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

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MACQUARIE University
SYDNEY·AUSTRALIA

LIFESPAN HEALTH AND WELLBEING RESEARCH CENTRE

Submission to the Standing Committee on Social Issues: Inquiry into the prevalence, causes and impacts of loneliness in New South Wales

Submitted by: Macquarie University Lifespan Health and Wellbeing Research Centre.

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Background

Prevalence of social isolation and loneliness. Social isolation and loneliness has been recognised as a growing global public health issue impacting physical health, mental health, and social functioning. Although the COVID pandemic has highlighted this issue, social isolation and loneliness were already a problem prior to the pandemic. By 2022, almost 1 in 7 (15%) Australians (18% of males and 12% of females) were experiencing social isolation (AIHI, 2024). People across all age groups appear to be having less social contact from 2001 to 2021. The frequency of social contact has been declining across all age groups in Australia for at least 2 decades, with data from the HILDA survey showing a decline of 13% overall from 2001 to 2021 (AIHI, 2024). The average person now gets together socially with friends or relatives about once a month. Approximately 33% of Australians self-reported an episode of loneliness between 2001 and 2009, with 40% reporting more than one episode (Baker, 2012). This prevalence follows a non-linear trajectory, such that elevated levels of loneliness are observed in young (i.e., ≤30-years) and older adults (i.e., ≥70-years), with an additional peak being observed in middle-age (i.e., 50-60 years; Hawkley et al., 2022). In Australia, incident rates of loneliness among individuals aged 15-24 years have notably increased from 18.5% in 2001 to 26.6% in 2020 (Wilkins et al., 2024). For approximately 10-30% of the population, loneliness develops into a chronic state (Steed et al., 2007; Theeke, 2010).

Consequences of social isolation and loneliness. Chronic loneliness is associated with poorer physical, cognitive and mental health, increased stress-related inflammatory and neuroendocrine responses, and increased risks for premature mortality (Hawkley & Cacioppo, 2010; Holt-Lunstad et al., 2015). Evidence from cross-sectional and longitudinal studies have highlighted the association of loneliness with poorer health behaviours including reduced physical activity, increased tobacco and alcohol use (Lauder et al., 2006; Matthews et al., 2019; Newall et al., 2013) and poorer treatment compliance for chronic conditions (e.g., Kusaslan Avci, 2018). As could be expected, loneliness poses substantial socioeconomic burden. Loneliness has also been associated with reduced work productivity, excess health care costs, increased use of emergency services, and increased use of GP visits by lonely older adults (Chamberlain et al., 2022; Mihalopoulos et al., 2020).

Risk factors for loneliness. Many factors contribute to risk for social isolation and loneliness, and probably interact with each other to exacerbate and maintain these conditions. Sociodemographic factors have mostly indirect links to loneliness and research suggests that many risk factors for loneliness are interrelated and impact each other (Barjaková et al., 2023). A recent cross-sectional study using a large sample of 52,341 Dutch individuals found several risk factors are associated with loneliness across the lifespan, lower education levels, inadequacy of financial resources, mental health, informal caregiving that is experienced as

burdensome, and limited social contact or network type (Hutten et al., 2023). In addition, having a non-western migration background was associated with greater loneliness in early and middle adulthoods, and older adults who live alone and have a physical disability are also at greater risks of experiencing loneliness (Hutten et al., 2023). Chronic illness has a bidirectional relationship with social isolation and loneliness (e.g. Kusaslan Avci et al., 2018).

Our work in loneliness and social isolation relevant to this inquiry

In our Centre we have conducted novel research into understanding and treating social isolation and loneliness across the lifespan. Based on the work conducted in our Centre we would like to highlight the following points for consideration that stem from our findings.

Focus Area 1: Distinction between social isolation and loneliness

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Recommendation 1: More research is needed to understand how social isolation and loneliness are linked and distinct from each other, so they can be better identified and treated.

Whilst social isolation is strongly linked to loneliness, these are distinct constructs and can exist independently. In simple terms, you can be socially isolated but not lonely, or lonely but not socially isolated (Weiss, 1973). Evidence by our team has shown that social isolation and loneliness are caused by different things and require different interventions to treat them. Social isolation refers to an objective absence of social interactions, ties or contact with other people, and social relationships in general. It is an inherently objective construct that is frequently operationalised as the size of one's social network (Masi et al., 2011), wherein a smaller social network is indicative of greater social isolation. Loneliness is conceptualised as the distressing emotion that accompanies a perceived discrepancy between one's desired and actual quality of social relationships (Pinquart & Sorensen, 2001) and is therefore subjective. As such, an individual may be socially isolated without being lonely, and a lonely individual may not necessarily be socially isolated (Weiss, 1973).

