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Social Isolation of Older Adults

Strategies to Bolster Health and Well-Being

Lenard W. Kaye
Clifford M. Singer

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Social Isolation of Older Adults
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Preface

THE PRECIPITATING EVENT

This book project was conceived during the planning of the 2016 University of Maine Clinical Geriatrics Colloquium, which convened in Orono, Maine, the home of the flagship campus of the University of Maine System, on October 7, 2016. The theme of the 11th Annual Colloquium was “Relationships in Later Life.” It drew more than 200 health and human service providers, educators, and students from across the state. The sense of urgency regarding the challenge of social isolation that pervaded that day’s presentations and discussions and the call that was heard to mobilize meaningful responses to this troubling social issue were undeniable. This volume aims to continue inquiry into the evolving nature and all too frequent fragility of late life relationships and the grand challenge of social isolation. We do this by documenting our current understanding of the complex and multidimensional nature of the interrelated issues of social relationships and health in late life, and the promising health and human service practices that have emerged to lessen the negative impacts of weakened relational ties for older adult health and well-being.

ABOUT THIS VOLUME

In this collection of chapters, we explore from multiple disciplinary perspectives the characteristics and significance of a wide range of social relationships that, when taken together, can determine the extent to which older adults will be at risk of being socially isolated, disengaged, lonely, and otherwise at risk in late life. We consider the influence on older adult social health of trends in multigenerational family relations, friendships, grandparenting, love, intimate and sexual relationships, divorce and widowhood, and interactions with community and healthcare providers and other public entities. We highlight innovative and alternative forms of community and later life relationships that can serve to forestall or prevent altogether social isolation.
and loneliness. Creative programs and intervention techniques that help maintain the integrity of an older adult’s individual, group, and community relations, communication pathways, and a sense of belonging are showcased, as are multidisciplinary and integrated best practices for minimizing the risk of late life social isolation. Special cases are offered that highlight the issues that arise in practice and service delivery and proven responses for successfully addressing them.

With explicit intent, contributors to this volume have been drawn from a diverse range of disciplines and professions as well as from multiple practice perspectives including those of direct service providers, administrators, researchers, and educators. As a result, the reader benefits from a series of well-informed, yet different, voices and experiences and bodies of research pertaining to the changing nature of late life relationships.

Time and attention are given to both the long-standing and evolving influence that diversity in all its forms including gender, sexual preference, marital status, personality traits, race, ethnicity and culture, physical and behavioral health, housing and living arrangements, and geographic location plays in impacting the quality of our social lives and the changing nature of the relationships we maintain or else newly establish in the later stages of life.

Given the significance placed on the quality of our social lives in preparing us for a satisfying old age, we explore as well a variety of strategies for bolstering older adult social health and community engagement. While one’s physical health status in late life may not be able to be dramatically altered for the better, we argue that one’s social health and the relationships that constitute one’s social life can. Whether you are an older adult yourself or a professional or family caregiver of an older adult, you have the capacity to shore up potential gaps in the integrity of your own or another person’s social world.

THE INTENDED AUDIENCE

Health and human service professionals working in the fields of aging, healthcare, long-term care, and the human services will find this book relevant as will practitioners in a range of allied professions including medicine, social work, nursing, and public health. Clinicians, administrators, planners, researchers, educators, care managers, supervisors, and even community first responders are appropriate targets for this content as are students enrolled in professional health and human service programs.

Readers will gain a better understanding of the ways in which the quality of late life relationships can be influenced by physical, behavioral, environmental, social, and economic forces. They will also develop an enhanced
understanding of preferred assessment and treatment techniques that will be most beneficial in helping older adults and their significant others address the challenges to the integrity of their personal and public lives. Finally, readers will expand their knowledge of available resources and specialized interventions that are available to help older adults minimize their isolation and disengagement from others and maintain healthy and mutually satisfying personal and public relationships while remaining integrated in their communities.

