Submission No 57

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

Organisation: Older Women's Network NSW

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PREVALENCE, CAUSES AND IMPACTS OF LONELINESS IN NEW SOUTH WALES

SUBMISSION
STANDING COMMITTEE ON SOCIAL ISSUES

Older Women's Network NSW

We acknowledge the Traditional Custodians of the lands on which this report was drafted - the Gadigal people of the Eora Nation, the Dharug people, and Wurundjeri Woi-wurrung and Bunurong / Boon Wurrung peoples of the Kulin Nation. We recognise their continued connection to the land and waters of this place, and acknowledge that they never ceded sovereignty.

We pay our respects to Elders past and present, and extend that respect to all First Nations peoples.

Always was. Always will be.

Background

The Older Women's Network (OWN) has been at the forefront of progressive change, activism and advocacy since 1985. We have gone from strength to strength as a dynamic members-led organisation expanding throughout NSW. Over the years, OWN has developed services and resources for older women; and written and contributed to numerous influential reports on key issues for older women such as income security, homelessness, ageism, wellbeing, abuse of older people and violence against older women. We have worked over decades to put these issues at the forefront of public policy debates.

Experience in Supporting the Wellbeing of Older Women

The Older Women's Network NSW is currently working on key programs as follows:
(i)'Hear Our Voices' which is aimed at developing training resources for frontline services on how to better respond to disclosures of sexual assault by older women
(ii)'Pathways to Employment' which provides one-on-one support for older women to return to the paid workforce.
(iii)Ending Homelessness of Older Women which involves lobbying, advocacy and networking for better housing policies and outcomes for housing insecure older women. The Blue Mountains OWN group is running a special project to connect homeless older women with compassionate homeowners who are prepared to provide affordable rentals.
(iv)Keeping older women connected through activities organised through various OWN groups across the state. The Southern Highlands OWN group has designed FLOWN – Friendship Links Through OWN – which enables OWN members access to a directory providing information of other OWN members who are willing to host short stays/visit to their local area to help reduce isolation.

This submission will be referring to these initiatives and the value of supporting their administration, testing and evaluation.

Experience During COVID-19 Lockdowns

During lockdown, OWN provided essential connections for the community of older women across New South Wales as well as other parts of Australia by continuing our services online. Confirming other studies and experiences of this time, we discovered an unmet need that existed prior to lockdown. Women, who were housebound or unable to travel to centres were, for the first time, able to participate in a variety of activities. Women who were homeless and living in their cars also took part in the online activities. Post lockdown, even though most of the funding has ceased, OWN is still providing support for online activities due to some funding from South West Sydney Local Health District.

We also learned that relying on technology also failed many women, such as those who felt unsafe using a public medium, or were unable to purchase a device or who could not afford to access unlimited data streams, or lived in an area with poor reception. While there are some benefits to providing online activities for social connection, it does not fully replace the social capital and strong connections that are built with ongoing and slow build of relationships through face to face contact that survive periods of hardship. This submission will also be referring to learning from this period of service delivery.

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

Data on social isolation and loneliness has been collected and reported on in numerous reports over the past decade. The APO, for example that links most Australian government reports calls up nearly 40 reports in the past decade (https://apo.org.au/). The AIHW Topic Summary on Social Isolation and Loneliness provides a snapshot of the demographic data by age and gender, as with other studies it presents variation of only a few percentage between age groups of women up until 2016, and again 2021.[1] The data during lockdown restrictions found more extreme variations, but they were not sustained. We encourage the Committee to view a time series for this data rather than a one point snapshot or focusing only on the previous year. It will show natural variations for each age group. We also recommend that the Committee consider the cost and benefits; and cross generational gains which can be made with community wide interventions.

More recent studies have expanded the view of causation and measurement of loneliness for women and older people by examining ageism and gender discrimination.[2] This is an area that requires further exploration. It indicates the need for further community wide interventions regarding age and gender rather than primarily health-based interventions that have a more simplistic response.

In regard to measurement of data, it is always an issue of how data is collected in locked or closed environments with those who are already isolated. For example, in a study OWN undertook for a submission to the Royal Commission on Aged Care on the implications of lockdowns, family members reported premature deaths of their loved ones of non-Covid illnesses.