In our work we have also shown this distinction between these constructs, as well as that they are distinct from, but also linked to, common mental disorders such as social anxiety and depression in different ways (Wolters et al., 2023). We have tracked these constructs over a 3-year period in a large longitudinal study of university students (n = 1,357) and found loneliness was associated with the development of depression which in turn was associated with subsequent social isolation (Mobach et al., 2024). We did not find that depression and anxiety caused subsequent loneliness. Similar results were found in older adults over a 5-

year period (Cacioppo et al., 2010). This suggests how loneliness and social isolation are linked as well as how chronic loneliness might result through the development of subsequent depression and social isolation across all age ranges. This suggests subjective experiences of loneliness are key to identify and target early before they lead to depression and social isolation, which in turn are likely to maintain loneliness over the longer term and make it harder to treat and resolve. Better identification of the causes of loneliness and social isolation will provide more opportunities for prevention and early intervention of transient loneliness before it becomes chronic. **Increased detection of loneliness is needed. This can be done through inclusion of measures to screen and detect social activity levels, social isolation and loneliness in schools, health settings, national surveys and workplaces.**

Importantly in our systematic review and meta-analysis of psychosocial interventions for reducing social isolation and loneliness (Zagic et al., 2021) we found that different types of interventions had differential effects on reducing social isolation and loneliness, and associated emotional distress. Whilst overall we found that psychosocial interventions (n=58) collectively led to significantly: (1) reduced social isolation, (2) reduced loneliness, and (3) decreased symptoms of depression; different interventions led to different benefits. Interventions that targeted increasing social activity and facilitating access to other people were the most effective strategy for reducing objective social isolation (with moderate to large effects), but had non-significant effects on reducing loneliness. Hence, decreased social isolation did not automatically lead to reduction in loneliness.

Instead, we found that psychological interventions that taught skills to manage maladaptive cognitive biases, reduce fear-related avoidance of social situations and barriers to social participation, were the most effective strategy for addressing loneliness (with moderate effects) but had non-significant effects on social isolation. This review highlights that **loneliness is not treated by increasing social access alone, instead targeted psychological interventions are needed to address underlying causes. Therefore, increased access to *both* social activities as well as psychological treatments that target loneliness are needed.**

Recommendation 2: More research is needed to identify underlying mechanisms that cause and maintain loneliness to enable development of potent targeted programs.

As noted above we have some evidence for how to treat loneliness using psychological interventions, but a key challenge in the field is that our understanding of the mechanisms underlying loneliness is in its infancy. Theoretical models of loneliness (Cacioppo & Hawkley, 2009; Qualter et al., 2015) purport that loneliness is caused by social factors (e.g., poor social support network), cognitive factors (e.g., hypervigilance to social rejection, and

mistrust), and behavioural factors (e.g., social withdrawal). The evidence for most of these components come from studies using correlational designs such that causal conclusions cannot be drawn; however, there is evidence for the causal role of maladaptive cognitions in causing and maintaining loneliness. The nature of these cognitive components has been largely unknown, but we have clues about some of the cognitive and behavioural mechanisms underlying loneliness that if targeted are likely to provide effective new treatments for treating loneliness.

We have shown that group cognitive behavioural therapy for treating depression and anxiety in an older community sample that targeting maladaptive cognitions associated with loneliness, and increasing participation in social activities resulted in medium effect size reductions in loneliness symptoms over time compared to waitlist controls, and this benefit was maintained three-months later (Smith et al., 2021). In a series of novel experimental studies our team has identified key cognitive mechanisms that are specific to feelings of loneliness (Wolters et al., 2024; Zagic et al., 2024), and that targeting these specific cognitions using cognitive therapy strategies reduced feelings of loneliness (Zagic et al., under review). **More targeted research is needed to understand the key components of interventions to treat loneliness so more effective interventions can be developed.**

Focus Area 2: Increase social connections and social participation for all

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Recommendation 1: Public health messaging about the importance of social participation to prevent social isolation and loneliness (and maintain good overall health).