Lenard W. Kaye, DSW, PhD
Clifford M. Singer, MD
Share
Social Isolation of Older Adults: Strategies to Bolster Health and Well-Being
PART I

Setting the Context
The Scourge of Social Isolation and Its Threat to Older Adult Health*

Lenard W. Kaye and Clifford M. Singer

INTRODUCTION

Increasing numbers of socially isolated older adults have caught the attention of social and health organizations as well as the federal government. In the spring of 2017, the U.S. Senate Special Committee on Aging held a hearing on the risk of isolation for older adults who may become disconnected in virtually all respects from other individuals and communities. Testimony presented by Kaye (2017a) and other experts underscored the alarming rates of social isolation and loneliness confronting older adults in today’s world. The facts speak for themselves. Fueled by a 40% increase in the number of individuals living alone between 1980 and 2010, the prevalence of social isolation and loneliness may be as high as 43% among older adults living in the community (Nicholson, Molony, Fennie, Shellman, & McCorkle, 2010). The stoicism and resistance to seeking help of particular subgroups of older adults (e.g., individuals residing in small towns and rural communities) may place them at even higher risk of becoming isolated (Kaye, 2017b).

The escalating risk of isolation has put too many older adults on a troubling trajectory with potentially life-threatening consequences. The need to reduce social isolation and loneliness has been designated as one of 12 great challenges (Lubben, Gironda, Sabbath, Kong, & Johnson, 2015). As an underaddressed social issue in contemporary society, it is argued that we are in immediate need of new ideas, scientific inquiry, and bold innovation for reducing the negative impacts of this pervasive social problem. Both the World Health Organization and the National Institutes of Health have highlighted the need for this issue to receive greater attention. Likewise, the American Association of Retired Persons (AARP) has prioritized social isolation as an issue warranting greater attention (Lubben et al., 2015).

Closely associated with the downward trajectory in social connectedness that many older adults find themselves moving along are the increasingly fragile relationships that exist between them and family, friends, neighbors, and other members of the communities in which they reside. The threat posed by the weakening of one’s social network is increasingly recognized as a threat to health. Social relationships provide not only social support but increase our access to resources, create a buffer against stress, and serve as a trusted social influence. Research suggests that social relationships have as much influence on our health as a number of lifestyle factors including obesity and smoking.

Older adults at greatest risk of becoming socially isolated are lesbian, gay, bisexual, transgender, and questioning (LGBTQ) elders, as well as those with physical, sensory, and functional impairments; those who live alone, are 80 years of age and older, are geographically isolated, live on limited income, or lack instrumental supports (access to transportation, the Internet, telephones, etc.); and those with poor mental health, weak social networks, and who face critical life transitions (divorce, death of a spouse or partner, an abrupt retirement, a health crisis, children moving out, etc.); see Lubben et al. (2015). This high risk pool includes older men who, as a group, may be more likely to have fragile and sparse social support networks, and are less likely to engage with informal support networks.

Social isolation can shorten your life. Socially isolated individuals have both higher morbidity and mortality rates including increased rates of disability, dementias, hospitalizations, falls, poor health practices, psychological distress, neglect and exploitation, and lower self-reported health and well-being (Lubben et al., 2015). Social isolation was found to increase the relative risk ratio of being a current smoker compared to having never smoked by 67%, and this risk was found to be greatest among males and non-Hispanic Whites. Similarly, social isolation was also found to increase the relative risk ratio of being depressed by 13% (Choi & Dinitto, 2015). These
are associations and not cause-and-effect relationships, but the strong correlations between social isolation and ill-health are startling.

**SOCIAL HEALTH: A CRITICAL PART OF HEALTH AND WELL-BEING**

Social health is the critical third leg of the stool that combines with physical and psychological health to determine late life well-being. How communal and connected we are ultimately predicts the extent and quality of our personal relationships. Research has firmly established that social contact and committed relationships promote physical and emotional health. Conversely, social isolation is a major risk factor for multiple chronic illnesses and earlier death. While the most important contributor to social health in older adults is close personal ties, the quality of relationships with others in public settings also plays a significant role in determining overall well-being and especially timely access to needed assistance and support from both professional and nonprofessional helpers.

Inevitably, regardless of who you are and no matter how socially connected you are to the world, aging is likely to be accompanied by alterations in the integrity of your social network. Relatives, friends, and neighbors move away, die, or lose their connection to you for any variety of reasons. Marriages may dissolve and rifts arise in relationships with even close confidants and significant others. At the same time, people may be fortunate enough to meet other individuals who become extremely meaningful participants in their life story. And so, the size, strength, and intensity of one’s social network naturally wax and wane over the years.

