



PERSPECTIVES

Journal of the Canadian Gerontological Nursing Association

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Perspectives, Journal of the Canadian Gerontological Nursing Association (CGNA), formerly the Journal of the Gerontological Nursing Association (Ontario) welcomes original manuscripts describing qualitative or quantitative studies, pilot studies, research protocols, discussion papers, practice or quality improvement projects, literature reviews (e.g., systematic, scoping, rapid), and clinical, educational and administrative innovations of interest to gerontological nursing. Manuscripts from nurses and others in the field of gerontology, and from students in collaboration with their instructors or advisors will be accepted for review.

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The Editorial Team affirms our commitment to ensuring use of an equity, diversity and inclusivity lens in our journal. The mission of *Perspectives* is to advance the scholarship of gerontological nursing by:

- Promoting the scholarship of gerontological nursing in Canada and internationally;
- Sharing the practice innovations of gerontological nurses;
- Facilitating the dissemination of gerontological nursing knowledge and expertise;
- Encouraging interprofessional collaboration; and
- Promoting scholarly debate on issues across the continuum of care.

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The required style for manuscripts is the current *Publication Manual of the American Psychological Association*. Manuscripts must be submitted as Word documents in 12-point Times New Roman font, double-spaced with one-inch margins. All graphics (figures, tables, charts) must be in Word document format. Manuscripts can be of any length but should not exceed 3000 words excluding the title page, figures, and references. Manuscript length may be negotiated with the Editor-in-Chief. Manuscripts must have a title page (not including author names), an abstract (not to exceed 200 words), and keywords (maximum of 6). All manuscripts should use headings and subheadings to divide areas of content and one heading must identify and address the implications of the described research, practice improvement project, literature review or innovation to gerontological nursing. Manuscripts that are literature reviews (e.g., systematic, scoping, rapid) should identify all search resources, have a key points box (a snapshot of the major findings from the review), and a PRISMA flow diagram.

The cover letter must declare any conflict of interest, acknowledge funding and list all the authors, their educational degrees, diplomas and certifications, and their affiliation

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- For research studies, authors must report the year(s) of data collection in the methods section, and a full description of the sample and methods, by clearly stating the inclusion and exclusion criteria and the associated rationales
- Authors must use bias-free language
- Authors are encouraged to review Equator Network guidelines <https://www.equator-network.org/guidelines> for research studies prior to submission

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THE POWER OF NURSES' VOICES IN GERONTOLOGICAL CARE

It is both a privilege and a responsibility to serve as Editor-in-Chief of *Perspectives*, the journal of the Canadian Gerontological Nursing Association. Gerontological nurses across Canada play a profound role in the lives of older adults and their families. Every day, in hospitals, long-term care homes, community settings, and homes across the country, nurses witness moments of vulnerability, resilience, creativity, and care that shape what aging means in our society. Yet many of these insights, these powerful lessons from practice, remain largely invisible beyond the walls of the settings in which they occur.

Perspectives, our Journal is a space where the voices of gerontological nurses matter. It is a place where clinical wisdom, research discoveries, reflections from practice, and innovative ideas can be shared, debated, and built upon. When nurses write, they do more than document their work; they shape the future of care. Writing allows us to challenge assumptions, share solutions, and inspire change in how we support older adults.

Gerontological nursing is at the forefront of some of the most pressing issues of our time. Canada's population is aging rapidly. Health systems are evolving. Long-term care, home care, dementia care, palliative care, and social support systems are transforming. Nurses are often the professionals who understand these challenges most deeply because they experience them firsthand in practice.

But here is the question we must ask ourselves: Whose knowledge is shaping the conversation about aging and care?

Too often, nurses' insights, especially those grounded in everyday practice, are underrepresented in scholarly and professional publications. Yet nurses hold some of the most valuable knowledge in our health system: relational knowledge, practical wisdom, ethical insight, and a deep understanding of what matters most to older adults and their families.

Your stories, observations, innovations, and research matter.

Perhaps you have developed a creative way to support a person living with dementia. Perhaps you have redesigned a care process to improve residents' quality of life. Perhaps you have navigated ethical challenges in practice that deserve broader discussion. Perhaps you have participated

in research that offers new insights into aging and care. These experiences are not simply part of daily work; they are knowledge worth sharing.

Writing can feel intimidating. Many nurses believe they must be seasoned researchers or experienced authors before contributing to a journal. In reality, writing often begins with curiosity and reflection. What surprised you in practice? What problem did you solve? What question continues to trouble you? What change made a difference for the people you care for? These questions can serve as the foundation for meaningful contributions.

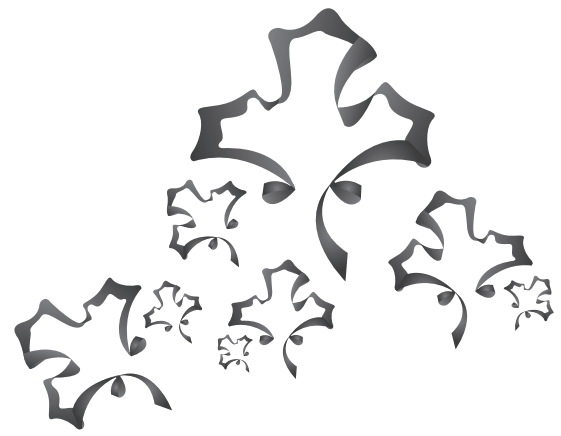
Our editorial team welcomes submissions from nurses at all stages of their careers: students, early-career nurses, clinical leaders, educators, and researchers. We encourage reflective pieces, practice innovations, quality improvement initiatives, and brief research reports. Our goal is not only to publish knowledge but also to cultivate a community of nurse writers and thinkers committed to advancing gerontological care.

Writing is also an act of advocacy.

When nurses publish, they bring attention to the realities of aging, the challenges faced by older adults and caregivers, and the innovations that improve quality of life. In doing so, they influence policy, education, and practice. They ensure that the experiences of older people, and those who care for them, are visible and valued. Gerontological nurses have long been leaders in advancing compassionate, person-centred care. Through this journal, we have the opportunity to amplify that leadership. I invite you to share your work with us. Tell the stories of your practice. Describe the innovations you are testing. Reflect on the ethical questions that shape your care. Contribute to building a stronger body of knowledge that supports older adults across Canada.

Your voice matters. Your experience matters. Your writing can make a difference. Together, through dialogue and shared learning, we can strengthen gerontological nursing and improve the care of older adults in our communities. I look forward to reading your work.

Lillian Hung, RN, PhD
Editor-in-Chief, *Perspectives*
Canadian Gerontological Nursing Association (CGNA)



MISSION AND VISION

A. VISION

The vision of CGNA is to promote excellence in gerontological nursing through leadership, knowledge, and scholarship.

The vision of the *Perspectives Journal* is to be the premier Canadian journal in gerontological nursing.

B. MISSION

The Mission of the Canadian Gerontological Nursing Association (CGNA) is to address the health of older Canadians and the nurses who participate with them in health care. The Canadian Gerontological Nursing

Association is an organization that represents gerontological nurses and promotes gerontological nursing practice across national and international boundaries.

The mission of the *Perspectives Journal* is to advance the scholarship of gerontological nursing by:

- Promoting the scholarship of gerontological nursing in Canada and internationally;
- sharing the practice innovations of gerontological nurses;
- facilitating dissemination of gerontological nursing knowledge and expertise;
- encouraging interprofessional collaboration; and
- promoting scholarly debate on issues of interest to nurses about older adults across the continuum of care.

PERSPECTIVES, JOURNAL OF THE CGNA NEEDS REVIEWERS!

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We are seeking manuscripts for review and possible publication.

Share your research, innovative gerontological nursing practice and your expertise.

Submit to: *Perspectives*

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Lillian Hung, RN, PhD
Editor, *Perspectives*



THE HEALTH IMPLICATIONS OF SOCIAL ISOLATION AND LONELINESS AMONG OLDER ADULTS DURING THE COVID-19 PANDEMIC: A SCOPING REVIEW

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Keywords: COVID-19, health impacts, loneliness, older adults, scoping review, social isolation

ABSTRACT

The unprecedented social distancing measures during the COVID-19 pandemic forced people to separate from their social support networks through restrictions that prevented in-person interaction. Older adults are more likely to live alone or have mobility limitations that restrict social interaction, increasing their risk of social isolation and loneliness, and related health problems. The purpose of this review was to examine the implications of social isolation and loneliness on the health and well-being of community-dwelling older adults during the COVID-19 pandemic. A scoping review of relevant literature was performed using Joanna Briggs Institute scoping review guidelines and the PRISMA-ScR checklist. CINAHL, Medline (OVID), and Emcare were searched for refereed journal articles. Following the screening process, a total of 38 studies were included in the final sample. Data were extracted and a narrative approach was used to synthesize the results. Analysis revealed four themes: (a) detrimental effects on physical health and well-being, (b) decreases in mental health and well-being, (c) deterioration of social health and well-being, and (d) positive coping strategies adopted to reduce social isolation and loneliness during the pandemic. The findings highlight the health impacts of

social distancing on older adults and the need for strategies to mitigate these effects.

INTRODUCTION

The COVID-19 pandemic created an unprecedented global state of emergency, and the World Health Organization (WHO) declared a pandemic on March 11, 2020 with over 118,000 COVID-19 cases reported in 114 countries and 4291 deaths (WHO, 2020). In response, most countries enforced public health measures to prevent transmission of the COVID-19 virus, including social distancing, self-isolation, quarantine, and stay at home orders (Usher et al., 2020; Vahia et al., 2020). Some countries, such as Sweden and South Korea, however, opted for less restrictive measures (Bhatia et al., 2021; Dighe et al., 2020). The stringent social distancing measures adopted by other countries, though supportive in reducing the spread of the COVID-19 virus, was a foreign and distressing experience that required separation from loved ones (Usher et al., 2020). These changes threatened individuals' sense of social connectedness (Usher et al., 2020). Evidence shows that imposed quarantine and social distancing measures were associated with social isolation and feelings of loneliness, which are widely recognized as predictors of poor health and mortality (Cacioppo & Hawkley, 2003; Usher et al., 2020).

Social isolation is defined as a state in which an individual has a small number of social contacts, lacks a sense of social belonging, does not engage or interact with others, and has inadequate, unfulfilling, and poor quality relationships (Nicholson, 2009). Loneliness, a relevant but distinct concept, is characterized as a subjective sense of lacking both the quantity and quality of social connection (Perlman & Peplau, 1981). Literature has found both social isolation and loneliness can commonly coexist during imposed quarantine and are widely recognized as predictors of ill health and mortality (Cacioppo & Hawkley, 2003; Usher et al., 2020). Older adults are particularly vulnerable to social isolation and loneliness due to changes in their social support network and health that come with age (Government of Canada, 2022; Kobayashi & Steptoe, 2018). Often, the dynamics of individuals' interpersonal relationships change as life progresses. Previous literature has found that the size of social networks decreases as people age (Bruine de Bruin et al., 2020). This is due to life course transitions: death of a companion (Government of Canada, 2022); retirement (Government of Canada, 2022); and changes in residence that include living alone (Centers for Disease Control and Prevention, 2021; Government of Canada, 2022; National Council on Aging, 2022). In addition, as one ages, their capacity to participate in social interactions and maintain social connections can be hindered due to worsening health and limitations in mobility (Kobayashi & Steptoe,

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2018; Schrepft et al., 2019). These changes often result in social isolation and loneliness (Goll et al., 2015; Santini et al., 2020; Yanguas et al., 2018). The restrictions imposed during COVID-19 exacerbated these risks and their impacts on older adults.

Therefore, this scoping review was undertaken to explore what is known in the literature about the health implications of social isolation and loneliness among older adults during the COVID-19 pandemic. This scoping review focused solely on older adults living in the community. Even prior to the COVID-19 pandemic, previous research has reported remarkable levels of social isolation and loneliness experienced by community-dwelling older adults (Savikko et al., 2005). Given the nature of residential care environments (nursing homes and personal care homes) which allows for physical proximity to others through amenities such as nursing and medical care on-site, older adults who reside in residential care settings have been reported to experience lower social isolation and loneliness (Su et al., 2021). Moreover, both groups of older adults would encounter different experiences during the COVID-19 pandemic due to differences in terms of access to social support systems, or incidences of neglect or abuse from nursing and medical healthcare professionals (Su et al., 2021). Therefore, to ensure older adults living in the community and those living in residential care environments are not treated as a homogenous group, this review focused on the health experiences of community-dwelling older adults as the target population. No scoping reviews could be located that analyzed the health implications of social isolation and loneliness among community-dwelling older adults during the COVID-19 pandemic period. To address this gap, this present review examines how experiences of social isolation and loneliness affects the health and

well-being of community-dwelling older adults during the COVID-19 pandemic. For the purpose of this review, a community-dwelling older adult was defined as individuals aged 65 years or older and living in a private home.

METHOD

This scoping review used the Joanna Briggs Institute (JBI) methodology outlined in the Preferred Reporting Items for Systematic Reviews and the Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist (Peters et al., 2015). The intersectionality lens (Crenshaw, 1989) was applied to examine health implications of social isolation and loneliness among community-dwelling older adults. This lens allowed for a comprehensive analysis of how an older adult's overlapping social identities, such as gender, race, age, and socioeconomic status intersect with structural factors to shape health outcomes and experiences of isolation in later life (Crenshaw, 1989). The review question and eligibility screening criteria were developed using the population, concepts, context (PCC) framework outlined in Table 1 (Tricco et al., 2018). The review question was: What is known from the existing literature on the health implications of social isolation and loneliness among community-dwelling older adults during the COVID-19 pandemic period? To maximize robustness, the research team created a PCC framework to guide the formulation of the research question. This framework was supported by a predefined, comprehensive search strategy and inclusion/exclusion criteria, which were developed in collaboration with a subject librarian. A clear audit trail was also maintained to ensure each step of the scoping review process was documented. This included the number of records that were produced from each database search, keeping a record of the number of studies excluded at each stage with the rationale for exclusion.

