Submission No 99

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

Name: Name suppressed

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Partially Confidential

NSW Legislative Council's Standing Committee on Social Issues
Clerk of the Parliaments, NSW Legislative Council
NSW Parliament House
6 Macquarie Street
Sydney NSW 2000

Friday, November 1st t, 2024

Dear Committee,

Re: Parliamentary Committee to examine the Prevalence, Causes and Impacts of Loneliness in NSW

This submission is made in response to the call for submissions for the NSW Legislative Council's Standing Committee on Social Issues, Parliamentary Committee to examine the Prevalence, Causes, and Impacts of Loneliness in NSW. This submission will speak to the following terms of reference.

- *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.* Particularly this will be discussed in terms of opportunities for improved data capture and reflections on the current landscape of the widely available public data.

- *Reference (d): Evidence linking social connection to physical health.* Specifically, this will be spoken to through the public health lens, with notes on the nuance and information that is already available about the health issue of loneliness.

- *Reference (i): steps the State Government can take to reduce the prevalence and impacts of loneliness in the community.* Particularly referencing precedent in other health interventions, and speaking to a potential shape of an approach.

The concept of loneliness is so incredibly subjective- individuals might experience identical circumstances to one another, and one individual will report the feeling of loneliness, while another might report feelings of contentment. To inquiry broadly into the nature of such a topic requires intersectional, subjective discussion, and must value many perspectives. Loneliness is an issue of social epidemiology.

Last August, Dr Melody Ding of the University of Sydney asked the audience of the Sydney Ideas panel the following question: "Have you ever felt lonely?". In the virtual recording, the camera pans to the audience. Every visible person in the audience has their hand raised (The University of Sydney, 2023). Of course, this interaction occurred in a public talk titled "the loneliness epidemic", so some correlation would be expected. Another perspective: The Australian Institute of Health and Welfare (AIHW) reports that just over 1 in 6 Australians were experiencing loneliness in 2022 (Australian Institute of Health and Welfare, 2024). The AIHW also reported, in 2021, that 1 in 4 females between the ages of 15 to 24 agreed with the statement "I often feel very lonely" (Australian Institute of Health and Welfare 2023). It is inarguable that loneliness is a prevalent social issue- not only in Australia, New South Wales, but universally, for humankind.

Reference A: Loneliness Data Collection Improvement Opportunities

Several immediate opportunities for improved data capture present themselves while reviewing the available literature. The primary locations for gathering population data for the Australian population are the *Australian Bureau of Statistics* and the *Australian Institute of Health and Welfare*. Upon investigation, both sources, as well as the *Mental Health Commission of New South Wales*, have gathered their data from the *Living in Australia* study, or the HILDA study (which stands for The Household, Income and Dynamics in Australia) (Department of Social Services, 2022). The HILDA study measures the responses of a population

of more than 17,000 Australians per year, and has been running since 2001, and measures data relating to household members of working age, i.e., 15 years and over (Department of Social Services 2022). Several improvements on this data capture could be identified. Firstly, the HILDA survey measures the entire Australian population. As of March 2024, the population of Australia was over 27 million people, and the population of New South Wales was over 8 million people (Australian Bureau of Statistics 2024). A study of 17,000 people per year would measure less than 0.5% of the population of Australia in one year. While the context, the background for longitudinal studies, data science, and the methodology behind the generation of HILDA is absolutely much more complicated and nuanced than this simple calculation, it does describe future possible data collection opportunities. It should also be noted that the HILDA study does not survey people living in remote regions, and it does not survey overseas residents living in Australia (Department of Social Services, 2022).

An consideration for data capture is highlighted by Dr Melody Ding in her presentation during the *Sydney Ideas- the loneliness epidemic* public talk in 2023 (The University of Sydney, 2023). Dr Ding describes loneliness as a relatively new variable that has been studied- within the past 20 years (The University of Sydney, 2023). Dr Ding also highlights, using international data sources, that the proportion of loneliness varies across different population demographics- it is influenced by age, sex, gender, location, and more (The University of Sydney, 2023). The HILDA study has been measuring data since 2001- 23 years ago. As the study captures data from the age of 15 upwards, so the youngest in the first capture of data would not yet be in their 40s (they would be, to date, around 38yrs of age). The data that is being captured by the HILDA survey has not been capturing data long enough to be able to measure a full life course.