While social isolation can occur at any stage of life, older adults may be especially at risk of finding themselves cut off from personal and public ties. For them, social isolation, characterized by a lack of consistent, reliable, and meaningful social relationships, can be lethal.

Social isolation, the consequence of a compromised and weakened network of social supports, has been associated with an exceedingly wide range of health problems and dangerous life situations (discussed in greater detail later in this chapter) including: risk of dementia and cognitive impairment; nonadherence to good health practices; risk of elder abuse, neglect, and exploitation; challenges surviving natural disasters; risk of depression and anxiety; and ultimately, heightened mortality. Even our susceptibility to the common cold has been associated with being socially isolated, suggesting an effect on immune function. Socially isolated individuals do not maintain as balanced a diet or other sound healthcare practices, nor visit their primary care practitioners on as regular a schedule as their socially connected counterparts.
Appreciating the association between compromised personal and public ties in later life and the potential for finding yourself enmeshed in inequitable, manipulative, and even abusive relationships is also important. A deeper understanding of the implications of this troubling relationship can be expected to further reinforce the call for more concerted steps that will reduce the all too common fragility of personal ties and the weakening of social networks in the lives of older adults. In this chapter, we explore the evidence supporting the connection between social isolation and ill-health and try to clarify whether it is isolation itself or loneliness that is the critical factor affecting health in people who are isolated.

HEALTH EFFECTS OF SOCIAL ISOLATION AND LONELINESS (ADAPTED FROM SINGER, 2018)

Social connectedness is in our genes. Throughout our history, social networks (families, tribes, communities, etc.) have enabled us to survive. Our survival was served by the evolutionary development of behaviors and physiologic mechanisms (neural, hormonal, cellular, genetic) that support social interactions (J. T. Cacioppo, Hawkley, Norman, & Berntson, 2011). But as with all human traits, there is variation in our social behaviors and needs. The fact is, most of us are driven to seek social connection. Social networks not only provide us with social support but are socially influential, creating a buffer against stress and increasing our access to resources. It is not surprising, therefore, that social isolation may impose stress on our minds and bodies, which has a significant impact on health.

Since social isolation and loneliness are common in older adults, much attention has been paid to clarifying their adverse effects on health in old age. The challenge is that it can be difficult to distinguish the effects of social isolation and loneliness on health when preexisting health conditions, such as immobility and depression, can themselves contribute to ill-health as well as increase isolation and loneliness. It is also challenging to distinguish social isolation and loneliness from one another; not all who are isolated are lonely and not all who are lonely are alone.

DEFINING SOCIAL ISOLATION AND LONELINESS

Not all people experience “aloneness” in the same way. Social scientists who study isolation and loneliness have attempted to define these terms in specific ways, since a person is considered socially isolated if he or she lives alone,
has less than monthly contact with friends or family, and does not belong to a group (religious congregation, club, work or volunteer organization, etc.); see Ciolfi and Jimenez (2017). Of course, some choose isolation as a preferred lifestyle. Others, likely far more in number, have isolation imposed on them through the death of loved ones, family and friends moving away, remote rural housing, recent moves to an unfamiliar city, impaired mobility, and other situations leading to depleted social networks and isolation. People in these situations may be more likely to experience loneliness and to feel isolated (“perceived isolation”). We can quantify social isolation and loneliness in terms of number and frequency of social contacts, but defining isolation in quantitative terms may not always be valid. The quality of our social interactions, more than the number of our relationships, determines loneliness.

Researchers have also approached these issues using qualitative methods. Cornwell and Waite (2009) use terms such as social disconnectedness and perceived isolation to define social isolation and loneliness using the objective and subjective nature of these states. Social disconnectedness is defined as lack of contact with others. Perceived isolation is defined as the subjective experience of lack of companionship and support. Loneliness may be part of that, although people can still experience subjective isolation around others. The assumption is that social disconnectedness without perceived isolation (i.e., isolation without loneliness) would be less stressful than states of loneliness and depression, thereby having less impact on health. Research has not always supported this assumption (Cornwell & Waite, 2009). Social isolation, with or without loneliness, can have as large an effect on mortality risk as smoking, obesity, sedentary lifestyle, and high blood pressure (J. T. Cacioppo et al., 2011).

