Submission No 39

INQUIRY INTO PREVALENCE, CAUSES AND IMPACTS OF LONELINESS IN NEW SOUTH WALES

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Dear NSW Legislative Council's Standing Committee on Social Issues,

We would like to submit the attached document for the **Inquiry into the Prevalence, Causes, and Impacts of Loneliness in New South Wales**

We are lodging the submission as a group of individuals and **request that our submission be published in full on the website including our name.**

Kind regards,
Dr Freak-Poli, Dr Htun and Mr Teshale

Submission to the NSW Legislative Council's Standing Committee on Social Issues

Inquiry into the Prevalence, Causes, and Impacts of Loneliness in New South Wales

1. Who we are

We are a team of experienced researchers from Monash University, comprising Dr Rosanne Freak-Poli, Dr Htet Lin Htun, and Mr Achamyeleh Birhanu Teshale. Our expertise spans loneliness, social isolation, and the epidemiology of chronic diseases, along with a strong focus on social determinants of health and social prescribing. We are committed to advancing understanding in these critical areas that are increasingly relevant in today's society, and we aim to provide valuable insights for the inquiry on loneliness to be submitted to the NSW Legislative Council's Standing Committee on Social Issues.

2. Executive summary

Our research demonstrates:

1. Loneliness and social isolation are separate, yet interconnected, concepts.
2. Loneliness and social isolation are not only about the individual, but also the wider community and social environment that supports the individual.
3. .Social isolation can increase the risk of loneliness, and vice versa, loneliness can increase the risk of social isolation.
4. Loneliness disproportionately affects older adults.
5. Long-term persistent loneliness or social isolation are both concerns as they negatively impact mental and physical health through separate mechanisms:
    - As highlighted in MJA InSights+: *"There is an abundance of evidence that people with positive social health… are at lower risk of developing serious chronic diseases and death."*
    - Social isolation and loneliness are associated with an increased risk of stroke.[1]
    - Older healthy Australians with poor social health (either socially isolated, had low social support or were lonely) were 42% more likely to develop cardiovascular disease and twice as likely to die from cardiovascular disease over approximately four and a half years follow-up.[2]
    - We have identified that older healthy Australians can engage in activities to reduce their risk of chronic disease.
        - Men can reduce their risk of cardiovascular disease by:[3]
            - maintaining close relationships with 3 to 8 relatives with whom they share personal matters
            - engaging in activities such as playing games like cards or chess,
            - attending educational classes
            - babysitting or childminding
            - participating in volunteer work
            - going to the cinema or theater
            - enjoying other social or sporting events can also help
            - owning a pet
            - providing care for another adult
        - Women can reduce their risk of cardiovascular disease by:[3]
            - having three or more close friends
            - living with someone else
            - engaging in babysitting or childminding activities.
        - Men can reduce their risk of dementia by:[4,5]

        - maintaining close relationships with >9 relatives with whom they can call for help
        - engaging in babysitting or childminding activities.
    - Women can reduce their risk of dementia by:[4,5]
        - caregiving for someone with an illness or disability
        - having a less extensive circle of close friends—specifically, four or fewer with whom they felt comfortable discussing private matters

RECOMMENDATIONS

1. We recommend addressing other social determinants of health simultaneously to facilitate socialising and prevent or mitigate loneliness.
2. We recommend that healthy Australians aged 70+ years
    - Seek help for feelings of loneliness if occurring three or more days per week over time
    - Participate in community activities at least once per month
    - Engage in informal caregiving at least once a week, for example babysitting, childminding, or looking after someone with illness or disability
    - Have contact with four or more relatives or close friends per month (for example in-person or by email, phone, video conferencing, text messaging)
    - Aim for three or four relatives or close friends with whom to discuss private matters or call upon for help. Only two people are required for benefits in health if they fulfil discuss private matters AND call upon for help
3. As there is a gender-based difference in how loneliness influences the risk of chronic diseases, we recommend that gender should be considered in intervention developments.
4. We recommend that social prescribing as a solution to prevent and mitigate loneliness, social isolation and unfavorable social determinants. Social prescribing is defined as a means for trusted individuals in the clinical and community settings, like a General Practitioner (GP), to refer the person to a link worker who can connect them to non-clinical supports and services within the community to address their non-medical needs to improve their health and wellbeing. Social prescribing addresses a range of social determinants of health, leading to enhanced patient outcomes, promoting health equity, and strengthening the healthcare system. Many Australian health professionals want to offer a holistic approach and social prescribing has the potential to revolutionise Australian healthcare. Social prescribing in Australia is currently being advanced by the Australian Social Prescribing Institute of Research and Education (ASPIRE).