Table 1
Population, Concept, and Context Framework

Framework Component	Criteria
Population	Community-dwelling older adults, defined as those aged 65 and older
Concepts	Social isolation, loneliness, health
Context	Any geographical location



Eligibility Criteria

Articles were included if they met the following criteria: (a) peer-reviewed primary sources of evidence, (b) focused on individuals who are 65 years of age or older, (c) involved participants living in the community who were socially isolated or experiencing loneliness, and (d) were set within the context of the COVID-19 pandemic. Grey literature was excluded to ensure the quality of the synthesized evidence, as it can vary widely in methodological rigor and reliability. Studies were excluded if they were conducted prior to March 2020 (i.e., prior to WHO declaration of the pandemic on March 11, 2020). Studies were also excluded if they were not written in English for feasibility of the review.

Information Sources and Search

Three electronic databases were searched: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline (OVID), and Emcare. In collaboration with the research team and a subject librarian, a search strategy was developed. As an example of a search strategy, the CINAHL database was queried using the Medical Subject Headings (MeSH) terms: ['Social Isolation' OR 'Loneliness'] AND ['Aged'] AND ['COVID-19' OR 'COVID-19 Pandemic' OR "SARS-CoV-2"]. Additional studies were located from

hand-searching reference lists of all included studies and titles from key journals (Journal of Applied Gerontology, Archives of Gerontology and Geriatrics, and Geriatric Nursing). The search was conducted in August 2023 and more recently in November 2024.

Selection of Sources of Evidence

A scoping review management software (Rayyan) was used to facilitate collaborative screening process (Rayyan, n.d.). All citations were uploaded onto Rayyan, and duplicates were removed. The eligibility criteria were applied at two levels of title and abstract, and full text review. The search results were reviewed by two researchers (KC and SG), and any conflicts were resolved with consultation with the rest of the team (KM and CC).

Data Items and Charting Process

The data charting process was conducted by the Principal Investigator (KC). Information was extracted from studies into an Excel data extraction tool and included author(s), year, title, journal, purpose, design, date, location, population/sample size, procedures/measures, relevant findings/themes/concepts, and conclusions. The extracted data are summarized in Table 2.

Table 2
Data Extraction Table

In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Atıcı et al., 2022)	To examine the interaction between fear of movement, fall risk, and physical activity levels among older adults during COVID-19.	Quantitative, Cross-sectional design	Turkey; December 2020 and February 2021	254	Decline in activity
(Bailey et al., 2021)	To analyze health trajectories and healthcare utilization while cocooning among older adults during COVID-19.	Quantitative, Cross-sectional	Ireland; October 2020 and December 2020	150	Decline in activity; Dietary Challenges and Risk Factors; Disrupted Sleep Patterns; Heightened Anxiety Levels; Loss of Social Networks
(Brooke & Clark, 2020).	To explore older adult's initial experience of household isolation and social distancing during the COVID-19 pandemic.	Qualitative, Longitudinal design	United Kingdom; April 2020-July 2020	19	Disruptions of Social Routines; Self-Care Strategies; Social Support

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In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Brooke et al., 2022)	To understand the lived experience of people aged 70 and older, living in England during the COVID-19 pandemic.	Qualitative, Longitudinal design	England; April 20 to July 7, 2020	15	Disruptions of Social Routines; Self-Care Strategies; Social Support
(Brown et al., 2021)	To examine the impact of the COVID-19 pandemic measures on the lives of older adults.	Mixed-method, Cross-sectional design	England; May 2020 to June 2020	142	Decline in Activity; Increase in Depression; Loss of Social Network; Self-Care Strategies; Social Support
(Capicio et al., 2022)	To investigate the effect of a brief education intervention on nutrition risk and use of adaptive strategies to promote resilience among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Alberta, Canada; July 2020 to December 2020	25	Dietary Challenges and Risk Factors
(Cigiloglu et al., 2021)	This study aimed to investigate the psychosocial effects of measures to prevent the spread of the COVID-19 virus on older adults in Turkey.	Quantitative, Cross-sectional	Turkey; April 2020 to May 2020	104	Decline in Activity; Dietary Challenges and Risk Factors
(Cipoletta & Gris, 2021)	The purpose of the study is to understand the experiences of social isolation and strategies used to cope with it among older adults during the first wave of the COVID-19 pandemic.	Qualitative, Cross-sectional design	Northern Italy; March 27 to April 15, 2020	30	Decline in Activity; Dietary Challenges and Risk Factors; Disrupted Sleep Patterns; Heightened Anxiety Levels; Increase in Depression; Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Erbesler & Demir, 2023)	The purpose of the study is to analyze the levels of death anxiety and death-related depression among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Turkey; June 2021 to August 2021	3247	Heightened Anxiety Levels; Increase in Depression
(Fingerman et al., 2021)	To analyze how living alone was associated with daily social contact and emotional wellbeing among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Texas, United States; May to June 2020	226	Loss of Social Networks

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In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Fiocco et al., 2021)	To explore the lived experience of older adults living in Ontario, Canada, during the initial wave of the COVID-19 pandemic, to capture individual perceptions of the pandemic and resources used to manage its impact.	Qualitative, Cross-sectional design	Ontario, Canada; May 8, 2020 to October 1, 2020	22	Decline in Activity; Disrupted Sleep Patterns; Heightened Anxiety Levels; Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Fuller et al., 2022)	The purpose of this study is to explore change in older adult's satisfaction with social engagement and interpersonal connections throughout the first year of the COVID-19 pandemic.	Mixed-method, Longitudinal design	Minnesota, United States; March 2020 to April 2021	76	Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Garner et al., 2022)	To investigate health-related behaviors and support resources older adults used during the COVID-19 pandemic.	Quantitative, Longitudinal design	Spain; May 2020 to October 2020	70	Decline in Activity
(Gen et al., 2023)	This study aimed to investigate the relationship between decreased frequency of going out during the COVID-19 pandemic with musculoskeletal pain, physical activity, and loneliness among older adults.	Quantitative, Cross-sectional design	Japan; November 1st–30th, 2020	266	Decline in Activity
(Gezgin & Ökten, 2022)	The purpose of this study is to examine insomnia and loneliness among older adults and affecting socio demographic factors during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Turkey; December 2020	412	Disrupted Sleep Patterns; Disruptions of Social Routines; Loss of Social Networks
(Guner et al., 2023)	The purpose of the study is to analyze the effect on death anxiety of loneliness among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Turkey; July 10, 2020 to October 15, 2020	392	Heightened Anxiety Levels; Social Support
(Hayashi et al., 2022)	To examine the relationship between social frailty and depressive symptoms in older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Japan; Between March to October 2020	1103	Increase in Depression

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In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Herron et al., 2021)	To investigate older adults' experiences of physical distancing, isolation, and loneliness in rural communities in the Canadian province of Manitoba during the COVID-19 pandemic.	Qualitative, Longitudinal design	Manitoba, Canada; May to July of 2020	26	Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Hsu et al., 2022)	To explore whether loneliness literacy is related to a lower risk of loneliness, increased loneliness during the COVID-19 pandemic, and improved mental well-being for older adults.	Quantitative, Cross-sectional design	Taiwan; November-December 2021	804	Increase in Depression; Loss of Social Networks
(Irmak et al., 2021)	The purpose of this study is to analyze the depression risk and the management of chronic diseases among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Turkey; May 2020 to June 2020	185	Dietary Challenges and Risk Factors; Increase in Depression
(Jun et al., 2024)	To understand how social isolation and support would be associated with depression among older adults in rural areas in the United States during the COVID-19 pandemic.	Mixed-Method, Cross-sectional design	United States of America; Summer 2021	103	Increase in Depression; Disruptions of Social Routines; Social Support
(Kilic et al., 2023)	To examine the relationship between fear of COVID-19, social isolation and depression in older adults.	Quantitative, Cross-sectional design	Eastern Turkey; August 2021-January 2022	362	Increase in Depression
(Kubo et al., 2022)	The purpose of this study is to analyze changes in psychosocial factors among older adults before and after Japan's declaration of a state of emergency over COVID-19.	Quantitative, Longitudinal design	Japan; April 16, 2020 to October 30, 2020	1103	Decline in Activity; Disruptions of Social Routines; Loss of Social Networks; Social Support
(Moustakopoulou et al., 2023)	To explore the presence and levels of depression in older adults during the pandemic and to explore any possible relationships with loneliness and fear.	Quantitative, Cross-sectional design	Four provincial towns in Greece; April-May 2022	200	Increase in Depression

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In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Müller et al., 2021)	To investigate the association between social isolation and loneliness with depressive symptoms and the effects of resilience among older adults during the first COVID-19 pandemic in Germany.	Quantitative, Cross-sectional design	Germany; April 6 to 25, 2020	1005	Increase in Depression
(Rawkins et al., 2022)	To explore the impact of COVID-19 on the health of older adults.	Mixed-method, Cross-sectional design	Castlegar, British Columbia; May 1, 2020 to September 10, 2020	78	Decline in Activity; Dietary Challenges and Risk Factors; Disrupted Sleep Patterns; Heightened Anxiety Levels; Increase in Depression; Disruptions of Social Routines; Loss of Social Networks
(Röhr et al., 2020)	To investigate the implications of social isolation and loneliness on mental health among older adults in Germany.	Quantitative, Cross-sectional design	Germany; April 6 to April 25, 2020	1005	Increase in Depression; Social Support
(Schmidt et al., 2023)	To gain an understanding of rural older adults' experience with physical activity and social interaction during the COVID-19 pandemic.	Qualitative, Cross-sectional design		10	Decline in Activity; Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Schorr et al., 2021)	The purpose of this study is to examine the direct and indirect effect of loneliness feelings on depressive symptoms, mediated by malnutrition, among older adults from different cultures during the COVID-19 quarantine.	Quantitative, Cross-sectional design	Israel; April to May 2020	201	Dietary Challenges and Risk Factors; Increase in Depression
(Shapira et al., 2021)	To investigate the efficacy of a short-term digital group intervention aimed at providing older adults with the tools and skills necessary for improving their coping ability during these stressful times.	Quantitative, Cross-sectional design	Israel; April to June 2020	82	Increase in Depression; Self-Care Strategies; Social Support

LITERATURE REVIEW

In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Siegmund et al., 2021)	To examine the relationship between physical activity and depression, and social isolation and depression in older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	Northeast Ohio; 2020	477	Decline in Activity
(Siette et al., 2023)	To explore how the COVID-19 pandemic affected older adults' habits.	Mixed-Method, Longitudinal design	New South Wales, Australia; June to October 2021	159	Decline in Activity; Dietary Challenges and Risk Factors; Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies
(Smith et al., 2022)	The purpose of this study is to analyze the impacts of the 2020 New Zealand COVID-19 lockdown on peer-led Steady as You Go (SAYGO) fall prevention exercise classes and members, and to develop recommendations for mitigating impacts during future lockdowns.	Qualitative, Cross-sectional design	New Zealand; April to May 2021.	24	Decline in Activity; Self-Care Strategies; Social Support
(Takashima et al., 2020)	The purpose of this study is to investigate the perceptions of older adults regarding how the COVID-19 pandemic restrictions restricted their daily lives.	Qualitative, Cross-sectional design	Japan; July to August 2020	24	Disruptions of Social Routines; Loss of Social Networks; Self-Care Strategies; Social Support
(Wang et al., 2023)	To analyze the relationship between social isolation, depression, nutrition status, and quality of life among older adults during the COVID-19 pandemic.	Quantitative, Cross-sectional design	China; May to July 2022	406	Dietary Challenges and Risk Factors
(Wei et al., 2023)	To determine prevalence of high nutrition risk and whether loneliness, mental health, and assistance with meal preparation/delivery were associated with risk in older adults during the COVID-19 pandemic.	Quantitative, Longitudinal design	Greater Hamilton area May 12, 2020 to August 19, 2020	272	Decline in Activity; Dietary Challenges and Risk Factors
(Yamada et al., 2021)	The purpose of this study is to analyze the influence of the COVID-19 pandemic on physical activity and the incidence of frailty among initially non-frail older adults in Japan.	Quantitative, Cross-sectional design	Japan; April 23 to 27, 2020	937	Decline in Activity

LITERATURE REVIEW

In-Text Citation	Study Purpose	Method	Setting & Time Period	Sample size	Relevant Findings
(Yildirim, 2022)	The purpose of this study is to analyze the psychosocial status, attitudes, and experiences of older adults during the COVID-19 pandemic in Turkey.	Qualitative, Cross-sectional design	Turkey; May to June 2020	51	Dietary Challenges and Risk Factors; Heightened Anxiety Levels; Disruptions of Social Routines; Loss of Social Networks; Social Support