**CORRELATIONS OF ISOLATION AND LONELINESS ON HEALTH**

Several indicators of social isolation have been associated with poor health. Several studies, in particular, can help us better understand the relationships of social networks, perceived isolation, health, and mortality. From a methodological perspective, these studies assume that health status contributes to one’s ability to be socially engaged. Therefore, health status can contribute to loneliness and isolation, thereby creating a “cause-and-effect” dilemma when attempting to define the relationships between loneliness, social isolation, health, and mortality. Investigators have to control for baseline health status in the design of their studies and in the analysis of their data. Despite this, the effects of social isolation and loneliness on health are a strong enough force that they consistently emerge as
unambiguous risk factors for ill-health and mortality in the many studies that have examined these relationships through various methodologies, including longitudinal cohort studies and meta-analyses (quantitative analysis of the combined results of carefully selected studies).

It is natural to assume that loneliness has a greater effect on health than isolation itself and some studies support that conclusion. Adverse effects on health from loneliness are seen at every stage of the life cycle (Hawkley & Capitanio, 2014). But older adults may be at particular risk both for loneliness and the health consequences of loneliness. For example, in a study involving a large number of older adults in Finland, 39% suffered loneliness at least some of the time; 5% “often or always.” Loneliness was statistically associated with several demographic variables, including rural living, older age, living alone or in residential care, widowhood, low level of education, and low income. Subjectively, the people in this study attributed their loneliness to illness, loss of spouse, and lack of friends. Poor health status and poor functional status were also associated with greater feelings of loneliness (Savikko, Routassalo, Tilvis, Strandberg, & Pitkalla, 2005). A study done by J. T. Cacioppo and Cacioppo (2014) found loneliness to be associated with ill-health to a greater degree than just social isolation. They examined two elements of social isolation independently (social disconnectedness and perceived isolation) on both physical and mental health. Stronger relationships were shown between loneliness and worse health, including cardiovascular disease, inflammation, and depression, than social isolation itself. Loneliness in older adults was shown to significantly increase risk of functional decline and death in a recent longitudinal cohort study of 1,604 individuals followed over 6 years. Some 43% of the cohort reported loneliness and they were at higher risk for both functional decline (activities of daily living, mobility) and death. The authors of this study found that loneliness was associated with these poor outcomes even after adjusting for baseline health status and depression, but did not compare those who were isolated to those who were lonely (Perissinotto, Cenzer, & Covinsky, 2012).

On the other hand, many investigators have found social isolation itself to be a risk factor for ill-health. In a meta-analysis of studies examining the magnitude of the effect of social isolation and loneliness on mortality in which important baseline health variables were controlled in the analysis, Holt-Lunstad, Smith, and Baker (2015) found a 29% increased risk of mortality over time from social isolation and 26% increase in mortality risk from loneliness. Interestingly, they found a 32% increased risk from just living alone, independent of social isolation. That is, they found no correlation of objective versus subjective social isolation. This finding is counterintuitive,
in that we would think that the stress of loneliness would be a driving factor for ill-health, yet “aloneness” seems to be at least as strong, if not a stronger influence on health. Steptoe, Shankar, Demakakos, and Wardle (2013) investigated whether the health impact of social isolation was “caused by loneliness” in 6,500 men and women more than 52 years of age participating in the English Longitudinal Study of Aging. They quantified contact with family, friends, and community organizations and administered a loneliness questionnaire. They monitored mortality for an average of 7.25 years per subject. After adjusting for demographic variables, social isolation increased mortality whereas loneliness did not. Those with the highest social isolation (least social contact) had an even higher risk. Although there was an increased mortality risk in lonely people, they also had higher baseline mental and physical health problems that may have accounted for the increased risk. That is, loneliness in this study was associated with higher baseline levels of depression, arthritis, and mobility impairment than the social isolation without loneliness cohort, so when baseline health variables were factored out, the cohort who expressed loneliness did not seem to have as high a mortality rate. In an effort to clarify the relative effect of loneliness and social isolation on cardiovascular mortality risk, Valtorta, Kanaan, Gilbody, Ronzi, and Hanratty (2016) conducted a meta-analysis of 11 cardiac and eight stroke studies. Poor social relationships in general (social isolation and loneliness) were associated with a 29% increase in risk of coronary heart disease and 32% increase in stroke risk. This increased risk is comparable to the risk of obesity and lack of physical activity and whether isolated people were lonely or not did not appear to make a difference. Across all studies, both social isolation and loneliness appear to increase the risk of premature death (Steptoe et al., 2013).