3. Submission details

3.1. Overview and prevalence of loneliness (and social isolation)

Loneliness and social isolation affect not only the individual but also the wider community and social environment that supports the individual. Loneliness and social isolation are distinct, yet interconnected concepts. Loneliness is a subjective experience characterised by social isolation and disconnection from others. It is more closely related to relationships' quality than quantity. Therefore, as detailed in *Figure 1*, a person can be surrounded by people yet still feel lonely, while another person can be alone but not experience feelings of loneliness. There are different approaches to measure loneliness, such as using single item

measure (e.g., usually using "How often do you feel lonely?") and multi-item measures (e.g., commonly using the three-item UCLA loneliness scale).

Social isolation is defined as "having objectively few social relationships or roles and infrequent social contact." Similar to loneliness, there is no specific or gold standard measurement or scale to measure social isolation. However, there are commonly used approaches to measure social isolation, such as the Duke Social Support Index (DSSI) and the six-item Lubben Social Network Scale (LSNS-6).

Loneliness in Australia. In 2022, over 16% (1 in 6) of individuals experienced loneliness, while 15% (1 in 7) faced social isolation. In New South Wales (NSW), around 40% of individuals experience loneliness. In 2021, 37% of people living in NSW reported that they felt lonely, 48% of them experiencing some of the time or often.[6] Persistent loneliness, defined as loneliness experienced over time, presents greater concern than loneliness at a single life stage. Data from the nationally representative Household Income and Labour Dynamics in Australia (HILDA) survey found persistent loneliness affecting 13% of the population and persistent social isolation affecting 4%.[7] Similarly, a community-based study of 1,968 individuals aged 55 and older from Newcastle, NSW, reported an 8.8% prevalence of persistent loneliness.[8] However, the available data on loneliness and social isolation in Australia do not enable reliable international comparisons.

Global loneliness data. A global study synthesising data from 57 studies estimated loneliness prevalence across various age groups. Among adolescents (12-17 years), loneliness ranged from 9.2% to 14.4%, with regional variation. For adults, prevalence estimates range from 2.9% to 7.5% for young adults (18-29 years), 2.7% to 9.6% for middle-aged adults (30-59 years), and 5.2% to 21.3% for older adults (60+ years), indicating a higher burden among older populations.[9] The reason why loneliness is common in later life could be due to different factors that are common in older age groups, such as retirement and loss of workplace connections, bereavement, hearing loss, and communication difficulties. Studies also report difference in loneliness prevalence between men and women. For example, a recent meta-analysis of 17 studies (up to November 2023) found a 20.8% prevalence of persistent loneliness in older adults, with notable gender differences: 16.3% (95% CI: 10.6-21.9%) in men and 21.7% (95% CI: 16.1-27.4%) in women, with wide ranges across studies (6-38% in men, 10-45% in women).[10] This may be due to differences in social expectations, life circumstances, and varying social needs. For instance, women generally live longer but face higher risks of widowhood and chronic illness in older age. Additionally, men and women differ in their willingness to report feelings of loneliness. These findings highlight the importance of giving attention to both age and gender in loneliness intervention.

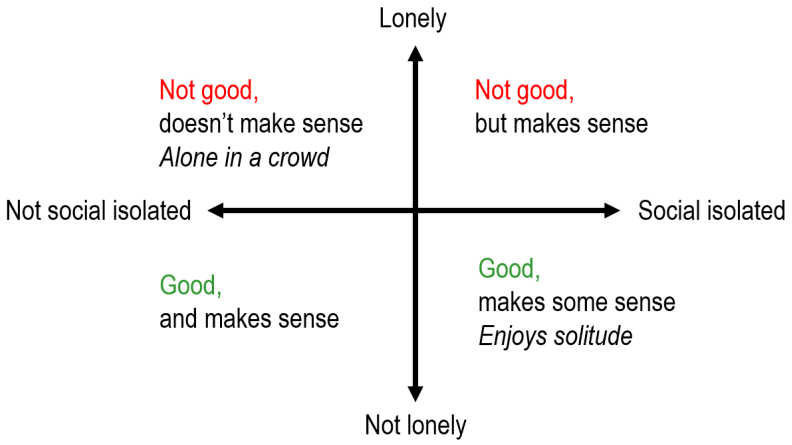

Figure 1. Loneliness and social isolation, the distinct poor social health constructs

3.2. Causes or factors contributing to loneliness

A supportive environment and opportunities to socialise need to be convenient and freely available to prevent loneliness. However, these are not always fulfilled and there are different factors that contribute to loneliness.