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[1] AIHW, Topic Summaries, Social Isolation and Loneliness, https://www.aihw.gov.au/mental-health/topic-areas/social-isolation-and-loneliness>

[2] Hajek and König Archives of Public Health (2024) 82:69<https://doi.org/10.1186/s13690-024-01297-2>, Perceived ageism and psychosocial outcomes during the COVID pandemic and Hackett RA, Hunter MS, Jackson SE (2024) The relationship between gender discrimination and wellbeing in middle-aged and older women. PLoS ONE 19(3): e0299381. https:// doi.org/10.1371/journal.pone.0299381

They reported that their relative who were unable to meet their family and friends, with no additional support from staff, had 'given up', and refused to continue to take medication or eat. Current measures are unlikely to capture these circumstances in any health data as being additional to expected deaths or caused by social isolation.

It is also an issue for women, regardless of age, who live with domestic violence and do not have access or are prevented by perpetrators from reporting their feelings of loneliness. It is important to consider who this data does not include and the implications for wellbeing (in the WHO understanding of this term), when funding the design and evaluate intervention strategies.

Access to data must be improved. In reviewing this data for the submission, it was found that improvements have been made in developing interactive charts and tables for data. However, it is still not possible to drill down to find data about NSW regions for example for cross matching with gender and age. This is essential for good place-based planning.

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

The markers differentiating population groups in the community are not always that significant or apparent. For example, in the Topic Summary by AIHW, there was only 1 percentage point separating age groups for women.[3] In addition, social stigma of loneliness is more likely to be internalised as it is associated with ageist ideas of uselessness and hopelessness. This stigma needs to be addressed for all age groups but particularly for older women.

Prior to lockdowns, OWN did not provide ongoing online activities. OWN was part-funded during lockdown to deliver some activities free of charge, and undertook to use its own resources to ensure that we had a range of activities for older women. We found participants fell into sub-groups:

- Older women who were meeting in groups prior to lockdown who continued on-line
- Older women who never attended in-house activities who participated in on-line activities
- Older women who were active in groups and did not move to online activities

[3]The social stigma of loneliness: A sociological approach to understanding the experiences of older people Barbara Barbosa Neves barbara.barbosaneves@monash.edu and Alan PetersenView all authors and affiliations
https://doi.org/10.1177/00380261231212100

OWN's online offerings uncovered a significant group of women who were isolated but could now meet online and participate in activities. When subsidies for these services ended, in the most part the older women who participated did not automatically transfer to face-to-face activities. The pandemic also created a new group who were active in the community who became isolated, some who remained isolated following the lifting of restrictions.

Post restrictions we now have:

- Older women who rejoined face to face activities following restrictions. They re-entered this community at different rates so that it was sometimes difficult to continue the same services.
- Older women who joined activities on-line and continue to do so and have not moved back to face-to-face activities.

To summarise, in terms of the population of older women, OWN has identified a group that had a brief reprieve from isolation, another that has returned to isolation and another that is able to participate in traditionally delivered services. While self reported benefits are that participation improved physical and mental wellbeing, we need to know more about long term benefits and how (or whether) online services can be improved to match the benefits of face to face interactions.

It was very clear to us that there were women who wanted to participate in online activities who could not do so because they did not have a device which enabled them to stream the classes; or they did not have the capacity to pay for internet charges; or they did not have the technological capacity to do so. Frequently, it was a combination of these factors.

OWN provided support for older women to learn how to connect to online classes, and even had tablets for free 'rent'. However, we could not provide free internet because we were not funded to do so.

We cannot disregard the cost of connection and access to technology when discussing online solutions to combat social isolation.

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

We refer to the body of evidence linking loneliness with mental health on each population group. The following quote from the AIHW summarises this work:

> *Social isolation has been linked to mental illness, emotional distress, suicide, the development of dementia, premature death and poor health behaviours (smoking, physical inactivity and poor sleep) – as well as biological effects, including high blood pressure and impaired immune function (Cacioppo et al. 2002 and Grant et al. 2009 in Holt-Lunstad et al. 2015). Social isolation is also associated with psychological distress (Manera et al. 2022) and sustained decreases in feelings of wellbeing (Shankar et al. 2015). Conversely, more frequent social contact is associated with better overall health (Botha 2022).*

This is backed up by the evaluation of OWN's program in Bankstown by Dr Pat Bazeley, Adjunct Professor, Western Sydney University. The Centre has a service coordinator and is funded to deliver activities by trained facilitators. The study found a positive relationship with attendance, reduction in social isolation and mental health:

> *The WHO-5 scale is used as a standardised and validated global measure to assess level of subjective wellbeing. It asks about recent experience (or not) of cheerfulness, calmness, vigour, feeling fresh on waking up, and whether daily life is filled with interest. Scores were computed to indicate serious depression (<13), depression (13-50), average wellbeing (50-70) and above average wellbeing (71-100), with differences in scores of 10 or more (over time, between groups) being regarded as significant (Topp et al., 2015). The mean score on the WHO-5 for the 61 participants for this year was 80 (SD=14.6) which compares very favourably with the average (of 67) found across samples of European women. Forty-four (72%) of the 61 review participants scored within the above average range of wellbeing (as defined above) and 16 (26%) were in the average range. Just one (new this year and with multiple morbidities) scored below 50, and even her comments about her participation so far this year expressed some positivity.*

The evaluation found a link between the number of times women attended activities and reported health benefits. The repeated visits increased social connection and in turn maintained attendance which further realised health benefits. Members listed multiple ways in which they see their involvement in the centre and associated benefits of

building and maintaining their health and wellbeing. The participants pointed out that it was the social connections made in the course of coming to the centre and engaging in its activities that are critical to providing the motivation that ensures continuing involvement, and thus to these benefits occurring. This means that long-term delivery of services is essential to have ongoing and multi-health benefits, including mental wellbeing which comes from being connected with others.

We should note that these activities in Bankstown Wellness Centre are funded by South West Sydney Local Health District, which makes it very affordable for the older women to take part.

d. Evidence linking social connection to physical health

Physical health and the link with loneliness is particularly significant for older women. Older women are proportionately more likely to experience health issues that will require ongoing medical services, be at risk of emergency services or reduce their life expectancy.

A recent JAMA publication[4] reported a study that followed a group of adults aged 40 to 70. Obesity is a significant contributor to a number of health conditions. This study compared the increased risk of mortality of obesity with loneliness. It found that those who were obese had a greater risk of mortality if they were high on the loneliness and socially isolated scale (than just being obese). This indicates significant rewards for individuals (regardless of body size) and the health system from social interventions.

To reinforce the link between loneliness and physical health, OWN refers to the evaluation of the Bankstown Wellness Centre by Dr Pat Bazeley, Adjunct Professor, Western Sydney University. As noted earlier, the Centre has a service coordinator and is funded to deliver activities by trained facilitators which makes access to activities very affordable. A summary of the evaluation results is as follows:

Twenty of the 61 participants reported having a medical condition that worried them or made them anxious. Compared to an international average of 70%, 75% of BWC members had no falls during the past year, and eight (13%) reported falling without hurting themselves. Three were hurt but did not need a doctor while four experienced falls necessitating medical treatment – just one of whom needed to be admitted to hospital. These numbers are better than international averages.

[4] ZhouJ,etalJ/\M/\NetwOpen.2024;doi:10.1001/jamanetworkopen.2023.52824.

This example is an average but many individuals had more specific physical health benefits, for example:
- Participant M35, observed that her active participation in group exercise served to minimise falls.
- Participant FG2 explained: “My doctor wanted to put me on a tablet for high blood pressure, and I've resisted. I went online and I found this line dancing and I came here and my blood pressure has dropped 20 points …so I have avoided tablets.”
- Participant FG1 said: “I stayed home for years when my husband died … all through COVID. And I went to the specialist and he says I have to have an operation for my knee, and I’m coming here and doing the exercise and I’m getting better.”

Services that reduce social isolation encourage participants to return and continue the activities, so that they gain ongoing physical health benefits. The evaluation showed that this reduced their need or delayed the use of more costly interventions.

e. Factors that contribute to the development of transient loneliness into chronic loneliness

The pathway for older women in which they can move them from transitory to chronic loneliness is significantly different; and are more difficult to interrupt. The pathway may be through separation or widowhood,[5] since women are more likely to live longer than their partners. This means they could be left in poverty, or near poverty, for a long period of their life given the fact that this cohort of women were more likely to have had little/no engagement with the paid work sector.