Frequent social activity is associated with reduced risk for social isolation and loneliness, as well as better physical health, mental health and cognitive health (Holt-Lundstad et al., 2018). It is important to note that not all social activity is equal in its benefits. In particular, engaging in a wide range of social activities with different groups of people may hold additional benefits over social contact with individuals and family members (Haslam et al., 2016). Although it is not clear how social activity results in these positive benefits, research suggests that it is via high quality social connections that build a sense of shared identity with other group members, lead to increased sense of social support, increased social and cognitive stimulation (Douglas et al., 2017; Haslam et al., 2014; 2016).

The importance of maintaining frequent social contact at all stages of life is not widely known to people in the community, but is an important prevention strategy with additional benefits for general health. Therefore, public health messaging needs to communicate the benefits and need for maintaining social connections throughout life. This can be done in

various ways including media and social media campaigns, marketing campaigns, holding community events and forums. In addition, all areas of government need to work together with local Councils, schools, NGOs, organisations and community organisations to facilitate this messaging. Therefore it **is important to facilitate social participation for all age groups in a variety of ways including through public health messaging, working with all areas of government, local councils and community groups.**

Recommendation 2: Interventions to increase social participation and build social connections to prevent and treat social isolation and loneliness need to be high-quality, inclusive and accessible to all.

Social isolation and loneliness effects all age groups and all populations. This includes people from all age groups (e.g., children, adults, older adults), backgrounds [e.g., First Nations people, refugees, culturally and linguistically diverse (CALD) communities, low and high socioeconomic status groups], genders (e.g., male, female, LGBTIQ+), living circumstances (e.g., single parents, families, people living alone, rural/remote/urban, living in residential aged care facilities), and those with comorbid physical disorders and mental disorders (e.g., chronic conditions, disability, common mental disorders, neurodivergent). Therefore research, interventions and services targeting social participation, social isolation and loneliness need to be inclusive and accessible to all. However, social participation is not always easy, and different sorts of social activities are more acceptable and feasible to different sorts of people. Also not all social participation is equal. As noted earlier, social participation needs to be high quality such that it increases peoples' sense of social support and feelings of being valued. Therefore **policy makers need to work with diverse groups of consumers to understand the needs of different groups, help to facilitate access to a wide variety of social activities and social groups, and to identify the barriers to participation for these groups and how these might be overcome.**

Recommendation 3: Identify and target barriers and facilitators to high quality social connections and participation.

In our systematic review, we reported on the common barriers identified in the literature (Townsend et al., 2021). Common barriers to social participation included accessibility, transport, and neighbourhood cohesion. Strategies should therefore include approaches to enhance the physical structures and community facilities in which we live to aid and facilitate social interactions (e.g., town planning that enhances easy access to community spaces, housing development that facilitates connections with neighbours), neighbourhood

cohesion (i.e., increasing how safe people feel in their community, how much they feel part of and identify with their community), and making social activities locally situated.

Our systematic review also identified that sub-populations that are more vulnerable to experiencing loneliness and social isolation are the least likely to have the resources (i.e., financial, transport, motivational, psychological, English-language skills, time) to be able to engage in social activities (Townsend et al., 2021). For example, individuals with a low socioeconomic status are unlikely to be able to afford to go out for meals with friends, entertain people at home, pay for clubs or activities, and may have limited transport means to travel to social activities. **Therefore, social interventions and activities need to be low cost (or free), subsidised for individuals with limited resources, and locally available**.