Age: Loneliness disproportionately affects older adults. Around one-third of people experience some degree of loneliness later in life, and approximately 50% of individuals over 60 are at risk of social isolation.[11] *Figure 2* demonstrates the prevalence of loneliness by age among an Australian representative sample of people living in their own homes. People in later life (aged above 75 years) are most affected.

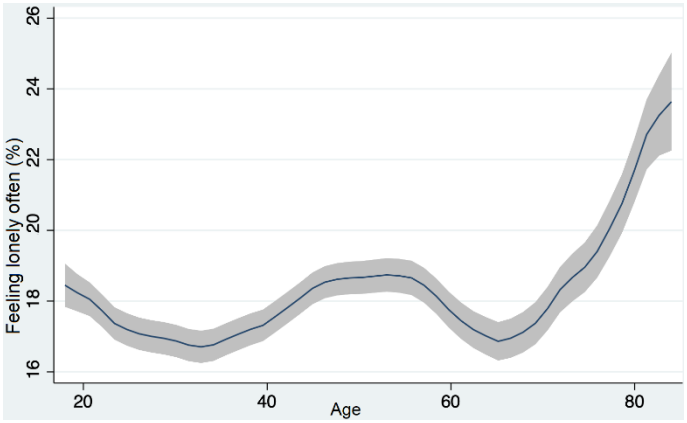

Figure 2: Loneliness across the life course

Note: Unpublished. Smoothed averages using pooled observations from annual HILDA (The Household, Income and Labour Dynamics in Australia[12] Survey) surveys 2001-2017 for ages 18+, which understates the current[13] high prevalence.

Physical and mental health: While these factors can be caused by loneliness, they are also risk factors for experiencing loneliness. Physical health conditions such as cardiovascular disease, or chronic disease in general, and mental health issues such as depression and cognitive decline can be strongly associated with loneliness.[14]

Behavioural factors: For, example, having inadequate leisure activities, physical inactivity, and sleep irregularity can increase loneliness.[15]

Social isolation: Social isolation involves a lack of regular contact with others, which can lead to feelings of loneliness due to unmet social needs. When people have few opportunities for meaningful interactions, they may feel lonely. However, it is important to note that, while social isolation often results in loneliness, the two concepts are not always directly linked.

3.3. Impacts of loneliness (and social isolation)

Loneliness and social isolation have been recognised as major public health problems due to their effect on both physical and mental well-being.

Mental and Cognitive Health

Prolonged loneliness and social isolation can significantly impact mental health, increasing the risk of conditions like depression and anxiety. Studies that assessed constructs simultaneously have demonstrated a cross-sectional association between lower social

isolation and lower loneliness with greater optimism and lower depression among healthy older men and women.[16,17] As we stated above, it is generally acknowledged that there is also a reverse association, with mental health conditions increasing the risk of social isolation and loneliness.[18] A meta-analysis involving over 2.3 million participants found that living alone, having a smaller social network, low frequency of social contact, and poor social support were risk factors for dementia; however, loneliness itself was not identified as a risk factor. Conversely, other meta-analysis indicated a significant association between greater loneliness and incident dementia.[19]

In our new study of Australians aged 70+ years, loneliness assessed at baseline was associated with a 40% higher risk of dementia in women, but no association was found in men. In terms of loneliness changes over time, compared to the “never lonely” group, new-onset incident loneliness (not lonely prior) in men was associated with a 52% increased risk, while persistent loneliness in women was associated with a 114% increased risk of dementia.