Synthesis of Results

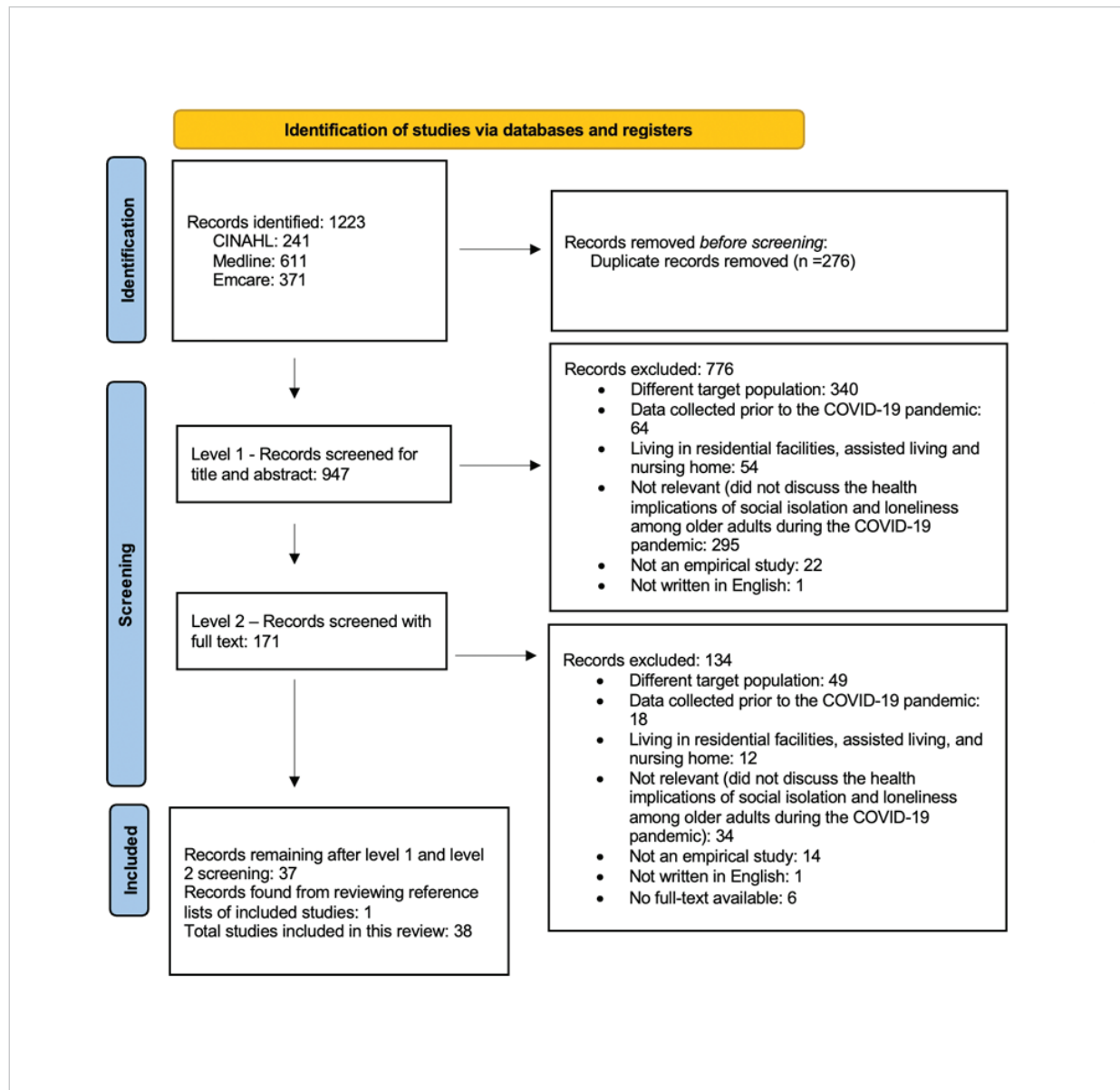
The narrative synthesis approach outlined by Popay et al. (2006) was selected to synthesize the findings of the included studies that varied in research design. The narrative synthesis consists of four elements: (a) selecting a theoretical framework, (b) developing a preliminary synthesis of findings, (c) exploring relationships within and between included studies, and (d) assessing the robustness of the synthesis.

applied to the 947 citations. At level one, 776 records were removed after screening for title and abstract, with 171 records moving to level two, full-text review. A total of 37 studies met the eligibility criteria after level two screening. No additional records were identified through hand-searching key journals, but one resource was included from reviewing the reference lists of included studies. A total of 38 studies were included. The number of records excluded at each level and the reason for exclusion are presented in the flowchart/Figure 1.

RESULTS

The initial literature search produced 1223 records (see Figure 1 for PRISMA flowchart). After removing 276 duplicates, the two-level eligibility screening process was

Figure 1
PRISMA Flow Chart



Included Studies

The scoping review captured a broad range of study designs (i.e., 9 qualitative studies, 24 quantitative studies, and 5 mixed methods) conducted in 15 countries. The country of origin of each study can be viewed in Table 3. Analysis revealed four themes: (a) detrimental effects on physical health and well-being, (b) decreases in mental health and well-being, (c) deterioration of social health and well-being, and (d) positive coping strategies adopted to reduce social isolation and loneliness during the

pandemic. Although many of the experiences identified in this scoping review, such as decline in physical activity, heightened levels of anxiety and depression, may also apply across different age groups during the COVID-19 pandemic, these experiences may have carried particular significance for older adults. The included studies highlight that older adults' experience of social isolation and loneliness, and greater health vulnerabilities likely intensified the impact of these disruptions. Thus, while the themes are not unique to this population, their magnitude and implications appear amplified in later life.

Table 3

Results by Country of Origin of Population Studied

Country	# of Articles	Key Contributors
Turkey	8	Atici et al., 2022; Cigiloglu et al., 2021; Erbesler & Demir, 2022; Gezgin & Ökten, 2022; Guner et al., 2021; Irmak et al., 2021; Yildirim, 2022;
Canada	6	Capicio et al., 2022; Fiocco et al., 2021; Herron et al., 2021; Rawkins et al., 2022; Schmidt et al., 2023; Wei et al., 2023
Japan	5	Gen et al., 2023; Hayashi et al., 2022; Kilic et al., 2023; Kubo et al., 2022; Takashima et al., 2020; Yamada et al., 2021
United States of America	4	Fingerman et al., 2021; Fuller et al., 2022; Jun et al., 2024; Siegmund et al., 2020
England	3	Brooke et al., 2022; Brooke & Clarke, 2020; Brown et al., 2021
Germany	2	Müller et al., 2021; Röhr et al., 2020
Israel	2	Schorr et al., 2021; Shapira et al., 2021
Australia	1	Siette et al., 2023
China	1	Wang et al., 2023
Greece	1	Moustakopoulou et al., 2023
Ireland	1	Bailey et al., 2021
Italy	1	Cipoletta & Gris, 2021
New Zealand	1	Smith et al., 2022
Spain	1	Garner et al., 2022
Taiwan	1	Hsu & Chao, 2022

Detrimental Effects on Physical Health and Well-being

Older adults who experienced social isolation and loneliness during the pandemic reported physical health consequences that can be broadly categorized into three subthemes: (a) decline in physical activity; (b) nutrition risk, and (c) disrupted sleep patterns.

Decline in Physical Activity

More than ten studies reported a reduction in physical activity (Atıcı et al., 2022; Bailey et al., 2021; Brown et al., 2021; Cigiloglu et al., 2021; Cipolletta & Gris, 2021; Fiocco et al., 2021; Garner et al., 2022; Gen et al., 2023; Kubo et al., 2022; Rawkins et al., 2022; Schmidt et al., 2023; Siegmund et al., 2021; Siette et al., 2023; Smith et al., 2022; Yamada et al., 2021). A cross-sectional study conducted by Yamada et al. (2021) analyzed physical activity time and the incidence of frailty among 937 older adults in Japan who were initially non-frail prior to the pandemic. They reported a significant decline in physical activity with a 42.9 % decrease in physical activity time in the first wave of the pandemic, 50 % in the second wave, and 61.9 % in the third wave compared to pre-pandemic levels. Most of these studies reported that involvement in fitness programs decreased in frequency or ceased altogether. This decline in physical activity was associated with deconditioning (Fiocco et al., 2021; Gen et al., 2023; Rawkins et al., 2022), the progression of osteoarthritis (Smith et al., 2022), weight gain (Rawkins et al., 2022), increased pain (Fiocco et al., 2021; Rawkins et al., 2022), and a greater incidence of frailty (Garner et al., 2022). Moreover, based on a cross-sectional study involving 254 older adults in Turkey, Atıcı et al. (2022) found that levels of physical activity decreased as the fear of movement and risk of falling increased, a trend that may have been exacerbated during the COVID-19 pandemic due to stringent isolation measures and reduced access to physical activity opportunities. Women were more likely to report experiencing a greater fear of movement and risk of falling, however an explanation for this relationship was not provided by the authors (Atıcı et al., 2022).

Nutrition Risk

Eleven studies reported influence on dietary habits and nutrition (Bailey et al., 2021; Capicio et al., 2022; Cigiloglu et al., 2021; Cipolletta & Gris, 2021; Irmak et al., 2021; Rawkins et al., 2022; Schorr et al., 2021; Siette et al., 2023; Wang et al., 2023; Wei et al., 2023; Yıldırım, 2022). Cigiloglu et al. (2021) conducted a cross-sectional study among 104 older adults in Turkey and found that women were more likely to report reduced food intake and subsequent weight loss, although the underlying cause of this association was not clarified. In a quasi-experimental intervention study, Capicio et al. (2022) conducted surveys

to explore the impact of a brief nutrition education program on nutritional risk among 25 older adults in Alberta, Canada. The surveys revealed that 19 participants were at high nutrition risk. Interestingly, very few reported experiencing food insecurity or financial strain, highlighting a potential disconnect between perceived and measured nutritional risk. Participants at higher risk were more likely to eat alone and have insufficient intake of key food groups, factors that may have been amplified during the COVID-19 pandemic. However, the authors did not discuss possible explanations for this dissonance between subjective experiences and objective indicators of nutritional risk.

Disrupted Sleep Patterns

Five studies reported disrupted sleep patterns (Bailey et al., 2021; Cipolletta & Gris, 2021; Fiocco et al., 2021; Gezgin Yazici & Ökten, 2022; Rawkins et al., 2022). A qualitative study by Fiocco et al. (2021) analyzed the lived experience of stress and adjustment among 22 older adults in Ontario, Canada and found that participants encountered transient sleep problems during the first six months of the pandemic due to initial concerns about contracting the virus. Similarly, a qualitative study by Cipolletta and Gris (2021) examined the experience of social isolation and loneliness among 30 older adults in Northern Italy. This study found that participants who had family and friends of older age experienced poor sleep quality. Two studies reported experiences of insomnia (Gezgin Yazici & Ökten, 2022; Rawkins et al., 2022). Of these, Gezgin Yazici and Ökten's (2022) in their cross-sectional study with 412 older adults in Turkey reported a greater severity of insomnia among older adults who described themselves as introverted, had contact with individuals diagnosed with the COVID-19 virus, and had a poor perceived health status. Moreover, older adults with less than an undergraduate degree were found to have a higher risk of experiencing insomnia (Gezgin Yazici & Ökten, 2022); however, the authors did not provide an explanation for this finding.

Decreases in Mental Health and Well-being

Several studies reported decreases in mental health among older adults who experienced social isolation and loneliness during the pandemic, identifying two primary areas of concern as heightened anxiety levels and increase in depression.

Heightened Anxiety Levels

Seven studies reported increased anxiety levels (Bailey et al., 2021; Cipolletta & Gris, 2021; Erbesler & Demir, 2023; Fiocco et al., 2021; Guner et al., 2023; Rawkins et al., 2022; Yıldırım, 2022). Cipolletta and Gris (2021) attributed heightened anxiety among older adults to several factors, including the health risks associated with aging,

the uncertainty about the pandemic's trajectory, and the fear of losing a member of their social support network who might have contracted the virus. Likewise, Fiocco et al.'s (2021) study participants reported feeling concerned about their family members catching the virus, especially those who were immune-deficient or living/working in high-risk environments. Participants also expressed ambiguity regarding the pandemic's progression, such as missing human contact and wondering when it would be safe to interact with others in person, to travel, and how long the pandemic might last (Fiocco et al., 2021). Cipoletta and Gris (2021) reported that some participants engaged in ineffective coping strategies, for example, an obsession with rigorous disinfecting regimens in an attempt to reduce the perceived risk of infection. Two studies reported that media exposure to negative and fearful messages about the pandemic contributed to anxiety among older adults (Cipoletta & Gris, 2021; Fiocco et al., 2021).

Three studies found higher rates of death anxiety (Erbesler & Demir, 2023; Guner et al., 2023; Yıldırım, 2022). Guner et al.'s (2023) cross-sectional study with 392 older adults in Turkey, reported that older adults who had low levels of formal education were single, lived alone, and diagnosed with chronic illnesses had statistically significant anxiety about dying as measured by the Death Anxiety Scale developed by Templer (1970). However, the authors did not offer an explanation for these findings. Utilizing the same scale, Erbesler and Demir (2023) investigated death anxiety among 3247 older adults in Turkey and found contradictory results, that is no correlation between death anxiety and education level. In addition, women were found to have higher average death anxiety scores compared to men, and married individuals scored significantly higher compared to individuals who were single. The authors did not provide an explanation for why women had higher death anxiety scores; however, they suggested that the elevated death anxiety among married individuals might be attributed to greater family responsibilities and fears of transmitting COVID-19 to loved ones or losing them to the infection. Although both studies were conducted in Turkey, data collection occurred during different waves of the COVID-19 pandemic. Guner et al. (2021) gathered data during the first wave (May 2020), whereas Erbesler and Demir (2022) collected data during the third wave (June 2021). Anxiety levels likely varied across these stages due to evolving understanding of the virus's transmission, severity, and rapid global spread. Therefore, differences in data collection periods may explain the variations observed in the relationship between death anxiety and the socio-demographic characteristics,

Increase in Depression

Fourteen studies reported an increase in depression (Brown et al., 2021; Cipoletta & Gris, 2021; Erbesler & Demir, 2023; Hayashi et al., 2022; Hsu et al., 2022; Irmak et al., 2021; Jun et al., 2024; Kilic et al., 2023; Moustakopoulou et al., 2023; Müller et al., 2021; Rawkins et al., 2022; Röhr et al., 2020; Schorr et al., 2021; Shapira et al., 2021). Of these, five studies reported having more worries/fears of COVID-19 were associated with higher depressive scores (Hsu et al., 2022; Kilic et al., 2023; Moustakopoulou et al., 2023; Müller et al., 2021; Röhr et al., 2020). A cross-sectional study by Röhr et al. (2020) with 1005 older adults in Germany reported that individuals who felt more restricted by the lockdown measures had higher depressive symptoms on the Brief Symptom Inventory Scale (Derogatis, 1975). In the study, women reported experiencing a greater COVID-19 threat, higher depressive symptoms, and slightly lower resilience than men (Röhr et al., 2020). Likewise, Erbesler and Demir (2023) found that women scored higher than men on the Death Depression Scale (Templer et al., 1990), and married individuals had higher death-related depression scores.