It is also important to target barriers to social participation. It is not sufficient to simply tell people that they need to socialise more, or to link them up with social activities as there are many barriers that hinder participation. Psychological barriers need to be overcome to aid people to engage in social activity and to be able build high quality social connections. This should include treating common mental disorders that reduce social participation (e.g., depression, social anxiety) through evidence-based psychological interventions, building confidence and self-efficacy in social activities, and teaching social skills as needed (Smith et al., 2021). People from particular groups have increased barriers to social participation. Poor health, chronic conditions, sensory impairments and immobility are well recognised barriers to social participation and are associated with increased social isolation and loneliness. For example, we have shown that chronic conditions such as endometriosis increase feelings of loneliness and reductions in social activities (Sullivan-Myers et al., 2021). Strategies are therefore needed to facilitate access to social activities that overcome health challenges. People from CALD communities may not have sufficient English-language skills to feel included in some social activities, and as such social activities that are culturally sensitive and linguistically appropriate also need to be available. People who are carers often have particular difficulties with being able to maintain social contact, particularly for carers who have difficulty going out due to the caring requirements or challenges that might arise if they were to try and take the person they are caring for out socially. In our work we have found that carers of individuals with dementia face several barriers to social participation, including psychological (such as embarrassment, lack of confidence in managing difficult behaviours,) and practical (like loss of friends, reduced social opportunities and transportation challenges). We have developed strategies to address these that include providing carers with a resource booklet that teaches skills to manage these barriers, with positive feedback. **Therefore linking people with social activities may not be enough. Attention needs to be given to addressing the practical and psychological barriers to social participation for different groups of people.**

Finally in our systematic review also found that prosocial motivations (i.e., socialising for the sake of making or maintaining friends), altruistic motivations (e.g., volunteering), and intrapersonal motivations (i.e., to maintain autonomy, pursue interests) for socialising were important facilitators of increased social engagement. **Public health messaging about the importance of regular social engagement, and activities to build motivation to maintain meaningful social engagement are important avenues to pursue.**

Therefore it is important to build high quality social interactions by increasing public messaging about the importance of maintaining social connections, as well as aiding people to do this by identifying suitable social activities for different groups of people, identifying and addressing barriers to participation as well as facilitators to participation.

Focus Area 3: Understand how online platforms can reduce social isolation and loneliness

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Recommendation 1: More research is needed to understand how online social contact and digital interventions can be used to reduce social isolation and loneliness in different age groups and populations.

Whilst online approaches should be explored, it is important to note that there is mixed evidence for the benefits of social media and online contact for use for reducing loneliness. There appears also to be differences in its effectives across different age groups and subpopulations. This is likely to be in part because people of different ages use social media in different ways, and because people use different sorts of online platforms for different purposes. Some of these may or may not be helpful for increasing social connection and reducing loneliness.

In a systematic review (Lei et al., 2024) we examined the effects of social media use in older adults. Cross-sectional studies reported greater social media use was associated with lower rates of loneliness (n = 13 studies). This was replicated across a wide range of social media use measures such as user status, frequency of use, number of online applications used, and duration of use. However, the results of longitudinal studies were mixed, with one of the two studies reporting that more frequent social media use predicted reduced loneliness over time, while the other found no association between time spent on social media and loneliness. Similarly, online interventions that attempted to reduce loneliness were also associated with mixed results. Given what we know about loneliness as outlined above, it is likely that online social contact is more likely to reduce loneliness when it facilitates high quality social connections (not just social contact).

In other work we found that easy access and digital competency can facilitate the maintenance of social connections via online platforms in older adults, but is a barrier to older adults without the means, knowledge or confidence (Townsend et al., 2021). Therefore, digital solutions might not be ideal for all. We also compared the effects of online social contact to face-to-face contact in terms of satisfaction and strength of social connectedness to the other person/people in an older adult sample. We found that while online social contact was beneficial and had positive effects, the effects were stronger for face-to-face contact than online contact (Chen et al., 2024). This work together suggests that **online social contact has mixed benefits for targeting loneliness in older adults, and while can be useful for maintaining social connections, should not be prioritised over face-to-face contact but used as an adjunct.**

When comparing the effectiveness of interventions designed to treat loneliness across the adult age range in our systematic review and meta-analysis reported above (Zagic et al., 2021), we found that technology-based interventions did lead to significant reductions in loneliness, albeit to a lesser extent than in non-technological based interventions. In other work we have developed and tested in preliminary work an SMS text messaging intervention for reducing loneliness in people with endometriosis. The results suggest that this text messaging intervention reduced loneliness by making people feel like they were not alone that they benefited from finding a "*community*" that had a shared understanding of "*what I am going through*" (Sherman et al., 2024). This demonstrates that simple interventions can be effective, most notably when they build high quality social connections that increase social support and sense of a shared identity.

Therefore online interventions may be beneficial but also may not be, and benefits might vary with age or subpopulation. Emerging evidence suggests that although online interventions probably provide benefits to some subgroups, the effects of non-digital connections are more potent. More research is needed to understand how digital interventions can be utilised to increase social connections and reduce isolation and loneliness.

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