If they have lived their adulthood alone, ageing in these circumstances, together with a loss of income and/or adverse health conditions can increase their social isolation. The factors that affect older women’s quality of life are well documented, and relate to layers of structural and individual risk factors such as:

- the loss of a partner/supporting family member or divorce
- loss of employment, retirement
- sudden illness/injury or serious mental health problem
- periods out of the workforce in caring responsibilities
- little or no superannuation
- repeated crisis caused by natural disasters and emergencies
- physical disability – including loss of hearing
- no access to new devices, cost of data access

[5]Transitory or Chronic? Gendered Loneliness Trajectories over Widowhood and Separation in Older Age Nicole Kapelle Body nicole.kapelle@hu-berlin.de and Christiaan MondenView all authors and affiliationsVolume 65, Issue 2

Interventions are possible for all of these factors. Some are structural and require long term strategies, others can be implemented with current evidence and a relatively small investment.

f. The financial costs of loneliness to the NSW budget and the state economy and steps that can be taken to reduce the financial burden of loneliness

From a state perspective, the greatest gain for the NSW budget is to reduce the demand on the health system. Lonely people use more health care. The report referred to earlier in this submission of OWN's Bankstown service demonstrates how a small investment in public health can have outcomes for the end use of more expensive health care. The Centre has a service coordinator and is funded to deliver activities by trained facilitators. The study found a positive relationship between ongoing attendance, reduction in social isolation and mental and physical health.

In other words, fully funding all of OWN groups, as well as other community organisations which are engaged in similar wellbeing activities for older people, can significantly boost the bottom line of the state's economy through savings made in healthcare interventions to treat conditions which are preventable when older people are socially connected.

g. The identification of existing initiatives by government and non-government organisations to mitigate and reduce loneliness and social isolation

A significant proportion of OWN's funding is through the Departments of Communities and Justice, and Health. This modest funding (of only 4 FTE positions) produces significant results. Funding limits the distribution of this service and what can be provided. Only Bankstown Wellness Centre is funded by the Department of Health. It has strong attendance, and a vibrant multicultural membership because it is affordable and economical for the older women, many of whom are on the pension.

OWN organises a variety of activities, both online and face to face, which bring older women together to breakdown social isolation and build friendships. Our ***Recipes for Connection*** project which brings older women from migrant/refugee backgrounds together for cooking classes have proven to be a great hit with the older women who start the activities as strangers and finish as friends. OWN serves as an example where trust has been built within a community, community connections established with service providers and clients, yet we are unable to scale up our offering as we do not have funding to do so.

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

To effectively address loneliness, government initiatives must account for the financial realities that hinder social connection. At its core, being socially connected comes with a financial cost. Engaging in social activities—whether it be dining out, participating in community events, or accessing recreational facilities—requires financial resources that many individuals, particularly those from lower socioeconomic backgrounds, lack. Moreover, the costs of transportation, and even devices and technology (for virtual connections) can further exacerbate the barrier to social engagement.

Many forms of socialization involve direct expenses. For instance, joining clubs, attending workshops, or participating in community sports often requires membership fees or entry costs. For individuals on a tight budget, these costs can be prohibitive. One member on a pension said that "even meeting a friend for a cup of coffee" has to be carefully budgeted. For low-income older women, spending money on social outings may mean sacrificing essentials such as food, or healthcare. This dilemma can lead to a cycle of social withdrawal, further entrenching loneliness. With the rising cost of housing, there is a growing number of older women who are in private rentals who are spending more than fifty percent of their income on rent which leaves very little for other expenses.

Government funding should be directed toward subsidizing community events, workshops, and social clubs. By reducing or eliminating costs associated with participation, these programs can become more accessible to individuals from lower socio-economic backgrounds.

In developing interventions[6] to decrease loneliness, the following principles should be applied:

- Strategic funding of grassroot services that reach those most at risk in the transitory stage of loneliness
- Public campaigns to reduce the stigma of loneliness
- Build in funding to evaluate sustainability and long-term benefits
- Involve participation of older adults in planning and decision making

[6] Ferguson, L. (2012), "Tackling loneliness in older age – why we need action by all ages", Quality in Ageing and Older Adults, Vol. 13 No. 4, pp. 264-269. Body
[7] Balki E, Hayes N, Holland C, Effectiveness of Technology Interventions in Addressing Social Isolation, Connectedness, and Loneliness in Older Adults: Systematic Umbrella Review, JMIR Aging 2022;5(4):e40125

- Target specific populations groups within age or gender demographic groups
- Incorporate one on one intervention, online options and group options into interventions so they build upon one another within the same service
- Ensure support for transport and translation services are available
- Use existing services that have developed trust as well as new services for those who are not represented (specific cultural groups/transgender/language groups)
- Ensure strategies include maintaining and growing social networks
- Ensure equal access by providing free and low cost services

j. Steps that community, technology/social media companies, organisations, and individuals can take to reduce impact of loneliness on individuals and the community

The evidence for the effectiveness of tech solutions to loneliness for older people is mixed. [7] While the value of online services was a lifeline for many people during pandemic restrictions and for high risk individuals, the long term benefits are yet to be determined. As referred to in an earlier section of this submission, online access had allowed us to reach those who were replacing existing networks as well as those who were making contact for the first time. We found that there were still others who could not afford to, or did not want to use this form of communication.