POTENTIAL MECHANISMS INFORMING SOCIAL SUPPORT AND HEALTH

Many potential mechanisms have been proposed to account for the relationships between social integration, perceived social support, and health outcomes. First of all, spending time with people who exhibit healthy habits may reinforce healthy behaviors, improve access to health-related information, maintain better nutrition, achieve more physical activity, arrange transportation to healthcare providers, and even increase financial resources. Of course, peer relationships can easily lead to unhealthful behaviors or interpersonal stress as well, but in the literature pertaining to older adults, the health-promoting benefits of social relationships seem to outweigh the negative effects
(Cornwell & Waite, 2009). But changing health behaviors is likely not the only mechanism by which social contacts protect health and well-being.

Loneliness is known to be a major risk factor for depression, which itself accelerates functional decline and increases mortality rate (Mehta, Yaffe, & Covinsky, 2002). Even subclinical depression may increase risk of all-cause mortality (Culipers & Smit, 2002), so depression may have contributed to the increased mortality and cardiovascular diseases found in the loneliness cohorts of those studies cited previously. Depression may increase mortality and illness through several mechanisms. Depression can increase platelet aggregation through diminished serotonin function and thereby increase risk for myocardial infarction and stroke. There may also be increased heart rate variability (unstable autonomic nervous system) and increased release of adrenaline, both leading to increased risk of cardiac arrhythmia (Seymour & Benning, 2009). Whatever the mechanism, the effect of depression on mortality is significant in size. In a large cohort study (Cardiovascular Health Study), investigators found that depression increased mortality risk by 24% when they accounted for all important covariables (Schultz et al., 2000).

Social isolation can have direct effects on cardiovascular disease risk factors. Perceived isolation and loneliness are associated with increased sympathetic nervous system activity, increased inflammation, and decreased sleep, all of which can accelerate brain and cardiovascular aging (J. T. Cacioppo et al., 2011). Loneliness increases risk for dementia, likely through these mechanisms; however, the absence of social interaction itself may also be a primary factor in that social stimulation can help maintain brain health (J. T. Cacioppo & Hawkley, 2009; S. Cacioppo, Capitanio, & Cacioppo, 2014). Grant and colleagues examined key metabolic risk factors for cardiovascular mortality, looking at blood pressure, lipids, and cortisol responses to stress. Using a measure of social integration (“Close Persons Questionnaire”), they found dysregulated blood pressure and cortisol responses to acute stress in people (238 middle-aged men and women) with few close friends. They also saw increased cholesterol in the socially isolated men, but not women. These physiologic changes increase risk of heart attacks and stroke. The authors note that these changes in cardiovascular risk factors in isolated individuals were independent of whether they expressed feelings of loneliness (Grant, Hamer, & Steptoe, 2009).

Finally, there is some evidence that loneliness can affect immune function, increasing susceptibility to infection (Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997). Loneliness is also associated with disrupted sleep. Insomnia affects immune function, glucose regulation, cardiovascular risk, dementia risk, mood, and daytime function (Hawkley, Preacher, & Cacioppo, 2010; Wilson et al., 2017).
SOCIAL PROGRAMMING TO REDUCE ISOLATION

The evidence linking social isolation in old age with poor health is strong enough that efforts to reduce cardiovascular disease need to consider social interventions aimed at reducing isolation (Valtort et al., 2016). There are studies that do suggest increasing social networks can improve health. In one such study, conducted over a 10-year period of follow-up, men (aged 42–77) with lower levels of “social integration” (by a standard social network index) were, as expected, found to be at greater risk of total mortality than those with more social connections. What was surprising in this study was that in a subanalysis of the older men of the sample who showed increasing social network size over the 10 years of study, an increased number of close friends or increased attendance at religious services were both associated with a reduced risk of death. The effect size was robust. Those reporting having more friends over time showed a reduction of 29% in mortality risk per year (Eng, Rimm, Fitzmaurice, & Kawachi, 2002). This does not prove causality; perhaps improvements in health for other reasons promoted behaviors that lead to more friends. Nevertheless, the finding is encouraging.