In contrast, a cross-sectional study by Schorr et al. (2021), which analyzed the relationship between loneliness and depressive symptoms among 201 older adults in Israel using the Geriatric Depression Scale (Yesavage & Brink, 1983), found that gender and marital status did not have a significant relationship to depression. Instead, lower formal education levels, older age, and an Arab ethnicity (as opposed to a Jewish ethnicity) were correlated with higher depressive symptoms (Schorr et al., 2021). In summary, social isolation and loneliness increased depression in older adults during COVID-19, though findings on sociodemographic factors were inconsistent. These discrepancies may stem from differences in sample characteristics, such as cultural and ethnic composition, as well as variations in the timing of data collection and the specific measures used to assess depression and loneliness.

Deterioration of Social Health and Well-being

During the COVID-19 pandemic, older adults who were socially isolated and lonely experienced negative impacts on their social health and well-being. The studies revealed that these individuals reported disruptions to their social routines and a loss of connection with members of their support networks.

Disruptions of Social Routines

Fourteen studies highlighted disruptions to social routines that limited opportunities for social engagement (Brooke et al., 2022; Brooke & Clark, 2020; Cipolletta & Gris, 2021; Fiocco et al., 2021; Fuller et al., 2022; Gezgin Yazici & Ökten, 2022; Herron et al., 2021; Jun et al., 2024; Kubo et al., 2022; Rawkins et al., 2022; Schmidt et al., 2023; Siette et al., 2023; Takashima et al., 2020; Yıldırım, 2022). In these studies, social events became infrequent or stopped including grocery shopping, out-of-home dining, participating in religious events, visiting institutional care centers, and attending funerals. Due to visitor restrictions in healthcare facilities, older adults reported having to regularly postpone medical appointments and were unable to visit hospitalized kin and companions.

Loss of Support Networks

Fourteen studies revealed that the pandemic restrictions disrupted older adults' support networks (Bailey et al., 2021; Brown et al., 2021; Cipolletta & Gris, 2021; Fingerman et al., 2021; Fiocco et al., 2021; Fuller et al., 2022; Gezgin Yazici & Ökten, 2022; Herron et al., 2021; Hsu et al., 2022; Kubo et al., 2022; Rawkins et al., 2022; Schmidt et al., 2023; Siette et al., 2023; Yıldırım, 2022). In most of these studies, older adults expressed infrequent or inadequate contact with their families, which might have contributed to the heightened sense of distress and disconnection. Two studies reported older adults felt dependent on their family members for regular physical support such as grocery shopping (Fuller et al., 2022; Yıldırım, 2022); and reported feeling like a burden to their families (Fuller et al., 2022). Cipolletta and Gris (2021) reported that some participants transitioned from being caregivers to needing assistance, losing their personal roles during the pandemic.

Thirteen studies found that older adults were not able to connect with friends or community members (Bailey et al., 2021; Brown et al., 2021; Cipolletta & Gris, 2021; Fingerman et al., 2021; Fuller et al., 2022; Herron et al., 2021; Hsu et al., 2022; Kubo et al., 2022; Rawkins et al., 2022; Schmidt et al., 2023; Siette et al., 2023; Takashima et al., 2020; Yıldırım, 2022). A cross-sectional study by Bailey et al. (2021) with 150 older adults in Ireland found that over half of the participants reported losing connection with friends. More specifically, studies found that some older adults struggled to maintain connections with community members, as they were no longer able to attend community activities, such as religious services or leisure events (Cipolletta & Gris, 2021; Fuller et al., 2022; Takashima et al., 2020) and institutional care centers such as medical facilities (Fuller et al., 2022; Kubo et al., 2022). As a result, older adults particularly those living alone indicated that they yearned for face-to-face contact (Brown

et al., 2021; Rawkins et al., 2022) and human touch (Fuller et al., 2022).

Positive Coping Behaviours

Despite various challenges reported by older adults, studies indicated that they adopted positive coping strategies related to self-care and social support to help counteract the impacts of social isolation and loneliness.

Self-Care Strategies

Twelve studies identified various self-care strategies adopted by older adults to effectively manage social isolation and loneliness during the pandemic (Brooke et al., 2022; Brooke & Clark, 2020; Brown et al., 2021; Cipolletta & Gris, 2021; Fiocco et al., 2021; Fuller et al., 2022; Herron et al., 2021; Schmidt et al., 2023; Shapira et al., 2021; Siette et al., 2023; Smith et al., 2022; Takashima et al., 2020). Self-care is defined as the capacity of individuals to promote their health, prevent illness, and cope with disability independently or with support from a healthcare provider (WHO, n.d.). Some older adults remained active using social media platforms to take part in home-based exercise routines and walking around their neighborhood (Brown et al., 2021; Herron et al., 2021; Siette et al., 2023; Takashima et al., 2020). Furthermore, some viewed the mandatory social distancing measures as an opportunity to reconnect with past hobbies or discover new leisure activities, such as arts and crafts (Cipolletta & Gris, 2021; Fiocco et al., 2021), puzzles (Brooke & Clark, 2020; Siette et al., 2023), gardening (Brown et al., 2021; Fiocco et al., 2021; Herron et al., 2021; Takashima et al., 2020), praying (Cipolletta & Gris, 2021), reading or writing (Brooke & Clark, 2020; Fiocco et al., 2021; Schmidt et al., 2023; Siette et al., 2023), and fulfilling household chores (Cipolletta & Gris, 2021; Fiocco et al., 2021; Herron et al., 2021). Others focused on positive thinking, such as the acceptance of the COVID-19 restrictions (Schmidt et al., 2023; Takashima et al., 2020), being aware of the positive changes made to oneself (Takashima et al., 2020), and expressing a sense of appreciation for life before the pandemic and anticipating a better life after the pandemic (Cipolletta & Gris, 2021).

Social Support

Sixteen studies highlighted various forms of external support that helped mitigate social isolation and loneliness among older adults during the COVID-19 pandemic (Brooke et al., 2022; Brooke & Clark, 2020; Brown et al., 2021; Cipolletta & Gris, 2021; Fiocco et al., 2021; Fuller et al., 2022; Guner et al., 2023; Herron et al., 2021; Jun et al., 2024; Kubo et al., 2022; Röhr et al., 2020; Schmidt et al., 2023; Shapira et al., 2021; Smith et al., 2022; Takashima et al., 2020; Yıldırım, 2022). One study conducted by Fiocco et al. (2021) reported that participants

living with their family members or a spouse expressed feeling grateful for consistent companionship throughout the lockdowns. Another study found that older adults depended on their social support network, commonly family members, to assist with everyday responsibilities such as grocery shopping or to provide emotional support (Cipolletta & Gris, 2021). While conforming to appropriate social distancing measures, older adults found ways to engage in social interactions with their neighbors such as walking their dogs (Brown et al., 2021) and exercising together on opposite sides of the same fence (Brown et al., 2021; Smith et al., 2022).

Twelve studies reported that older adults described technology-facilitated social connection interventions to interact with their social support networks (Brooke et al., 2022; Brooke & Clark, 2020; Cipolletta & Gris, 2021; Fiocco et al., 2021; Fuller et al., 2022; Guner et al., 2023; Herron et al., 2021; Jun et al., 2024; Kubo et al., 2022; Schmidt et al., 2023; Shapira et al., 2021; Smith et al., 2022). Schmidt et al. (2023) found that despite their limited digital literacy, older adults were eager to learn and adopt virtual social platforms to enhance communication with their social networks. Finally, three studies highlighted telephone calls as a means for socializing during the pandemic (Cipoletta & Gris, 2021; Fuller et al., 2022; Kubo et al., 2022), which enhanced emotional support and a sense of solidarity among some.

DISCUSSION

This scoping review provides a comprehensive summary of the health consequences experienced by older adults who faced social isolation and loneliness during the COVID-19 pandemic. While highlighting challenges, it also identifies positive coping strategies adopted by older adults to address their social isolation and loneliness, ultimately enhancing their health and well-being. Social isolation and loneliness were already significant concerns for some older adults prior to the COVID-19 pandemic with resulting health problems, such as increased risks for depression (Capicio et al., 2022; Taylor et al., 2018), diminished sleep quality (Yu et al., 2018), and cognitive decline (Cacioppo & Cacioppo, 2014). However, the nature and extent of these health concerns varied in the pre-COVID-19 pandemic period, as older adults often had relatively more resources and autonomy over their social engagement. Previous literature reported that social isolation was commonly associated with individual circumstances, yet the COVID-19 pandemic drastically intensified these challenges. This was typically mitigated by community engagement, social networks, and in-person support systems. The measures implemented to limit the spread of the COVID-19 pandemic drastically intensified these existing challenges (Hwang et al., 2020). The COVID-19 pandemic led to the sudden closure of

public spaces, community centers, and health services, along with the suspension of in-person interactions to prevent virus transmission. Older adults who were already vulnerable to social isolation now faced complete lockdowns, restrictions on social gatherings, and a significant disruption in routine social contacts. These measures not only limited face-to-face interactions but also hindered access to essential support services, such as physical therapy, and social programs, further exacerbating the negative health consequences (Brown et al., 2021; Hossain et al., 2020). While social isolation and loneliness was already a concern among older adults, the scale and intensity of its effects were amplified by the COVID-19 pandemic's unique circumstances, leading to more profound and widespread consequences for health.

Studies revealed that older adults were less active during the COVID-19 pandemic due to the enforcement of social distancing measures (Reed et al., 2011; Schrempft et al., 2019). More specifically, in this scoping review, one study by Atıcı et al. (2022) found that older women were more likely to experience fear of movement and lower physical activity levels compared to men, with existing literature attributing this increased susceptibility to falls to hormonal changes, such as estrogen decline during menopause, which leads to reduced bone mass density (Endocrine Society, 2022; Maltais, et al., 2009). This finding highlights how gender intersects with age to shape the physical health outcomes of older adults. Likewise, a decline in appetite and food intake was found among older adults, particularly in women who had a greater reliance on social engagement and shared activities, such as communal meals, as a coping mechanism for social isolation and loneliness (Bloom et al., 2017; Pettigrew & Roberts, 2008). Moreover, the literature suggests that being alone is correlated with a lower incentive to prepare and eat meals (Cohen & Cribbs, 2017; Hegge, 1991; Whitelock & Ensaff, 2018). The pandemic-related restrictions that limited social interactions and opportunities for shared dining experiences likely contributed to reduced motivation to cook and eat, leading to decreased food intake and potential nutritional concerns. These findings propose that social isolation intersects with gendered expectations, reinforcing how norms such as meal planning and preparing responsibilities can ultimately shape nutritional well-being. Finally, the reviewed studies identified a link between lower formal education levels among older adults and an increased risk of insomnia (Gezgin Yazici & Ökten, 2022). Research has found individuals with higher levels of formal education (bachelor's degree and above) report more positive attitudes toward COVID-19 and seem less affected by false rumours and news that can often lead to increased stress (Zhong et al., 2020). This finding suggests how a person's unique social determinants, such as education or digital literacy can influence their access to

reliable health information and shape the coping strategies they adopt during the pandemic period. Ultimately, these findings propose that the health of older adults' during the COVID-19 pandemic were influenced by intersecting factors. Gender and education were the most apparent influences on the physical health and well-being of older adults. More specifically, with older women and those with lower education levels reporting a greater susceptibility to physical inactivity, poor nutrition, and sleep quality. However, there are factors such as ethnicity, race, and income, which were not largely investigated or reported in the included studies, ultimately revealing an evident gap within the current literature and in the intersectional analysis.

The scoping review results showed that anxiety levels increased among older adults during the COVID-19 pandemic. This was attributed to factors such as health risks associated with aging, uncertainty about the pandemic's trajectory, fear of losing loved ones, concerns about family members in high-risk environments, and the negative impact of media exposure, with some individuals adopting ineffective coping strategies such as obsessive disinfecting routines. However, two studies reported contradictory findings on death anxiety among older adults during the COVID-19 pandemic. Guner et al. (2023) found higher levels of death anxiety correlated with being single, low levels of formal education, living alone, and chronic illness. In contrast, Erbesler and Demir (2023) found higher death anxiety among women and participants who were married but had no relationship to education level. Both studies were conducted in Turkey, however data collection took place at different times of the COVID-19 pandemic. Heightened levels of anxiety were reported during the beginning stages of the pandemic (Karmakar & Chattopadhyay, 2021), so, the differences in time of data collection in each study might account for the conflicting findings in the relationship between death anxiety and the socio-demographic characteristics of older adults.