Much was learned through the lockdown in online service delivery, unfortunately it is also the case that this is not being applied or developed.

In the experience of OWN, a group of vulnerable people would continue to use online services if they were free. The majority of older women would prefer access to meet in-person with their community. The most vulnerable need services to be subsidised/free, transport to be available and affordable, and access to trained facilitators who understand older women's physical capacity.

In responding to this issue, it is essential to look to the future, as the technology being developed now will be used by the next generation of older adults. Currently the high tech options are being developed without engagement with their potential users. The first adopters of future technology for older people are likely to be large scale organisations such as aged care or disability services who are focussed on reducing labour costs. Use of

[[7] Balki E, Hayes N, Holland C, Effectiveness of Technology Interventions in Addressing Social Isolation, Connectedness, and Loneliness in Older Adults: Systematic Umbrella Review, JMIR Aging 2022;5(4):e40125

technology in this and domestic environments may have its benefits. However to realise its potential, consumers aged over 50 need to be involved and considered in the early development stage.

The government could take a significant part in negotiating with researchers and product developers in this field by coordinating and facilitating consumer input from older adults. The products that will be introduced in the care industry and in the consumer market over the next decade are being developed now. This is an initiative that government can take now through its industry development portfolio. We encourage members of the committee to look to the next generation of technology rather than dwell on the possible outcomes from current technology and platforms. We know from history that use and popularity of these platforms are not static - they change with population groups and needs. Use of technology can be positive but it must be led by consumer interest. Devices that can be personalised to the interests and needs of the individual have potential to help people communicate as they age, improve safety and reduce abuse. For this to occur, quality of life measures that are important to the individual need to be incorporated into its design. It should not be used by institutions to replace as much human contact as possible.

RECOMMENDATIONS

1. **Strategic Funding for Grassroots Organizations**: Provide dedicated, ongoing funding to grassroots organizations with established trust among older women. Support services that directly address early-stage loneliness to prevent it from becoming chronic, and ensure these programs are available, accessible and sustainable.
2. **Public Awareness Campaigns to Destigmatize Loneliness**: Launch campaigns that focus on reducing the stigma of loneliness, especially among older women, who may feel the effects more acutely due to ageist stereotypes. Promote positive, community-oriented messaging that normalizes seeking social connection.
3. **Multi-Modal Program Delivery**: Fund a mix of one-on-one support, group activities, and online options to accommodate the diverse needs of older women. By providing various ways to connect, programs can reach individuals with different comfort levels and enable them to increase participation at their own pace.
4. **Affordable or Free Access to Services**: Ensure all programs are free or low-cost to allow older women on limited pensions to participate without financial stress. This ensures equitable access to support and helps eliminate financial barriers to engagement.
5. **Include Older Women in Planning and Design**: Involve older women in the planning and design of loneliness-reduction programs, drawing on their insights to tailor interventions that are responsive to their unique needs and lived experiences.
6. **Targeted Programs for Specific Subgroups**: Recognize the diversity within the older female population by creating programs tailored to subgroups, such as women who are newly widowed, those living with disabilities, or those from culturally diverse backgrounds. Addressing these nuances can increase program efficacy and reach.
7. **Provide Transportation and Language Support**: Increase funding for transport assistance and translation services to help older women who may lack access to independent travel or face language barriers. Ensuring accessibility is vital for economically dependent older women to participate fully in community events and services.
8. **Focus on Social Network Growth and Maintenance**: Fund programs that prioritize relationship-building among older women, fostering strong and lasting social networks that can overcome periods of isolation. Fund initiatives like community events, support groups, and peer-to-peer interactions.
9. **Sustainable, Long-Term Funding**: Allocate funding that considers both immediate and long-term program sustainability. Support services for older women should include resources for evaluation, growth, and adaptation to ensure they continue to meet evolving needs.
10. **Expand Reach through Trusted Community Partners**: Partner with community organizations that are well-known and trusted among older women, This will enhance program visibility and increase trust among participants, especially in communities traditionally underrepresented in mainstream services.