Another avenue for improved data collection is overtly stated on the Australian Institute for Health and Welfare's topic area page on '*Social Isolation and Loneliness*', last updated in April of 2024. It specifically states that "Australia's available data on loneliness do not allow for reliable international comparisons" (Australian Institute of Health and Welfare 2024). This is an easily indentifed area for improvement- being able to reliably compare the data on Australia to international context would afford the opportunity for deeper demographic and population understanding- to gain insight into international precedent, perhaps the behaviours of age-group similar populations, countries with similar- and different- economic climates, political environments, physical environments, social environments, countries with higher social support networks, different healthcare systems, different cultural and/or religious backgrounds. Guidance could be gained from international examples which might be further ahead in their journey's towards understanding loneliness, or to prioritising it as a social policy issue. As much as issue of loneliness is specific to a person, and to a person in a particular population (such as New South Wales), there is value to placing this issue into the context of a larger, intersectional context too. Loneliness is, after all, a *human* experience.

This enquiry seeks to understand the picture of loneliness, specific to New South Wales, particularly through the shape of social epidemiology (prevalence, causes, impacts). It would be absolutely beneficial to have data that describes the epidemiology of loneliness specific to the New South Wales population. Loneliness, as a subjective, personal, experience, needs to be understood with nuance in the context that it occurs. Critically, the collection of public health data, population health data, must be able to report subjective experiences, and this capacity must be built into the very systems for collection of data that are in place.

Reference D: Loneliness and Physical Health

What is meant by 'evidence linking loneliness to physical health'? The experience of health is, and has always been, a subjective experience. To understand loneliness as a public health problem, we view loneliness through the public health lens- meaning, health is subjective, nuanced, complicated, and intersectional. 'Health' is viewed through the lens of the determinants of health, and through the environment- in every sense of the word- that it exists in. While physiological, biomedical evidence to the experience of loneliness is absolutely available, a better understanding of the circumstances and behaviours of loneliness in a population is perhaps better understood through a wider lens. As Dr Melody Ding makes particularly emphasised during her presentation the loneliness epidemic with Sydney Ideas, loneliness is not a pathology- it is a not a discretely quantifiable, distinct variable that can be 'cured' or 'fixed' (The University of Sydney, 2023).

Evidence linking physical health and loneliness is widely available, it is detailed, available, and overwhelmingly comes to the same consensus: Loneliness is bad for your physical health. Professor Stephen Simpson of the University of Sydney synthesises this truth in his initial panel introduction of the '*Sydney Ideas- the loneliness epidemic'* to make the foundation of the topic clear- human beings have always been creatures of social connection. It is deeply rooted in our history, and our survival as a species, and loneliness, is, as he calls it, "the anthesis of social connection" (The University of Sydney 2023). Professor Matthew Lieberman of UCLA states in his book "*Social; Why Our Brains are Wired to Connect*", that "becoming more socially connected is essential to our survival" (Wolpert, 2013). In psychology, Maslow's 1954 hierarchy of needs places it second only to biological, physiological necessities for survival (McLeod, 2024). The World Health Organisation lists social connection as a determinant of health (Holt-Lunstad, Robles & Sbarra 2017). Social isolation is associated with increased risk for early mortality (Holt-Lunstad et al. 2015). It is approximated to have similar negative health impacts to smoking 15 cigarettes a day, and to be worse than drinking 6 standards of alcohol a day (Brown, 2024). To contextualise this, in 2023 substance misuse disorders are one of the leading contributors to the burden of disease in Australia (Australian Institute of Health and Welfare 2023). It is an important distinction to make that 'loneliness', when described in these ways, as a burden on human disease, refers to the experience of chronic loneliness, not episodic loneliness. As much as loneliness is a burden on health, it is also a normal human emotion.

While understanding the epidemiological behaviour of loneliness in a population must take into consideration a public health approach, there is also value in understanding how, mechanistically the ways that loneliness 'generates', or relates, to poor health outcomes. In order to understand, to reduce, to prevent- this is an immeasurably valuable exercise. Different fields have approached this idea from different, multi-disciplinary lenses. One study identified a relationship between biological, stress-related factors and loneliness, finding a relationship between levels of inflammation in response to acute stress, proposing the relationship between inflammation and immune dysregulation is one potential mechanism, as the lonelier individuals surveyed were found to have an increased inflammatory response (Jaremka et al. 2013). Another mechanism through which loneliness impacts a person's health is through influencing health behaviours. Loneliness has been found to be associated with increased sleep disturbance (Griffin et al. 2020). Even more significantly studied is the link between loneliness and exercise, with evidence indicating that loneliness is an independent risk factor in some populations for physical inactivity (Hawkley, Thisted & Cacioppo 2009). The relationship between loneliness and eating behaviours as also been studied- both in terms of incidence of disordered eating behaviours, and in terms of the kinds, and types, of food that are chosen and consumed, with an identified relationship between loneliness and likelihood to pick 'palatable' foods over healthy ones (Sirois & Biskas 2023).