Although the stress of being a caregiver to a disabled family member is not the same kind of stress as social isolation, caregivers consistently describe the isolation of the caregiver’s role as one of the most stressful aspects of the caregiving role. Caregivers consistently report higher levels of stress than noncaregivers, and chronic stress is associated with poorer health outcomes and higher rates of mortality. But caregivers, overall, have a lower mortality rate. The important variable is the level of stress a person experiences in the caregiver role. Not all caregivers experience significant stress, and those who do not may experience health benefits from the caregiving relationship. In fact, in one study, nonstressed caregivers had 43% lower rates of mortality relative to noncaregivers. In previous studies, caregivers experiencing significant emotional stress showed a 60% increase in mortality rate (Fredman, Cauley, Hochberg, Ensrud, & Doros, 2010). These findings are relevant to considerations of interventions for social isolation. Nonstressed caregivers are more likely to experience positive emotions from the person they are providing care for and to gain strength from having a vital role to play in another person’s life. To be a caregiver and not feel some reciprocal caring from your partner is a special form of isolation that is particularly demoralizing, stressful, and unhealthy. Even small efforts to make isolated people feel appreciated and useful may reduce the stress of loneliness and thereby improve health.
Innovative ways to help depressed, isolated people may also have positive effects on health. In a 12-month multimodality, home-based intervention, randomized controlled trial for older adults with depression, those receiving a home-based (as opposed to usual, office-based) treatment had significantly better responses. The home-based treatment group was more likely to be in remission from depression, had greater quality of life improvements, and displayed greater gains in functional well-being and emotional well-being (Ciechanowski et al., 2004).

Given the mobile nature of our society, social relationships frequently are maintained at a distance through telephone contact, email, and social media when physical contact is not practical. Interventions relying on technology to reduce isolation may be better than no intervention at all, but they are not the same as in-person visits. A large cohort study has recently revealed that different methods of contact are not equal in reducing feelings of loneliness and depression. These investigators found a higher risk of depression in those with less than once-a-month face-to-face contact with children, family, or friends. People with once- or twice-a-week contact had the lowest rates of depression. However, older age, interpersonal conflict, and depression at baseline decreased the effect of physical contact. That is, if a person is prone to depression, is physically frail, or the relationship causes tension, a phone call may be as good as (or better than) in-person contact (Teo et al., 2015).

There is an increasing amount of evidence that pets, especially dogs and cats, are associated with health benefits and reduced mortality. Research into whether animal companions can offset the deleterious effects of social isolation on health is needed.

**IMPLICATIONS FOR THE PROVISION OF GERIATRIC CARE**

Geriatric care providers may be in a better position than any other member of the healthcare team both to recognize social isolation and to organize interventions. Based on current evidence, they can justify increased focus on social relationships in the multidisciplinary healthcare treatment plan and in their individual efforts to reduce isolation in their clients. An understanding that social isolation is a significant risk factor to health, of similar magnitude to obesity and diabetes, may be persuasive for some of their clients who are able to increase social contact with others, either in person or through social technologies.
SUMMARY

Many older adults feel isolated and lonely. There are compelling data that these states are associated with poor health and higher rates of mortality. The effect of social isolation (with or without subjective loneliness) on health appears to be of a similar magnitude to other risks to health, such as high blood pressure, smoking, and obesity. Whereas these other health risk factors have stimulated major public health interventions in recent decades, efforts to reduce isolation and loneliness have not been made on a level of population health. We also have to keep in mind that being in toxic relationships may be even more stressful and unhealthy than loneliness (Birmingham, Uchino, Smith, Light, & Butner, 2015). Nevertheless, there is enough evidence to consider social isolation and loneliness among older adults a significant public health issue. There are also compelling hypotheses and some experimental data to explain the physiologic mechanisms by which social isolation increases the risk of disease. There is also an emerging body of evidence that interventions to reduce loneliness may improve health. Although there are no simple prescriptions to address isolation and loneliness, population-health authorities should take this issue as seriously as other known health risk factors. It is very likely that social interventions provided at relatively modest costs will result in cost savings in public health. At the very least, such efforts provide a safe, humane approach to a common cause of suffering in older adults.

REFERENCES


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