This scoping review also found higher depression scores among older adults during the COVID-19 pandemic. Two studies reported higher depression or death-related depression among women during the COVID-19 pandemic (Erbesler & Demir, 2023; Röhr et al., 2020), while one study found no significant gender differences (Schorr et al., 2021). Previous literature has also shown inconsistent findings on this topic prior to the COVID-19 pandemic. A previous study reported higher depression scores among women (Robb et al., 2020), while other research found no statistically significant relationship (Santini et al., 2020). These conflicting findings may be credited to not only the differences in data collection times and geographic context, but also how gender interacts with other social determinants of health. For example, a person's gender can also combine with their other identities such as their

current living environment, education, income, race, disability status, to influence their emotional responses during the COVID-19 pandemic. Therefore, it is difficult to explain the impact of the COVID-19 pandemic on the mental health and well-being on older adults based individually on gender or age. Overall, this represents an apparent gap in the literature as there is a need for future research that highlights intersectional approaches to better understand the mental health disparities among older adults during crises.

Despite the negative health consequences, studies shed light on older adults' resilience. Even while living with social distancing measures, older adults reported engaging in exercise, as well as different leisure activities and hobbies. The use of social media platforms was particularly effective in helping older adults stay connected with their social support networks and engage in home-based exercise. Even prior to the pandemic, research found that some older adults increasingly accessed virtual classes through devices (Aubertin-Leheudre & Rolland, 2020). Platforms like YouTube and Zoom became popular for home fitness due to their low cost and convenience (Sui et al., 2022). Online platforms enabled social engagement despite distancing measures (Ling et al., 2023). Further, technology helped older adults to pursue leisure and education, promoting independent living and enhancing their resilience to cope with isolation (Elimelech et al., 2022; Sixsmith et al., 2022). Ultimately, these findings underscore the importance of digital literacy and access to telecommunication technology as it played an important role in mitigating the negative physical, mental, and social impacts of the COVID-19 pandemic on older adults. It is important to note that these studies also suggest an ongoing digital divide, particularly among older adults with limited digital literacy. Therefore, it is imperative to develop interventions that focus on promoting digital inclusion and providing tailored technological support for older adults. Such efforts are important as they can support older adults' resilience and reduce health inequities in future public health crises.

LIMITATIONS AND STRENGTHS

While this scoping review provides valuable insights on the topic, one key limitation must be considered. The review excluded studies that were published in languages other than English; this may have resulted in the omission of relevant studies from particular cultural or geographical contexts thus limiting the global applicability of the findings. Despite this limitation, this scoping review has important strengths that contribute to the quality and reliability of the findings. It was conducted using JBI methodology, as outlined in the PRISMA-ScR checklist, which offers a comprehensive and structured framework that ensures validity, reliability, and trust in

the findings (Peters et al., 2015). While adherence to the JBI methodology and PRISMA-ScR checklist ensures transparency and replicability, the trustworthiness of the scoping review findings also depends on the reviewers' integrity, reflexivity, and collaborative analytic process. The screening process was undertaken by two team members independently to ensure reliability and reduce the potential for interpretive bias. Applying an intersectional lens revealed that experiences of social isolation and loneliness among older adults are shaped by overlapping social identities and contexts, such as a person's gender and socioeconomic position. Highlighting these intersections in this scoping review reinforces the utility of intersectionality as an analytical framework for future studies on social isolation among older adults.

IMPLICATIONS

Overall, this scoping review reveals the health implications of social isolation and loneliness among community-dwelling older adults that are shaped by intersecting factors. While experiences of social isolation were widespread across different populations, previous literature has reported older adults to be at increased risk due to their reduced social network, as well as health and mobility limitations. The findings of this scoping review have implications that extend beyond the individual-based nursing care and education. More specifically, it is important to consider broader community-level and system-level strategies that must be implemented to promote social connection and resilience in age-friendly communities that are prepared in times of public health crisis.

System- and Policy-Level Implications

There is a need for public health planning to create safe age-friendly communities that support engagement during public health crises, such as pandemic lockdowns, where older adults must maintain stringent social distancing measures. Moreover, the government must provide additional funding to bridge the digital divide among older adults. It is essential to ensure that the internet is accessible, so older adults can interact with their support system using different social media platforms. There is also a need to implement digital literacy programs that are accessible to older adults that provide training that is tailored to their unique needs (Zapletal et al., 2023)

Nursing and Practice Implications

As frontline practitioners, gerontological nurses must address social isolation and loneliness among older adults through a holistic and person-centred approach that extends beyond individual attention. In particular, gerontological nurses must implement regular screenings for social isolation and loneliness throughout their routine

nursing assessments across care settings. Gerontological nurses are well positioned to advocate for better access to technology and community resources that are accessible to older adults and that can promote their social connection and support healthy aging.

Research Implications

Quarantine policies differed across countries worldwide. South Korea and Sweden refrained from implementing stringent quarantine measures to mitigate the spread of COVID-19 (Bhatia et al., 2021; Dighe et al., 2020). However, no studies included in this review were conducted in South Korea and Sweden. Future research can explore whether older adults in countries that did not implement strict measures, experienced social isolation and loneliness, and the impact on their health compared to those in countries with more restrictive social distancing policies. Furthermore, important intersecting factors such as culture, race, and disability have been insufficiently investigated in current research. The literature also presents notable inconsistencies regarding how particular factors interact to influence the mental health and overall well-being of older adults. Addressing these gaps through intersectional and context-sensitive research is essential for developing a more holistic understanding of social isolation in later life.

CONCLUSION

The findings from this scoping review highlight the adverse health implications of social isolation and loneliness among older adults during the COVID-19 pandemic. The results of this scoping review emphasize that older adults are resilient, able to adopt coping strategies that reduce social isolation and loneliness, and in doing so, manage their health and well-being. Nurses can draw upon the findings of this scoping review to provide education on social connection and implement early screenings of social isolation and loneliness. More funding is needed from the government to improve accessibility to technology among older adults. Future research is imperative to determine the social isolation and loneliness experiences among older adults in countries with less strict social distancing mandates, and to contrast their health outcomes to those in countries with more restrictive measures.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

Key Points

- No scoping reviews could be located that investigated the health implications of social isolation and loneliness among community-dwelling older adults during the COVID-19 pandemic.
- Applying the Joanna Briggs Institute scoping review guidelines and PRISMA-ScR checklist, a comprehensive search undertaken in relevant databases identified 38 studies.
- Studies reported on the adverse effects of social isolation on the physical health of adults, including reduced physical activity, increased nutrition risk, and disrupted sleep patterns.
- Mental health of older adults was also negatively affected, with studies reporting heightened levels of anxiety and depression.
- Several studies noted that older adults experienced disruptions to their daily routines, which limited opportunities for social engagement.
- Despite these challenges during the COVID-19 pandemic, older adults demonstrated resilience by adopting coping strategies and drawing on their social support network to mitigate the negative implications of social isolation and loneliness on their overall health and well-being.

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INTENTION TO USE LONG-TERM CARE AMONG CHINESE CANADIAN FAMILY CAREGIVERS: A QUANTITATIVE STUDY WITH SUPPLEMENTARY QUALITATIVE FINDINGS USING ANDERSEN'S BEHAVIORAL MODEL

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ABSTRACT

Many Chinese Canadian caregivers face challenges when deciding whether to place aging parents in long-term care, often due to strong cultural expectations and limited access to clear information. Using Andersen's Behavioral Model of Health Service Use, this study examined how predisposing, enabling, and need factors shape caregivers' intentions to use long-term care. A 2019 survey of 61 caregivers included two open-ended questions to provide additional context. Quantitative results showed that male caregivers were more likely than female caregivers to consider long-term care, and in-law caregivers were more open to placement than adult children. Qualitative responses identified several key barriers, including financial concerns, language difficulties, and limited

knowledge of available services, while social support helped ease decisions. Cultural values, especially filial piety, continued to influence attitudes even when not reflected in quantitative scales. These findings highlight the need for culturally sensitive nursing approaches and better access to linguistically appropriate resources. Future research should include larger and more diverse samples to deepen understanding of long-term care decision-making.

BACKGROUND

The Chinese Canadian population is growing, and many families continue to follow filial piety, a value that emphasizes respect, obligation, and care for aging parents (Lum et al., 2016). These beliefs bring meaning to caregiving but also increase stress when support is limited (Awasthi & Awasthi, 2017; Cheung & Kwan, 2009;). Many caregivers face language barriers, limited knowledge of the health system, and a lack of culturally appropriate services, which can delay help-seeking and increase burden (Chou et al., 2002; Lai, 2007;). In this study, long-term care primarily refers to facility-based residential care, such as nursing homes or personal care homes, while home care services are discussed as related but distinct forms of formal support.

Long-term care decisions are often difficult. Some caregivers avoid placement because it may be seen as a failure of filial duty or may draw criticism from family or community members (Chang & Schneider, 2010; Hui et al., 2022). Strong cultural beliefs play a major role in how families think about institutional care (Gazaway et al., 2024). Relationship quality, acculturation, and gender further influence caregiving patterns. Positive relationships predict caregiving more than obligation alone (Vangen & Herlofson, 2024), and expectations persist across generations (Miyawaki, 2020). Women often take on more caregiving work and experience more strain (Gösenbauer et al., 2025). Family involvement can also limit individual autonomy when adult children act as surrogate decision-makers (Yan & Yang, 2025). Recent research has shown that caregiving roles and involvement in long-term care vary by family relationship and social context, as well as across countries and care systems. A Canadian study found differences in caregiving patterns between spouses/partners and adult children of long-term care home residents, highlighting how family roles shape caregiving involvement and decision-making (Ménard et al., 2025). Similarly, cross-country evidence demonstrates that expectations and responsibilities associated with the caregiver role differ across cultural and national contexts, underscoring that caregiving norms are not universal (Zarzycki et al., 2024). These findings support the importance of examining long-term care decision-making within specific cultural groups, such as Chinese Canadian

family caregivers. Although these studies highlight how cultural values, family dynamics, and gender roles affect caregiving, little quantitative research has examined how Chinese Canadian families make decisions about long-term care. This gap shows the need for research that explores how cultural beliefs, resources, and caregiver burden shape the intention to use long-term care.

CONCEPTUAL FRAMEWORK

This study used Andersen's Behavioral Model of Health Service Use (Andersen, 1968; Andersen & Newman, 1973), which groups influences on service use into predisposing, enabling, and need factors. Although the model was developed several decades ago, it remains widely used and has been adapted to examine both intention to use and actual use of health services across diverse populations. The model is well suited to this study because it allows cultural beliefs, family context, and caregiver burden to be examined together when exploring decisions about facility-based long-term care.

- Predisposing factors include demographic characteristics and cultural beliefs. In this study, predisposing factors included caregiver age, gender, relationship to the care recipient, living arrangement, and cultural values such as filial piety, which shape attitudes toward long-term care. Enabling factors refer to resources that support or limit access, such as income, social support, language, and culturally appropriate services.
- Need factors reflect the care recipient's health status and caregiver strain. Higher burden often increases consideration of long-term care (Bastawrous, 2012).

The Andersen model has been used in previous studies examining service use among Chinese Canadian caregivers (Lai, 2008). However, strong cultural expectations and family roles may still delay the use of formal long-term care services, even when care needs and caregiver burden are high.

METHODS

This study used a quantitative design with limited open-ended questions to provide contextual support, rather than a formal mixed methods approach to examine how predisposing, enabling, and need factors predicted caregivers' intention to use long-term care (Andersen, 1995). Data were collected through an online Qualtrics survey available in English and Chinese from September to October 2019.

The survey was translated into Mandarin using a forward-translation process by a bilingual researcher. The translated version was reviewed by a second bilingual individual

to ensure clarity and cultural equivalence. Minor discrepancies were discussed and resolved to ensure accuracy and consistency across languages.

SAMPLE AND RECRUITMENT

Participants were recruited through online community advertisements and flyers posted in a Chinese supermarket in Winnipeg. Eligible participants were adult Chinese Canadians who were primary caregivers for an aging family member. In total, 82 caregivers responded, and 61 completed the survey fully or partially. A priori sample size considerations were guided by Green's (1991) recommendation for multiple linear regression ($50 + 8m$), which indicates a minimum sample of 66 participants for a model with two predictors. The final analytic sample of 61 caregivers was slightly below this threshold; therefore, the results should be interpreted as exploratory. Missing data was minimal and occurred mostly at the item level rather than across full scales. Listwise deletion was used for analyses requiring complete cases, resulting in a final analytic sample of 61. No imputation was performed because the proportion of missing data was small and not systematic.

MEASURES

Demographic Questionnaire

Participants completed an investigator-developed demographic form that included age, gender, marital status, education, employment, income, and caregiving duration.

Contemporary Filial Piety Scale (CFPS-10)

Filial piety was measured using the CFPS-10, a validated 10-item instrument designed to assess contemporary filial attitudes and behaviors in Chinese cultural contexts (Lum et al., 2016). In the original validation study, the CFPS-10 demonstrated good internal consistency (Cronbach's $\alpha > .80$) and strong construct validity (Lum et al., 2016). In the present study, Cronbach's alpha was 0.82.

Caregiver Burden Inventory (CBI)

Caregiver burden was assessed using the CBI, which measures burden across five domains: time-dependence, developmental, physical, social, and emotional burden (Chou et al., 2002). The CBI is widely used in Chinese caregiving research. In the present study, reliability was excellent (Cronbach's $\alpha = 0.95$).

Desire-to-Institutionalize Scale (DTI)

Caregivers' intention to consider long-term care placement, specifically facility-based residential care, was measured using Morycz's DTI scale (Morycz, 1985).

This tool assesses caregivers' thoughts and plans regarding institutionalization. The Cronbach's alpha for the DTI in this study was 0.82, indicating good internal consistency.

Open-Ended Questions

To supplement quantitative data, two open-ended questions were included:

1. "What are the barriers you have encountered when making decisions about long-term care for your elderly parent(s)?"
2. "What are the factors that helped you make decisions about long-term care for your elderly parent(s)?"