There is an extremely significant correlation between loneliness and poor mental health. The NSW Mental Health Commission found that the prevalence of loneliness was significantly higher in the group of people experiencing poor mental health- more than 1 in 2 people, as opposed to a group of people with moderate-to-good mental health, which was 1 in 8 (Mental Health Commission of NSW 2020). Exactly how this works mechanistically is unlikely to be meaningfully delineated- as mentioned above, loneliness has a relationship with acute stress responses, with eating, disordered eating, with sleep quality, with exercise - all of which are things which are also associated with poor mental health. Another aspect of this might be to look at the relationship between loneliness and physical health as the ways the factor of loneliness might influence health outcomes, negatively compounding other behaviours and environments. Aside from the potential implications of the relationships already detailed here, of which there are many.

An example of this might be a theoretical relationship between disaster relief and recovery and the issue of loneliness. Dr Melody Ding partially outlines this her talk- as she describes, lonely people, lead to lonely communities, and lonely communities have less safety, less trust, less social capital- and less resilience (The University of Sydney, 2023). The Australian Disaster Resilience Knowledge Hub highlights community focused recovery as "essential" to disaster recovery and resilience- the use of local knowledge, and local strengths, social connection (Australian Institute for Disaster Resilience 2023). A community already predisposed to disconnection, might, in this context, experience a harder recovery. Recent approaches to disasters place heavy emphasis on the importance of resilience- and as numbers of disasters are increasing

into the future, so seem to be the rates of loneliness (KPMG, 2023) (Australian Institute of Health and Welfare 2023).

Reference I: The Shape of the Steps the State Government Could Take

As identified, loneliness is a problem which is incredibly complex, tangled, personal, prevalent, and hard to measure. It is not a pathology- it cannot be 'cured'. In the field of public health, we would call this a 'wicked problem'. To look at loneliness from the public health perspective takes a wide view at the environment which produces it. There are identified relationships between the prevalence of the experience of loneliness, and the increased use of social media (Brown, 2024). While social media and technology use might be blamed as the villain of this story, it is important to understand two things: blame has never been a functional public health response, and, social media does not exist in isolation.

There are multiple facets of loneliness that need to be systemically, and systematically addressed, to look at addressing the prevalence of loneliness. While loneliness is described as the lack of social connection, it is not necessarily solved by the meeting of new people- it is the issue of connecting deeply to people, the quality, and meaningfulness of the connection (Mind UK, 2019).

The way this could translate to a structured approach might be to work under harm reduction paradigms, and move not toward one specific, targeted behaviour-based or environment-based intervention, but many, easily accessible avenues of opportunity for individuals and the community.
To equate this to different public health campaigns for a different issue with precedent with the NSW government, this could be shaped like the 2018 NSW Government anti-tobacco campaign "*Never Give Up Giving Up*" (Cancer Institute NSW, 2021). As an intervention, this campaign was grounded in a harm reduction paradigm, with knowledge of behaviour patterns, and supported other campaigns by targeting implementation gaps. The idea was that if your first attempt to quit smoking was unsuccessful, you should keep trying to quit- to 'never quit quitting' (Cancer Institute NSW, 2021). The issue of chronic loneliness will not be solved by a single social interaction but creating a pattern of deeper engagement which is for the people, the path of least resistance. It is also worth noting that this idea is supported idealistically by common therapeutic advice for social anxiety and social isolation but operating structurally for whole-of-population (Mayo Clinic, 2021). Another lesson to learn from anti-tobacco policies is the success of infrastructure which makes it more physically difficult to engage in the behaviour- anti-smoking signs, designated smoking areas placed intentionally separate from the main throughfares, intending to, in part, make not smoking the path of least resistance. With an issue as complex, prevalent, and personal as loneliness is, it will never be a single catch-all 'solution', but rather a systematic approach that factors in the need for intervention, everywhere.

To conclude- interventions for the issue of chronic loneliness are wider, population health solutions that are already well known to government. Improving the cost-of-living crisis would improve the issue of loneliness but giving people space, and time, and the ability to afford to venture out and connection. If we had a four-day work week, we would have more time for recreation, and leisure, and behaviours that foster community. The issue of transient-to-chronic loneliness could be investigated from the perspective of the modern workforce- Gen Z workers on average more jobs, in more fields, than previous generations (Osorio 2024). In 2019-2020, more than 40% of Australian households reported moving in the last five years (Australian Bureau of Statistics 2022). Colloquially, I would expect this number to be higher, and higher still in the age demographic of 20-somethings. Meaning, people are experiencing a high number of transient periods, and may not have enough time in between to recover, and develop meaningful connections.

Thank you for your time.

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