In addition to loneliness, other aspects of social connection are associated with dementia risk in older Australian adults. For women, caregiving for someone with an illness or disability was associated with a 35% reduced dementia risk, while having a smaller circle of close friends—specifically, four or fewer with whom they felt comfortable discussing private matters—was associated with a 41% reduction in risk. Among men, those who had nine or more close relatives they could call on for help showed a 44% lower risk of dementia, and those who participated in babysitting or childminding activities experienced a 25% risk reduction.[4] In another study examining the patterns of social connections, findings indicate that these patterns affect dementia risk differently for men and women. The study identified three social connection patterns: strong social connections with an Intermediate Friend-Relative Network, weak social connections, and strong social connections with a Larger Friend-Relative Network. Compared to those with strong connections within an intermediate-sized friend-relative network, women with extensive friend-relative networks (i.e., typically > 4 friends/ relatives) had a 27% higher risk of dementia, while men with weaker social connections had a 38% increased risk. These findings suggest that patterns in social connection and loneliness have a gender-specific impact on dementia risk.[5]

Physical Health (e.g., cardiovascular disease)

There are several key reviews that have assessed social isolation and/or loneliness as predictors of cardiovascular disease. In 2003, an Expert Working Group of the National Heart Foundation of Australia concluded that there is strong and consistent evidence of an independent causal association between social isolation and the causes and prognosis of coronary heart disease. However, loneliness was not assessed [20]. In 2023, an umbrella review of systematic reviews examining social determinants of health in cardiovascular diseases found that social isolation and loneliness were associated with an increased risk of stroke [1].

Older healthy Australians with poor social health (either socially isolated, had low social support or were lonely) were 42% more likely to develop cardiovascular disease and twice as likely to die from cardiovascular disease over approximately four and a half years follow-up.[2] This was unchanged after accounting for already established cardiovascular disease risk factors of age, gender, tobacco smoking, systolic blood pressure, high-density lipoprotein, non-HDL, diabetes, serum creatinine, and antihypertensive drug use.

Older healthy Australians can engage in activities to reduce their risk of cardiovascular disease.[3] There is evidence that men can reduce their risk of cardiovascular disease by

maintaining close relationships with 3 to 8 relatives with whom they share personal matters. Engaging in activities such as playing games like cards or chess, attending educational classes, babysitting or childminding, participating in volunteer work, going to the cinema or theater, and enjoying other social or sporting events can also help. Additionally, owning a pet and providing care for another adult are beneficial for reducing CVD risk. Women can reduce their cardiovascular disease risk by having three or more close friends, living with someone else, or engaging in babysitting or childminding activities.[3]

Pathways linking loneliness (and social isolation) with physical and mental health

The primary pathways connecting loneliness and social isolation to mental and physical health are often described through biological or physiological mechanisms, health behaviors, and chronic disease risk factors, such as metabolic syndrome. These factors can contribute to long-term mental and physical health issues, as well as increased mortality; with each step being impacted by socio-demographics, the sociological environment, life events and personality.[21]

4. Recommendations

As highlighted in MJA InSights+: "*There is an abundance of evidence that people with positive social health… are at lower risk of developing serious chronic diseases and death."* Many Australian health professionals want to offer a holistic approach and social prescribing has the potential to revolutionise Australian healthcare. Social prescribing is defined as a means for trusted individuals in the clinical and community settings, like a General Practitioner (GP), to refer the person to a link worker who can connect them to non-clinical supports and services within the community to address their non-medical needs to improve their health and wellbeing. Social prescribing addresses a range of social determinants of health, leading to enhanced patient outcomes, promoting health equity, and strengthening the healthcare system.

There are various initiatives aimed at reducing loneliness, one of which is the Australian Social Prescribing Institute of Research and Education (ASPIRE). This program focuses on advancing research and education in social prescribing across Australia. It aims to connect individuals with community resources through link workers, enhancing well-being by addressing non-medical needs. The primary goal is to improve mental health, reduce loneliness, and increase social connections. ASPIRE collaborates with healthcare providers, community organisations, and government bodies to promote these practices, improve health outcomes and alleviate the burden on healthcare systems. By fostering evidence-based approaches, ASPIRE plays a vital role in integrating social prescribing into the Australian healthcare landscape. There have been also different initiatives launched in Australia and New South Wales to address loneliness and social isolation. These include national initiatives such as Ending Loneliness Together and non-governmental initiatives including "R U OK?" and the Australian Psychological Society. While current initiatives aimed at preventing loneliness are significant, there remains a pressing need for a comprehensive national strategy to address loneliness and social isolation in Australia. Numerous organisations are advocating for enhanced governmental action and funding to confront this escalating public health issue effectively.

5. Conclusion

Loneliness is a major public health concern that impacts a significant portion of populations both globally and in Australia. Its effects are extensive, influencing physical health (such as CVD and weakened immune function), mental health (including depression and anxiety),

and cognitive function. Addressing loneliness cannot be solely the responsibility of the government or non-governmental organisations; rather, it requires a collective effort from all sectors.

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