These responses provided additional contextual depth to the quantitative results.

DATA ANALYSIS

Quantitative data were analyzed using descriptive statistics to summarize sample characteristics and scale scores. Cronbach's alpha confirmed good reliability for all instruments. Because several variables were ordinal or non-normal, non-parametric tests were used. Spearman's rank correlation assessed associations with the DTI score, and group differences were examined using Mann-Whitney U and Kruskal-Wallis tests. Variables with $p < .10$ in bivariate analyses were entered into a multiple linear regression model. Assumptions for normality, linearity, and multicollinearity were checked before running the model, which included caregiver gender and caregiver relationship as predictors of intention to use long-term care. Given the exploratory nature of the study and modest sample size, a significance level of $p < .10$ was used for bivariate screening to reduce the risk of excluding potentially meaningful predictors from multivariable analysis. All individual variables within the predisposing, enabling, and need domains were examined in bivariate analyses. Most did not reach statistical significance and were therefore not entered into the regression model. The study focused on individual predictors rather than aggregated domain scores.

Qualitative responses were analyzed using thematic content analysis. The researcher coded all responses, and a second reviewer examined a subset to refine the coding structure. Discrepancies were resolved through discussion, and final themes were used to support and enrich the quantitative findings.

Ethics Considerations

Prior to the commencement of data collection, ethical approval was obtained from the University of Manitoba Health Research Ethics Board.

All participants were informed about the purpose of the study and provided informed consent before participation.

RESULTS

Descriptive Statistics

A total of 82 family caregivers responded to the online survey, with 61 completing it either fully or partially. Typical Chinese Canadian family caregivers were younger than 40 years of age (47.5%), female (80.3%), legally married or living common-law (90.2%), daughters of the care recipient (60.7%), and had lived in Canada for more than five years (63.9%). Approximately 48% of caregivers lived with their care recipients. The majority of caregivers (93.4%) had graduated from college or university and were employed (70.5%). Most caregivers reported an annual income of more than \$50,000 (63.9%) and had been caregivers for at least five years (63.9%).

The mean age of care recipients was 69.6 years ($SD = 9.7$, ranging from 49 to 89 years). Most care recipients were not receiving formal home care services (95.1%) and only 8.2% of caregivers reported having any knowledge about home care. Most caregivers spoke Mandarin (91.8%).

Correlation and Regression Analyses

Spearman's rank correlation coefficient analysis showed no significant correlation between the caregiver's intention to use long-term care (as measured by Morycz's DTI) and continuous variables, such as care recipient's age, caregiver filial piety, and caregiver burden inventory scores. Length of residence in Canada was examined descriptively and in bivariate analyses but was not significantly associated with caregivers' intention to use long-term care. However, the Mann-Whitney Rank Sum Test indicated that male caregivers had a significantly higher intention to use long-term care ($Mdn = 2$) than female caregivers ($Mdn = 0$; $U = 101$, $p = 0.043$). The Kruskal-Wallis H test revealed no statistically significant differences in caregivers' intention to use long-term care based on the relationship with the care recipient, the care recipient's age, or primary language. However, an exploratory analysis identified a borderline significant relationship ($p < 0.1$) between 'in-law' caregivers and their intention to use long-term care.

Following the exploration of bivariate association, a multiple regression analysis was conducted to predict caregivers' intention to use long-term care facilities, as measured by Morycz's DTI scale (the dependent variable). Independent variables included caregiver gender and caregiver relationship with the care recipient, which were selected based on prior bivariate tests that showed statistical or borderline significance.

A significant regression equation was found ($F(2, 43) = 6.262, p = 0.004$), with a R^2 of 0.226. The predicted caregiver's (CG) intention to place the care recipient (CR) into a long-term care facility was calculated to be equal to $2.179 - (1.679 * \text{CG Gender}) + (0.833 * \text{CG relationship with CR})$. In this equation, caregiver gender was coded as

1 for male and 2 for female, and CG relationship with CR was coded as 1 for son, 2 for daughter, and 3 for others. In other words, the caregiver's gender and relationship with the care recipient explained 23% of the variability in the caregiver's intentions to use long-term care services (see Table 1 below).

Table 1

Multiple regression selection model for the intention to use long-term care facility (n=61)

Variable	P	Coefficient	Std. error	Model R2
Caregiver gender	0.005	-1.679	0.568	0.226
Carer relationship with CR	0.026	0.833	0.362	
Constant	0.082	2.179	1.225	

These findings suggest that male caregivers were more likely than female caregivers to consider institutionalizing their aging parents. This may reflect traditional gender roles in Chinese culture, where women—especially daughters—are culturally expected to assume hands-on caregiving responsibilities at home (Chappell & Kusch, 2007). In contrast, male caregivers may feel more socially permitted to seek external caregiving support, including long-term care services. Additionally, caregivers who were sons- or daughters-in-law (coded as “others” in this study) showed a higher intention to institutionalize care recipients than biological sons or daughters. This may indicate a lower sense of filial obligation among in-law caregivers or more practical decision-making when cultural expectations are perceived as less personally binding.

Open-Ended Questions

Participants were asked about barriers and facilitators in their decision-making process for long-term care and home care services. Responses were categorized into five themes: finances/costs, filial responsibility/cultural expectations, language barriers, need for information, and social support/assistance. These are summarized in Table 2. Of the 61 participants, 29 responded to the question on barriers and 21 responded to the question on facilitators. Responses were brief and typically consisted of single words or short phrases rather than detailed narratives. The qualitative data were therefore used to provide contextual support for the quantitative findings rather than for in-depth qualitative analysis.

The most frequently identified theme was need for information, followed by social support and assistance, filial responsibility/cultural expectations, finances or costs, and language barriers. Although participants' responses were concise, the distribution of themes highlights the practical and cultural factors that caregivers considered when making decisions about long-term care and home care services.

The qualitative themes complemented the quantitative findings by highlighting the complex interplay between cultural expectations, resource availability, and practical constraints faced by Chinese Canadian family caregivers. The importance of filial responsibility, language barriers, financial considerations, information gaps, and available social supports is closely aligned with Andersen's Behavioral Model of Health Service Use's predisposing, enabling, and need factors. This underscores the necessity for culturally attuned nursing interventions, improved access to linguistically appropriate information, and targeted support systems to effectively assist Chinese Canadian caregivers in their roles.

Table 2
Themes

Theme	Description	Supporting Quotes
Finances/Costs (n = 6)	Economic factors significantly influenced caregiving decisions	"Economic factors"; "Financial burden"; "Costs are very high"
Filial Responsibility/Cultural Expectations (n = 8)	Cultural norms, especially filial piety, played a critical role in decision-making	"Filial responsibility"; "Traditional culture"; "Cultural expectation to provide care myself"
Language Barriers (n = 6)	Primary language posed challenges for both caregivers and care recipients in accessing services	"Language barrier"; "My parent can't communicate in English"; "Language is a barrier for accessing long-term care"
Need for Information (n = 13)	Lack of information about available services hindered informed decision-making	"Need more information"; "Don't know much about long-term care services"; "Information is not easily accessible"
Social Support/Assistance (n = 12)	Availability of social support significantly impacted caregiving decisions	"When parents are healthy, no need to send them to nursing home"; "Availability of family support"; "Community support"

DISCUSSION

This study explored how predisposing, enabling, and need factors influence Chinese Canadian family caregivers' intentions to use long-term care services for their aging parents. The primary quantitative finding was that male caregivers were significantly more likely than female caregivers to consider institutionalization. Additionally, the relationship between caregiver and care recipient was a borderline significant predictor, with in-law caregivers being more likely to consider long-term care than biological sons or daughters. This finding aligns with existing literature that suggests caregiving roles and decisions can differ markedly based on familial relationships (Mitchell, 2014; Rubinstein, 1987). The relatively young age of caregivers may reflect immigration patterns among Chinese Canadian families, where adult children often assume caregiving roles while balancing employment and family responsibilities. Recruitment through a community supermarket may also have favoured younger, mobile caregivers. Although this study found that in-law caregivers were more inclined to consider institutionalization, the underlying emotional or social pressures they may experience were not explicitly explored in this study. This suggests a potential area for future research. These findings help explain why many Chinese Canadian caregivers delay or avoid considering long-

term care, even when caregiver burden is high. Cultural expectations, limited system knowledge, and lack of culturally safe services continue to shape how families make decisions. By identifying which factors most strongly influence intention to use long-term care, this study shows where support is most needed. The results add new evidence for an under-studied population and highlight the importance of addressing cultural values and caregiver strain together rather than separately. Although caregivers also discussed home care in the qualitative responses, the primary outcome of this study focused on intention to use facility-based long-term care. Consistent with recent Canadian and cross-national research demonstrating variation in caregiving roles and expectations, the findings of this study suggest that cultural values and family roles continue to shape long-term care decision-making among Chinese Canadian caregivers (Ménard et al., 2025; Zarzycki et al., 2024). Together, these studies reinforce the need to consider cultural context when examining caregivers' intentions to use long-term care services, rather than assuming caregiving experiences and decisions are uniform across populations.

In the present study, the participants' qualitative responses provided deeper insights into the quantitative findings. Participants highlighted key factors influencing their

decision-making, including financial constraints, strong cultural expectations rooted in filial piety, communication challenges related to language barriers, gaps in information regarding available services, and the critical role of social support. These qualitative themes illuminated the nuanced, real-world complexities caregivers navigate, extending beyond what could be captured by standardized quantitative instruments. Of particular note was participants' strong emphasis on cultural expectations, notably filial piety, despite quantitative measures not showing significant correlation. The absence of these culturally specific factors from standardized research instruments highlights a critical limitation and points to the need for more culturally attuned assessment tools. This discrepancy also suggests that cultural norms are deeply ingrained and continue to influence caregiving decisions in ways traditional measurement scales might not fully address. Additionally, the emergence of themes such as finances, language barriers, and information gaps, areas not directly addressed by the quantitative instruments highlight the added value of qualitative data and points to important avenues for future research and tool development.

These findings collectively underscore the importance of adopting quantitative study with supplementary qualitative insights research approaches to comprehensively understand caregiving experiences and decisions. In addition, the integrated qualitative and quantitative findings emphasize crucial implications for nursing practice. There is a clear need for culturally sensitive interventions, improved access to linguistically appropriate resources, and targeted support systems tailored specifically to the unique context of Chinese Canadian family caregivers.

IMPLICATIONS FOR GERONTOLOGICAL NURSING

The findings of this study highlight several important implications for gerontological nursing practice. First, nurses need to recognize how cultural expectations, especially filial piety shape Chinese Canadian caregivers' beliefs about long-term care. Understanding these cultural values can help nurses provide care that is respectful, non-judgmental, and culturally safe. Taking time to explore caregivers' concerns about "fulfilling filial duty" can also open conversations about realistic caregiving expectations and reduce feelings of guilt or stigma.

Policy Implications

These findings suggest that supportive policies are needed to reduce barriers for immigrant caregivers. Policies can

expand interpreter access, improve navigation support, and increase outreach to communities that may delay seeking long-term care. Funding for culturally safe programs in long-term care and home care can also reduce stigma and help families make more informed choices earlier.

Practice Implications

Health-care providers should recognize how filial expectations influence decision-making. Simple actions such as asking about cultural beliefs, offering interpreter support, and explaining long-term care processes clearly can reduce caregiver stress. Providers should also monitor caregiver burden more closely and offer early referrals to community programs. Working with community leaders may help build trust and improve communication with families who feel torn between cultural duty and care needs.

Economic Implications

Delayed use of long-term care can increase caregiver burnout and lead to higher health-care use, including emergency visits or unplanned hospitalizations. Helping families access timely support may lower these downstream costs. Investments in culturally appropriate services—such as language access or outreach programs—are relatively low-cost but may prevent crisis-driven admissions, which are more expensive for the system. Supporting family caregivers earlier can also help sustain caregiving at home, reducing long-term system pressure.

Second, many caregivers in this study identified difficulty accessing information and services, especially due to language barriers and unfamiliarity with the health care system. Gerontological nurses can play a key role in improving access to clear, culturally appropriate information about long-term care options, home care programs, and community supports. Offering translated materials, connecting families with interpreter services, and directing them to community organizations that support Chinese caregivers can make a meaningful difference.

Third, the association between caregiver burden and intention to consider long-term care shows that nurses should routinely assess caregiver stress. Early identification of physical and emotional strain can help prevent crisis-driven decisions. Nurses can support caregivers by encouraging respite use, arranging earlier referrals to home care, and providing education on managing stress.

Finally, nurses working with older adults and their families can help normalize conversations about long-term care as one option within a continuum of care. Approaching these

discussions early, using culturally sensitive language, and inviting family participation can support shared decision-making and improve trust in the health care system. These nursing actions may help caregivers feel more prepared and confident when making long-term care decisions.

LIMITATIONS

This study has limitations. The sample size was modest and may reduce the statistical power to detect smaller associations. Length of residence in Canada was measured as a proxy for acculturation; however, the modest sample size limited the ability to examine its influence in greater depth. Future research with larger samples should examine acculturation using more comprehensive measures. The use of a convenience sample recruited primarily from a single community supermarket limits generalizability and may reflect the experiences of more engaged or mobile caregivers. In addition, the final sample size was slightly below recommended guidelines for multiple regression analysis, which may have limited the ability to detect weaker relationships among variables. Missing data were minimal but may still have affected the precision of some analyses. As an exploratory study, the findings are intended to identify early patterns rather than make broad generalizations. Future research with larger samples and longitudinal designs is recommended.

