Submission No 49

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

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Submission to the Inquiry into the Prevalence, Causes, and Impacts of Loneliness in New South Wales
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Dr. Nancy Kong is a Senior Lecturer in Health Economics at the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney. Her research examines the determinants of loneliness, especially in the context of the COVID-19 pandemic. This submission reflects the views of the author and does not represent the views of the University of Technology Sydney, or any associated entities. It draws on her research and relevant literature to address the determinants and consequences of loneliness, with a focus on the relationship between physical isolation and loneliness.

Thank you for the opportunity to provide a submission to this inquiry. For the convenience of the Standing Committee on Social Issues, my submission follows the format of the Terms of Reference and provides feedback on those areas that are within my areas of expertise.

Responses to the Terms of Reference

(a) The extent of loneliness and social isolation in NSW and how this is measured and recorded, including opportunities for additional and/or improved data capture

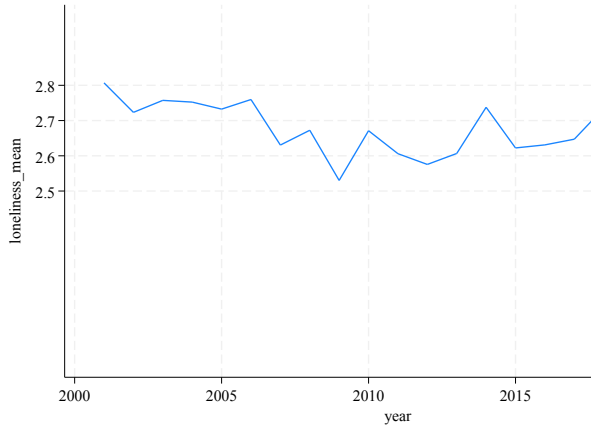
Over the last two decades, NSW has consistently reported high levels of loneliness, ranking third among Australian states, following Queensland and Tasmania (Table 1). The highest recorded levels of loneliness in NSW occurred in 2022, with the lowest in 2009 (Figure 1). Data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey, which measures loneliness using the question, "How much do you agree or disagree: I often feel very lonely" (1 = strongly disagree, 7 = strongly agree; mean = 2.69, SD = 1.76), has been widely used in studies of loneliness in Australia. Despite being a single-item measure, it has been validated for effectively capturing the experience of loneliness.

Maes et al. (2022) highlights that loneliness is multidimensional, encompassing emotional and social loneliness, and that relying on single-item measures may overlook important nuances. For the NSW government, adopting multi-dimensional scales such as the UCLA Loneliness Scale or the De Jong Gierveld Loneliness Scale (DJGLS) would provide a more comprehensive understanding of loneliness. Longitudinal data collection could help monitor trends and intervention impacts, while including contextual factors like living situation and health would offer a richer perspective. Ensuring cultural and demographic relevance, particularly by testing for measurement invariance, would make the data more accurate and actionable across NSW's diverse population.

(b) The identification of populations most at risk of loneliness and social isolation

Certain populations are more susceptible to loneliness, including women, young people, those who are separated, divorced, or widowed, individuals with low income or low education, indigenous populations, people living with disabilities, and residents of remote areas (Table 2). During periods of physical isolation, such as lockdowns, certain groups were found to be particularly vulnerable. Specifically, young people (aged 15–25) and extroverted individuals experienced increased feelings of loneliness during lockdowns (Kong & Lam, 2024).

Figure 1. NSW loneliness over time



Source: HILDA 2001-2022 waves in NSW. N= 87,535.

Table 1. Loneliness level in 2022 by state on a scale of 1-7

State	Mean
NSW	**2.68**
VIC	2.63
QLD	2.76
SA	2.74
WA	2.62
TAS	2.70
NT	2.54
ACT	2.53
Total	2.69

Source: HILDA 2001-2022 waves. N=450,574.

This evidence suggests that policies aimed at reducing loneliness in NSW should prioritize these at-risk groups, particularly in circumstances of prolonged physical or social isolation. Tailored interventions that address both the emotional and social needs of vulnerable individuals may help mitigate the negative effects of isolation on mental health (see (i) for more on interventions).

Table 2. OLS regression analysis of factors contributing to loneliness

VARIABLES	(1) Loneliness
Age	-0.00365***
	(0.000280)
Female	0.119***
	(0.00759)
de facto (compared to married)	0.151***
	(0.0112)
Separated	0.979***
	(0.0230)
Divorced	0.702***
	(0.0159)
Widowed	0.586***
	(0.0191)
Never married	0.524***
	(0.0110)
Indigenous Origin Status	0.247***
	(0.0210)
Employed full time (compared to not in labour force)	-0.0771***
	(0.0102)
Employed part time	-0.0954***
	(0.0109)
Unemployed	0.334***
	(0.0201)
Trade/diploma (compared to year 12)	0.0540***
	(0.00864)
Bachelor and above	-0.124***
	(0.00987)
Equivalent HH income	-2.21e-06***
	(9.94e-08)
Remote	0.00886*
	(0.00469)
Chronic health condition	0.496***
	(0.00926)
Observations	235,950
R-squared	0.061

Source: HILDA 2001-2022 waves.

(c) Evidence of the psychological and physiological impacts of loneliness on people, including young people, the elderly, those living with a disability, those living in regional areas, and the bereaved

Loneliness has significant psychological and physiological impacts, comparable to risks associated with smoking and obesity. Research shows that loneliness is associated with increased mortality risk, mental health disorders, and poorer overall health outcomes (Cacioppo & Cacioppo, 2018). Analysis of HILDA data indicates that a rise in loneliness correlates with a 0.24 standard deviation decrease in mental health, as measured by the Short Form-36 (SF-36) mental health component. This effect is similar to the impact of divorce on mental health.

(d) Evidence linking social connection to physical health

Holt-Lunstad (2015) conducted a meta-analysis of over 70 studies on the relationship between loneliness, social isolation, and early mortality (3 of these studies were conducted in Australia). The findings indicated that individuals who are socially isolated, lonely, or live alone face a 26% to 32% higher risk of early death compared to those who are socially connected. This risk remained consistent across gender and region, though it varied based on age and initial health status. Both perceived and actual social isolation were found to have comparable effects on physical health as other well-established risk factors for early mortality.

(i) Steps the State Government can take to reduce the prevalence and impacts of loneliness in the community

Strong social connections are closely linked to reduced loneliness. Evidence shows that individuals with more frequent social interactions and those who stay in touch with friends and family experienced lower levels of loneliness during physical isolation (Kong & Lam, 2024). Furthermore, individuals with higher levels of community satisfaction reported lower levels of loneliness. These findings support broader evidence suggesting that social support acts as a protective factor against loneliness, ultimately contributing to improved health outcomes.

Based on the meta-analysis findings from Masi et al. (2011), an effective intervention strategy for the NSW government should prioritize targeting maladaptive social cognition, as cognitive-behavioural interventions focused on reframing negative social perceptions have proven most effective in reducing loneliness. Additionally, structured, group-based interventions that incorporate educational or social skill-building components—such as community classes or support groups for specific demographics like seniors and young adults—can foster a sense of belonging and mitigate loneliness. Consistent engagement through regular, structured activities in community and mental health centres can further support lasting social connections, making this multi-faceted approach highly suitable for reducing loneliness across NSW.

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