http://www.is-gw.ca/storage/project-wisdom/Kilbride per cent20- per cent20Phase per cent201 per cent20full per cent20report.pdf

[129] Kilbride, K.M.; et al. 2010. *Speaking with Senior Immigrant Women and Sponsoring Families: A First-language Investigation of the Needs for Holistic Approaches to Service.* (CERIS – The Ontario Metropolis Centre, Ryerson University). Retrieved October 16, 2012 from http://www.is-gw.ca/storage/project-wisdom/Kilbride per cent20- per cent20Phase per cent201 per cent20full per cent20report.pdf.

[130] Victor, C.; Bond, J.; Bowling, A.; Schambler, S. 2000. *Loneliness, Social Isolation and Living Alone in Later Life.* (Economic and Social Research Council). http://www.shef.ac.uk/uni/projects/gop/gop21.html.

[131] Chenoweth, J.; Burdick, I. 2001. *The Path to Integration: Meeting the Special Needs of Refugee Elders in Resettlement.* (York University, Centre for Refugee Studies. Retrieved October 16, 2012 from http://pi.library.yorku.ca/ojs/index.php/refuge/article/viewFile/21244/19915.

[132] New South Wales Refugee Health Service. 2006. *Caring for Older Refugees in NSW: A Discussion Paper.* (Sydney, New South Wales, Australia: New South Wales Refugee Health Service); Keefe, J., Andrew, M., Fancey, P.; Hall, M. 2006. *Final Report: A Profile of Social Isolation in Canada.* Working Group on Social Isolation. (Halifax, NS: Centre on Aging Nova Scotia).

[133] Chenoweth, J.; Burdick, I. 2001. *The Path to Integration: Meeting the Special Needs of Refugee Elders in Resettlement.* (York University, Centre for Refugee Studies. Retrieved October 16, 2012 from http://pi.library.yorku.ca/ojs/index.php/refuge/article/viewFile/21244/19915.

[134] Coalition of Limited English Speaking Elderly (CLESE), http://clese.org/elder-programs.

[135] Doan, L.; MacFarlane, S. 2003. *Immigrant Seniors: No Longer a Forgotten Group. Presentation at the National Settlement Conference,* Voluntary Sector Initiative: Settlement Project, Calgary, Alberta, October 2-5, 2003. Retrieved October 14, 2012 from http://integration-net.ca/english/ini/vsi-isb/conference2/session/8a.htm. The most recent reference to this program that the writer could find was in Kilbride, K.M.; et al. 2010. *Speaking with Senior Immigrant Women and Sponsoring Families: A First-language Investigation of the Needs for Holistic Approaches to Service.* (CERIS – The Ontario Metropolis Centre, Ryerson University). Retrieved October 16, 2012 from http://www.is-gw.ca/storage/project-wisdom/Kilbride per cent20- per cent20Phase per cent201 per cent20full per cent20report.pdf.

[136] New South Wales Refugee Health Service. 2006. *Caring for Older Refugees in NSW: A Discussion Paper.* (Sydney, New South Wales, Australia: New South Wales Refugee Health Service); Chenoweth, J.; Burdick, I. 2001. *The Path to Integration: Meeting the Special Needs of Refugee Elders in Resettlement.* (York University, Centre for Refugee Studies).

[137] Beckie, M.; Bogdan, E. 2010. "Planting roots: Urban agriculture for senior immigrants." *Journal of Agriculture, Food Systems, and Community Development,* 1(2), 77-89.

[138] Engler-Stringer, R.; Berenbaum, S. 2007. "Exploring social support through collective kitchens participation in three Canadian cities." *Canadian Journal of Community Mental Health,* 26(2), 91-105, p. 97

Positive social ties and vulnerable populations

139 Lee, J.; et al. 2010. "Process evaluation of community kitchens: results from two Victorian local government areas." *Health Promotion Journal of Australia,* 21, 183–188; Furber, S.; et al. 2010. "The role of a community kitchen for clients in a socio-economically disadvantaged neighbourhood." *Health Promotion Journal of Australia, 21,* 143–145; Engler-Stringer, R.; Berenbaum, S. 2007. "Exploring social support through collective kitchens participation in three Canadian cities." *Canadian Journal of Community Mental Health,* 26(2), 91-105; Engler-Stringer, R.; Berenbaum, S. 2007. "Exploring food security with collective kitchens participants in three Canadian cities." *Qualitative Health Research,* 17, 75-84; Engler-Stringer, R.; Berenbaum, S. 2005. "Collective kitchens in Canada: A review of the literature." *Canadian Journal of Dietetic Practice and Research,* 66(4), 246-251.

140 Iacovou, M.; et al. 2012. "Social health and nutrition impacts of community kitchens: A systematic review." *Public Health Nutrition,* 1(1), 1-9.

141 Engler-Stringer, R.; Berenbaum, S. 2007. "Exploring social support through collective kitchens participation in three Canadian cities." *Canadian Journal of Community Mental Health,* 26(2), 91-105, p. 97.

142 NiCarthy, G.; Merriam, K.; Coffman, S. 1984. *Talking it Out: A Guide to Groups for Abused Women.* (Seattle, WA: Seal). Cited in Tutty, L.M.; Bidgood, B.A.; Rothery, M.A. 1996. "Evaluating the effect of group process and client variables in support groups for battered women." *Research on Social Work Practice,* 6(3), 308-324

143 Tutty, L.M.; Bidgood, B.A.; Rothery, M.A. 1993. "Support groups for battered women: Research on their efficacy." *Journal of Family Violence,* 8(4), 325-344.; Cox, J.W.; Stoltenberg, C. 1991. "Evaluation of treatment programs: Battered wives." *Journal of Family Violence,* 6, 395-413; Bourassa, F; Sharma, M.M. 1997. *Second Stage Support Group. Moving on From the Abusive Relationship.* (Vancouver, BC: FREDA).

144 Statistics Canada. 2010. "Public transit in Canada, 2007." *Envirostats,* 4(2), 3-8. Statistics Canada Catalogue No. 16-002-X.

145 Heisz, A.; Schellenberg, G. 2004. *Public Transit use Among Immigrants.* Statistics Canada Catalogue No. 11F0019MIE — No. 224. (Ottawa, ON: Minister of Industry).

146 Turcotte, M. 2012. "Profile of seniors' transportation habits." *Canadian Social Trends,* January 23, 2012. Statistics Canada Catalogue No. 11-0008-X.