CONCLUSION

This study shows that combining quantitative data with brief qualitative insights helps capture the complex factors that shape long-term care decisions among Chinese Canadian caregivers. Cultural expectations, especially filial piety, continue to influence how families view institutional care, even when caregiver burden is high. Using the Andersen Behavioral Model provided a useful way to understand how cultural beliefs, available resources, and practical barriers interact in this decision-making process.

The findings highlight the need for culturally sensitive approaches in gerontological nursing. Clear information, language support, and accessible community resources can help caregivers feel more confident and reduce crisis-driven decisions. Developing multilingual materials, improving navigation support, and building stronger community partnerships may also strengthen caregiver support. Future research should include larger and more diverse samples, as well as assessment tools that reflect cultural values more accurately. These findings can guide both nursing practice and policy development to better address the cultural and practical needs of immigrant family caregivers.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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ARTFUL MOMENTS: AN ARTS-BASED PROGRAM TO FOSTER WELLBEING IN PERSONS LIVING WITH DEMENTIA

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Keywords: dementia, art galleries, museums, wellbeing, stigma, social isolation.

ABSTRACT

Engaging in art can enrich the lives of people living with dementia by increasing creativity, enhancing self-worth, offering a means of expression, and providing social connection. Art galleries are now working hard to become welcoming and inclusive. For people whose abilities are different or have changed, museums can be places for relevant, safe, and meaningful participation and connection; opportunities to share enjoyable experiences; a great stimulus for communication and sharing; and a place to be reminded that persons living with dementia are part of a community to which they can contribute. We describe how *Artful Moments*, a program created by the Art Gallery of Hamilton (AGH) with an interdisciplinary team of art gallery educators/artists and health professionals from a complex continuing care hospital, sought to improve the wellbeing of older adults living with dementia. An evolving model for successful engagement that guided the development of the program is described, as well as a brief outline of the two pilot projects that were implemented and evaluated. We introduce *Artful Moments: Shared Learning*, an innovative e-learning curriculum that has resulted from this successful collaboration and encourage gerontological nurses to become involved with creating programming at their local museums and galleries.

ARTFUL MOMENTS: AN ARTS-BASED PROGRAM TO FOSTER WELLBEING IN PERSONS LIVING WITH DEMENTIA

Research has demonstrated that engaging in art can enrich the lives of persons living with dementia (Belver et al., 2018; Kenning & Visser, 2021; Letrondo et al., 2023). When persons living with dementia engage in art the benefits include increased creativity, enhanced self-worth, and a means of expression (Clarke-Vivier et al., 2017). The focus is on enhancing abilities rather than focusing on disabilities. There also appears to be a link between social and creative activities, and the preservation of cognitive function (Hendriks et al., 2019). As well, in the past few years as art galleries have been seeking ways to connect with diverse populations, there has been a shift towards galleries as important places for health- and wellbeing-related experiences (Camic et al., 2014; D'Cunha et al., 2019; Pearman, 2014; Rosenberg, 2009).

In this article we describe how *Artful Moments*, a program originally created by the Art Gallery of Hamilton (AGH) with an interdisciplinary team of educators from the AGH and health professionals from a complex continuing care hospital, sought to improve the wellbeing of older adults living with dementia. An evolving model for successful engagement that guided the development of the program is described, as well as a brief outline of the two pilot projects that were implemented and evaluated. We introduce *Artful Moments: Shared Learning* an innovative e-learning curriculum that has resulted from this successful collaboration and encourage gerontological nurses to explore this curriculum and become involved with creating programming at their local museums and galleries.

Wellbeing vs. Stigma and Social Isolation

The Canadian Index of Wellbeing National Report (University of Waterloo, 2016) indicates that "time spent in leisure and culture is often when our lives are most fulfilling – when we can really be ourselves with friends, family and people in the community" (p. 76). Art can open new experiences, emotions, interpretations, and recollections of past memories. Museums and galleries are places where rich cultural collections and stories connect us to our world, help us find meaning, and take us out of the everyday – and they can do this no matter our knowledge of the subject, our abilities, or personal circumstances. Thomson et al. (2018) found that people living with dementia who participated in museum-based programs reported several benefits including feeling socially engaged, increased positive emotions, and overall enhanced wellbeing.

Falk (2009, 2022) has spent many years investigating the impact museums can have on the wellbeing of their visitors. Clarke et al. (2020) have written extensively about wellbeing in persons living with dementia, and Moll and colleagues (2014) have developed the 'Do-Live-Well Framework' that encourages "reflection and discussion about the ways in which everyday activities impact health and wellbeing" (p. 17).

Conversely, isolation caused by stigma, fear, or lack of access can be a barrier for people living with dementia to live fully with dignity and respect (Ioannidis et al., 2025). In a recent survey by the Hamilton Council on Aging (2021) only 20% of respondents indicated that persons living with dementia felt they were a valuable part of the community and 47% felt there were no opportunities for persons living with dementia to engage in community activities in the region. When full community access is prioritized, participants see themselves as vital members of the community. But this requires change – eliminating barriers, improving awareness and belief in access, and focusing on people first.

The stigma or fear associated with a diagnosis or a visible disability can shrink a person's social connections (Ioannidis et al., 2025). Social isolation and loneliness are increasingly being recognized as a priority public health problem and policy issue across all age groups. Older adults and persons living with disabilities or other conditions including dementia are particularly at risk (Sabatini et al., 2024). Stigma profoundly affects the wellbeing of people who experience it and it can change the way they feel about themselves and how others see them.

How Can Museums and Galleries Make a Difference?

While traditionally perceived as places for people with higher education, knowledge, experience, social standing or artistic talents, museums and galleries are working hard to present a very different sense of welcome and inclusion. For people whose abilities are different or have changed, museums can be places for relevant, safe, and meaningful participation and connection; opportunities to share enjoyable experiences; a great stimulus for communication and sharing; and a place to be reminded that they are part of a community and can contribute (Kilgour-Walsh et al., 2024). When programs are focused on strengths and people, facilitators adapt to the participants – not the other way around. When people feel seen, safe and welcomed, feelings of social isolation are quickly replaced with social connection (Kilgour-Walsh et al., 2025).

Museums and galleries provide a unique setting for engagement and the validation of identity and self-worth for people living with dementia. As non-medical settings,

they offer meaningful and creative opportunities for self-expression and connection prompted by works of art and hands-on experiences, while also demonstrating the strengths and abilities of persons living with dementia and other at-risk populations to contribute and succeed in a variety of activities (Cotter & Pawelski, 2022). Through museum experiences, people are encouraged to pursue their individual interests, ideas, and expressions that enhance "flourishing" (Cotter & Pawelski, 2022, p. 288) regardless of their abilities.

There can be a great deal of value for health care professionals, including gerontological nurses, becoming involved in the creation of these programs and recommending participation in activities and experiences such as art and music programs that will impact a person's wellbeing. It does, however, need a formalized, structured approach with concrete direction on how to engage with an organization (Cotter & Pawelski, 2022) – just recommending to a client that they attend an art or music program is not enough incentive.

Developing a Learning Resource for Museums and Galleries

The Art Gallery of Hamilton (AGH) was founded in 1914 and is the oldest and largest art gallery in southern Ontario with a permanent collection of over 12,000 objects that is recognized as one of the finest in Canada. The collection comprises historical and contemporary Canadian and international art. In recent years the AGH has focused on collecting works by Indigenous artists, artists of colour, and women artists. In the past decade it has developed programs to address specific wellness needs in the community using the arts to support people's social, emotional, and physical wellbeing in meaningful ways regardless of abilities, circumstances, or prior experiences with art (Kilgour-Walsh et al., 2025).

In 2022, funding was received by the AGH from the Public Health Agency of Canada (Dementia Strategic Fund – Awareness Raising Initiatives) to develop a resource to help organizations create programs of their own for people living with dementia. This resource was designed by an interdisciplinary group of people, including AGH staff, retired clinical staff who had worked in dementia care in a complex continuing care hospital in Hamilton, Ontario, and an online learning web design company. It was a culmination of what was learned from the literature and from our own experiences over 10 years of developing the *Artful Moments* program for persons living with dementia.

The product was a 6-module online self-directed learning curriculum (*Artful Moments: Shared Learning*) to guide museums and galleries through the process of designing and delivering a program that is specific to their own

museum and collection. On the *Artful Moments: Shared Learning* website is a downloadable workbook, videos, and several additional learning resources. There is no cost to accessing the website at www.artfulmoments.ca

To continue to encourage other museums and galleries to develop their own programs, the Canada Council for the Arts' Sector Innovation Fund has recently provided funding to the AGH to offer a coaching initiative to 25 museums across Canada to help them implement their own *Artful Moments*-type programs using the '*Artful Moments: Shared Learning*' curriculum as a guide. Seven synchronous virtual sessions guide the museum participants through each module with opportunities to connect individually with members of the *Artful Moments* team including those with expertise in dementia, in art, and in education. Through this collaborative effort museums can design their personalized program aligned with their collections and mandate.

THE AGH ARTFUL MOMENTS PROGRAM

The seeds for *Artful Moments* were planted as the result of a collaboration between the AGH and St. Peter's Hospital, a complex continuing care hospital in Hamilton. In 2009, a new wing (Behavioural Health) was built at St. Peter's for persons experiencing the later stages of dementia with behavioural expressions that could not be managed in long term care. The AGH was asked to coordinate artwork for this new wing. Instead of the art being chosen by administrators or staff, the patients themselves were asked to choose what would hang on the walls. Over a series of visits, artworks were brought to the hospital and shown to patients, and through facilitated discussion in focus groups, patients selected the artworks for purchase. Table 1 outlines the evolution of the program.

The Initial Pilot Project at the Hospital and the AGH

This early collaboration between the AGH and St. Peter's led to the initial *Artful Moments* pilot project. This project was inspired by the Museum of Modern Art (MoMA) in New York City's 'Meet Me at MoMA' program (MacPherson et al., 2009; Rosenberg, 2009), one of the first major museums to develop a program of art for persons living with dementia. *Artful Moments* differed from the MoMA program in that the participants were persons living with dementia in the later stages who were in hospital. It included both art conversation and art making, and it took place in alternating settings – at the AGH and at the hospital. This pilot project was held over a 10-month period in 2012/13 and was funded by the Ontario Arts Council and the St. Peter's Hospital Foundation with ethics approval from the Hamilton Integrated Research Ethics Board (REB#13-105).

Table 1

Timeline – the Evolution of the ‘Artful Moments’ Program

Date	Initiatives	Funding Source
2009	Initial collaboration between the Art Gallery of Hamilton (AGH) & the St. Peter’s Behavioural Health Program (BHP).	Private donor
2012/13	Initial pilot project at the AGH & St. Peter’s BHP (complex continuing care hospital) for persons living with dementia in the later stages.	Ontario Arts Council & St. Peter’s Hospital Foundation
2014/15	Continuation of the <i>Artful Moments</i> program at St. Peter’s BHP – twice monthly sessions at St. Peter’s with patients and family/friends participating.	‘100 Women Who Care Hamilton-Wentworth’
2018/19	Second pilot project at the AGH for persons living with dementia in the early stages in the community.	Ontario Trillium Foundation
2020/21	Covid-19 Pandemic – <i>Artful Moments</i> program offered by the AGH via Zoom.	TD Bank
2022/23	<i>Artful Moments: Shared Learning</i> – online learning curriculum developed by AGH artists/educators and health professionals with expertise in dementia care.	Public Health Agency of Canada (Dementia Strategic Fund – Awareness Raising Initiatives)
2025/26	Coaching initiative for 25 museums across Canada using the <i>Artful Moments: Shared Learning</i> curriculum as a guide.	Canada Council for the Arts’ Sector Innovation Fund
2022 to Present	<i>Artful Moments: Memory Care</i> continuing at AGH in a hybrid format (one week at the AGH & the next week on Zoom) – eight session segments throughout the year.	TD Bank

Our initial research question asked whether arts-based activities could promote engagement in persons living with dementia in the later stages. The evaluation focused on the demonstration of engagement using the ‘Affect and Engagement Rating Scale’ (Lawton et al., 1996), which was completed by trained observers, and a questionnaire (Rosenberg, 2009) completed by care partners at the end of each session. There were eight participants and eight care partners (mostly spouses). Results indicated that the program promoted engagement and expression in persons in the middle to late stages of dementia, as well as positive benefits for their care partners (Hazzan et al., 2016; Humphrey et al., 2019).

One year later, new funding was received from the ‘100 Women Who Care Hamilton-Wentworth’ organization to hold a second program for 12 months at St. Peter’s Hospital without trips to the AGH.

This project was championed by two women whose husbands had been part of the initial pilot project.

Successful Engagement Can Lead to Wellbeing

From our early experiences we have formalized our original ideas into a framework that guides our work. Our focus is on enhancing the strengths and abilities of the person living with dementia regardless of those abilities, state of health, or social circumstance while presenting activities at a level of engagement and rigour expected of museum and gallery programming. It is the process and the experience that are more important than a final product or demonstration of learning. Once the needs of the participants are met by adapting the environment, the approach and the activity, a participant is engaged in the experience that will in turn lead to the ultimate goal of heightened wellbeing.

DISCUSSION

Combining specialized strategies for dementia care with arts-based activities, the program explores how art can help to open up a world of ‘in-the-moment’ engagement and enjoyment for the participants while providing opportunities for social connection and shared experience with loved ones and peers. It is not art therapy as is the case in some arts-based programs (Dupuis et al., 2012), rather its purpose is “to present opportunities for participants to more fully express themselves, in the moment with others” (Mitchell et al., 2019, p. 1148).

Developing a Model for Successful Engagement

Cohen-Mansfield et al. (2009) proposed the ‘Comprehensive Process Model of Engagement’, that conceptualizes engagement as being influenced by environmental attributes, person attributes and stimulus attributes. Our adaptation of that framework, the ‘Model for Successful Engagement’, is based on our observations and research (Humphrey et al., 2017; Kilgour-Walsh et al., 2025). The six elements/components in the model are key to the success of the *Artful Moments* program – these components are interconnected and must be applied to fully engage the participants.

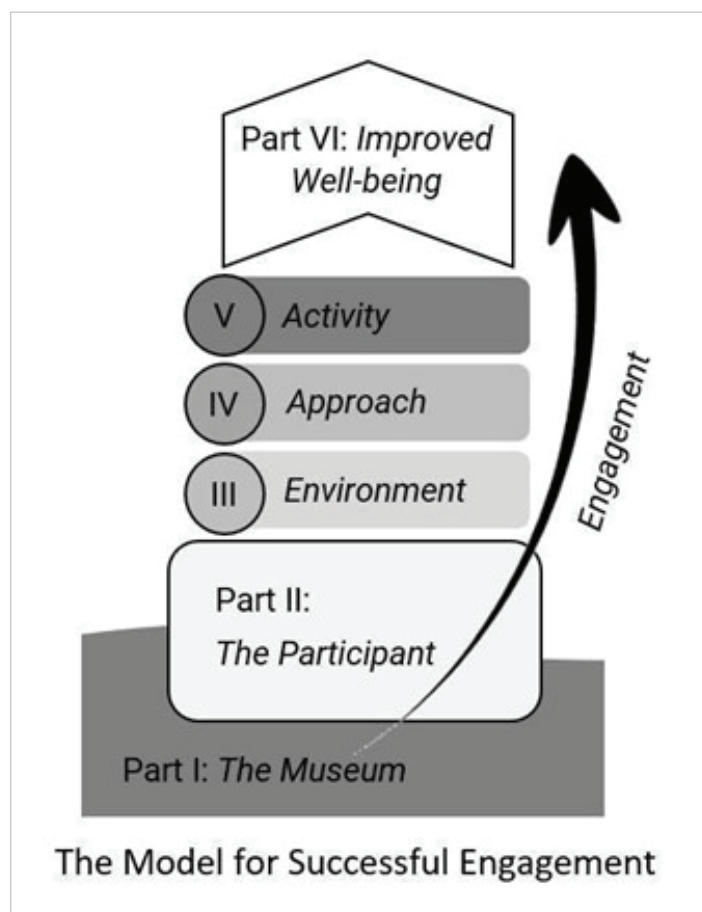
The museum is the foundation of the program, and the participant, the person living with dementia, is the central focus. Three pillars of environment, approach, and activity form the structure of the program and are interconnected. These pillars support engagement, which is the key process of the program. If the participant is engaged through a well-considered environment, an effective approach, and well-planned activities, the outcome will be improved wellbeing.

A Working Definition of Wellbeing

Wellbeing has become ubiquitous in conversations about health and life improvement. After consulting a number of sources across both the museum and health care fields (Clarke et al., 2020; Falk, 2009; Moll et al., 2014) certain themes emerged and led us to develop a working definition of wellbeing specific to persons living with dementia that not only resonated with us, but has proved helpful for measuring the impact of the program. Our focus has narrowed to six key categories of inquiry: connection with others, being active, feeling fulfilled, having meaningful experiences, recharging, and contributing (Kilgour-Walsh et al., 2025).

Figure 1

The Model for Successful Engagement



Kilgour-Walsh, L., Humphrey, J., Montemuro, M., Moros, K., & Stanners, S. (2025). *Artful Moments: Building Meaningful Museum Experiences for People Living with Dementia*. Rowman & Littlefield Press, p. 7.

The Second Pilot Project at the AGH

Following the initial collaborative project between AGH and St. Peter's, *Artful Moments* continued solely at the AGH with the same format as the initial project. All sessions were held at the AGH and it focused on persons experiencing the early stages of dementia and living in the community either in their own homes or in a retirement home. The Ontario Trillium Foundation provided funding to develop, implement, and evaluate this program. For nine months in 2018, four series (each series comprised of six sessions) were held weekly at the AGH – the first hour included a guided discussion about art in the gallery (art conversation – usually four or five artworks in close proximity to each other were discussed) led by the AGH educator followed by an hour of creative art making activities in the studio led by an AGH artist-educator. The activity was linked to the art that had been viewed in the conversation segment of the session. Each session was also developed around a particular theme such as 'still life', 'landscape', and 'portraiture'. Evaluation measures focused on social isolation and wellbeing. Six participants living with dementia, two family members, one friend, and one formal care provider attended the AGH for four 6-week sessions. Evaluation measures included the 24-item 'Social Provisions Scale' (Cutrona & Russell, 1987), a tool mandated by the funder, and the 'Museum Well-Being Measures Toolkit' (Thomson & Chatterjee, 2015). These tools were administered before and after each session and a focus group was held at the end of the program (Art Gallery of Hamilton, 2019).

With very few exceptions participants reported an increase in positive emotions and a decrease in negative ones after each session. Many of the reflections were linked to engagement and satisfaction with the art activities, but many also shared enjoyment in "being with others", spending time with "like-minded" people, and sharing experiences. One family member who came with her mother said that her enjoyment of the experience was more than caregiver relief: "I want to be part of it. It's like a date with my mom" (Art Gallery of Hamilton, 2019).

Based on our experience using the "Well-Being Measures Toolkit" in this second pilot project and on our own working definition of wellbeing, we have been inspired to develop a wellbeing tool that would personalize what is important to each participant for their own wellbeing. An early version of this tool has been tested with a group of participants at an *Artful Moments* session and will be refined for use in evaluating future programs.

The culminating event of this second pilot project was an art exhibit held in the bright and airy atrium of a new Health Sciences Centre that is located adjacent to the AGH with the participants, family, friends, and community

members in attendance.

Influence of the Covid-19 Pandemic

When the pandemic hit Canada in March 2020 the AGH closed its doors and turned to virtual programs. For two years the program ran very successfully on Zoom (a videoconferencing platform). Each week a themed selection of five artworks from the AGH collection was shown, one by one, on screen to prompt conversations among participants, followed by hands-on activities – a very similar model to the in-person sessions. Prior to each program, participants received packages with printed reproductions of the art and all supplies needed for the program. It was a very welcome surprise to see how well the participants adapted to the technology. Not only did they enjoy the art conversation and the art making on Zoom but the social connection among the participants continued and flourished.

Artful Moments Today

In 2022 the program, now known as *Artful Moments: Memory Care*, returned to in-person sessions at the AGH with a difference – in-person sessions were held every other week with virtual sessions on Zoom in the intervening weeks. Participants enjoyed travelling to the AGH every other week, but appreciated the rest in between. Most participants attended weekly but a few chose to come only to the in-person sessions or only to the Zoom sessions – flexibility is key. The program is currently held in eight-session segments throughout the year except during the summer months. The group is kept small with about five participants and their family members or friends (also known as care partners) attending. The program has received funding from TD Bank since 2020.

Building a Dementia-Friendly Community

Artful Moments is designed to support participants regardless of their current or past knowledge of art or art galleries. Art is part of the conversation – a prompt for people to share observations, ideas, questions, and humour. Each session is planned as a single experience – this allows for differences in memory and for busy schedules where a participant may have to miss a session – learning is 'in the moment'.

The facilitators of the program, that is, educators and artists at the AGH, have learned about dementia and the adaptations that are necessary to develop and present the most effective program possible for the persons living with dementia. Once the facilitators learn about dementia so they can work effectively and compassionately, they leave it at the door – they don't talk about dementia, instead they talk about art in a way that works best for each person in the room. By preparing conversations and activities that

consider the specific abilities of the participants they are easily able to adapt to different levels of ability and to the changing conditions of the day.

Programs like *Artful Moments* fight stigma as participants living with dementia and their care partners see themselves as important members of the community who can contribute and succeed. Seeing them as active participants in the gallery programs or as regular visitors can change their own sense of their abilities, as well as the perception that others have of them.

When organizations become educated about supporting persons living with dementia, they are able to create opportunities for participation and inclusion. When they centre the experiences of people living with dementia in their mandates, operations and activities, they become inclusive. When members of the public see people living with dementia as active members of a community, the public's preconceptions change and stigma-based ideas are reduced (Camic et al., 2014). At AGH, education about dementia is provided to the educators, artists, and volunteers who are involved with the *Artful Moments* program, as well as to other staff and security.

Impact on Family and Friends

One of the key take-aways we have seen with *Artful Moments* is the relationships that grow as people spend time together. Conversations about art lead to conversations about life, memories, hopes, and experiences. Relationships between partners, between parents and children, can shift when a person experiences a change in their health or ability. When one person becomes a caregiver and the other person is being supported, the way that they have related in the past often changes (Camic et al., 2014). By participating together in programs like *Artful Moments* that care-based relationship is suspended for a time and both people work, talk, and build memories together.

The family member or friend sees their loved one in a new light – really seeing their abilities in action or seeing talents that they didn't know were there. They experience their loved ones engaging, expressing themselves, and enjoying the activity in a safe, comfortable environment. For some, the joy that results from creative experiences is 'in the moment', but for others those memories are a lasting light long after the program concludes. As well, family and friends appreciate the experience themselves, socializing and sharing time with others.

Expanding Artful Moments Beyond Persons Living with Dementia

While the majority of the research and program exploration has been focused on persons living with dementia, it became clear that the approach could be broadly applied to many different audiences. Several studies have found that experiences with art and museums can have a significant impact on the wellbeing of participants across a spectrum of abilities and diagnoses (Cotter & Pawelski, 2022; Thomson et al., 2018).

Informed by the participant-centered 'Model for Successful Engagement' (Kilgour-Walsh et al., 2025, p.13), we have been able to adapt our work to connect with different populations through a similar strengths-focused lens. The AGH is now offering *Artful Moments* programs for older adults, for persons living with cancer, and for some younger populations living with disabilities. To differentiate these programs for diverse audiences, subtitles have been added to *Artful Moments* so that the program for persons living with dementia is *Artful Moments: Memory Care*, for seniors it is called *Artful Moments: Seniors Connect*, and for persons living with cancer it is entitled *Artful Moments: Cancer Care*.

INTERDISCIPLINARY COLLABORATION AND PARTNERSHIPS

One of the keys to the success of *Artful Moments* is in the ways that we learn, consult and collaborate. From the early days when the program started at St. Peter's we learned that understanding the participants was the key to meaningful engagement. The project team consisted of AGH educators and artists, as well as the health care team from St. Peter's. This belief in interdisciplinary knowledge exchange continues in the *Artful Moments* sessions that are facilitated by a team of AGH staff and artists, as well as two retired nurses with experience in dementia care who are key (volunteer) members of our team.

As the program has expanded to other audiences, collaboration has continued with organizations including Good Shepherd Centres of Hamilton, the Cancer Assistance Program, Autism Ontario, and the Young Caregivers Association. In each case, we look to our partner organizations to provide training or insight about their clients for our team and to offer ongoing program support to ensure that each new participant receives the individualized support needed to thrive in the program.

IMPLICATIONS FOR GERONTOLOGICAL NURSING

This article has explored how arts-based activities can decrease social isolation and loneliness, and enhance overall wellbeing in older adults, particularly persons living with dementia. Gerontological nurses can play a key role in promoting non-medical strategies to meet these priority public health issues for their clients by helping them access and be part of meaningful activities that exist in their community.

Social prescribing is “a complex health and social model of care that aims to use a person-centred approach to connect people with unmet non-medical needs to community assets” (Percival et al., 2022, p. 1). The UK has been at the forefront of social prescribing with programs such as ‘Books on Prescription,’ ‘Education on Prescription,’ ‘Exercise on Prescription’ (Chatterjee et al., 2017), and ‘Arts on Prescription’ (Cotter & Pawelski, 2022). In Ottawa there is a collaboration between health care providers and the Canadian Museum of Nature where admission passes to the museum are prescribed (Canadian Museum of Nature, 2023), and a recent Hamilton Spectator newspaper article (Frketich, 2025) highlighted one of Hamilton’s teaching hospitals giving out “social prescriptions for food and housing”.

For nurses and other health providers working with older adults, social prescribing is an emerging non-medical option that can positively benefit the wellbeing of their clients. Gerontological nurses in the Greater Hamilton Area (GHA) can encourage their clients to participate in *Artful Moments* to help them: connect with others, be active, feel fulfilled, have meaningful experiences, recharge, and contribute to their community. Outside of the GHA, they can seek similar initiatives at museums and galleries in their region. If such a program does not exist in their community, gerontological nurses in cities and towns across Canada are encouraged to partner with their local museum or art gallery and take advantage of *Artful Moments: Shared Learning* to create a program similar to *Artful Moments*.

In addition to learning more about, advocating for the launch of such programs, and recommending them to their clients including their clients’ significant others, gerontological nurses can participate as volunteers and become conversant in the value of such programs, especially through storytelling. One persuasive conversation with someone who might know of a funding source cannot be underestimated. Stories are compelling. Collaboration is key to encouraging older adults to stay active and engaged in supportive and meaningful activities in their community.

CONFLICT OF INTEREST

The authors have no conflicts to declare.

DEDICATION

In memory of Janis Humphrey (BScN, MS, GNC(C), RN) who passed away in December 2023. She was a visionary who saw a better way to care for persons living with dementia. She was the inspiration behind *Artful Moments* as the clinical manager of the Behavioural Health Program at St. Peter’s Hospital in Hamilton. She set in motion the collaboration between the Art Gallery of Hamilton and St. Peter’s in 2009. She was very involved with *Artful Moments* until her death as it continued to grow and expand. Janis was a dedicated Volunteer Docent at the AGH from 2015 to 2023.

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