REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

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

CORRECTED

At Macquarie Room, Parliament House, Sydney on Friday 15 November 2024

The Committee met at 11:20.

PRESENT

The Hon. Dr Sarah Kaine (Chair)

Dr Amanda Cohn
The Hon. Anthony D'Adams
The Hon. Natasha Maclaren-Jones
The Hon. Taylor Martin

PRESENT VIA VIDEOCONFERENCE

The Hon. Scott Barrett
The Hon. Bob Nanva

The CHAIR: Welcome to the first hearing of the Standing Committee on Social Issues inquiry into the prevalence, causes and impacts of loneliness in New South Wales. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we meet today. I pay my respects to Elders, past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respect to any Aboriginal and Torres Strait Islander people joining us today.

I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of their evidence at the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

Professor MICHELLE LIM, Chief Executive Officer, Ending Loneliness Together, and Associate Professor, Prevention Research Collaboration, University of Sydney, affirmed and examined

The CHAIR: Welcome, Professor Lim, and thank you for making the time to give evidence. Would you like to start by making a short statement?

MICHELLE LIM: Yes. I am an associate professor at Prevention Research Collaboration, University of Sydney, and also the chief executive officer of Ending Loneliness Together. Ending Loneliness Together is seen as the national authority in the area of loneliness and connections. We have about 65 organisations that do channel into our network. We are currently involved in assisting the Victoria, Queensland and South Australian governments in various activities targeting loneliness.

I'm also the founder and vice-chair of the international scientific board of the Global Initiative on Loneliness and Connection, which supports about 28 countries around the world on their agenda with loneliness and social connection. In late 2023 I was appointed by the World Health Organization to serve as one of 20 experts around the world. This role is to assist the secretariat on the activities in connection to social connection. For example, we are assisting with the development and launch of the commissioner's report at the WHO, which will be released early next year. The evidence that I bring today will be in line with the World Health Organization's approach to this issue, and I really urge the Committee over the next couple of weeks to think really deeply about the solutions and strategies targeting these communities.

It takes an average of 17 years of evidence to change practice on the ground, and the kinds of questions I really hope that you do keep in mind are really things about how strong is the evidence on particular interventions. Have they been evaluated or do they simply show associations? Are these interventions actually measuring loneliness, or do they simply track social isolation? Because we do know that those issues are different. Just because you are connected to people does not mean you are less lonely. In fact, having particular social connections and social relationships can also be unhealthy. They're not necessarily always healthy for us. Those are some of the things that I hope that the Committee will keep in mind.

The CHAIR: Thank you so much; I appreciate that. Thank you again for being here and for Ending Loneliness Together's submission. From reading a number of the submissions it does appear that the work that you've been doing in Ending Loneliness Together really has been the basis for a lot of consideration of these issues. We appreciate you being here and kicking us off today. I wanted to pick up a bit more on what you've just mentioned in your introduction and in our terms of reference we talk about loneliness and social isolation. Could you explain a bit more the difference, but also why it matters that we think about them differently?

MICHELLE LIM: Yes, I will. I will align with the World Health Organization's definitions. Loneliness is very much a subjective experience, where you feel like you do not have those meaningful relationships that you desire. There is a difference between what you have versus what you hope to have. Loneliness can only be assessed if you ask someone specifically. It has to be measured. You can't actually observe that as a third person. Social isolation is very much more of an objective state. I can see, as a third person, whether you may be more vulnerable to social isolation if you do not have people around you, you have fewer social contacts, fewer group memberships, less social interactions around you.

How we would tackle the issue is very different. One is very much based on quality and improving the quality of those interactions and the other is around just simply providing social opportunities. A lot of the interventions that you might hear over time is that they do bring people together. My question back is: Do they make a meaningful difference to loneliness? Do they measure loneliness as a primary outcome? Those are the kinds of questions I tend to ask myself.

The CHAIR: Could I ask you a bit about that? As I said, we've been reviewing other submissions and I am a bit interested in the research side of things. You're clearly across it. Is there any other data or research that you would point to for us to consider? As I said, a lot tend to refer to your work. Is there anything else that you could point us to that's useful?

MICHELLE LIM: We do also use the HILDA survey, for example. As you know, the HILDA survey has some loneliness questions, but we have recently also validated some items there and actually distinguished what loneliness is versus social isolation. We do know, for example, the prevalence of what we call episodic or transient loneliness versus persistent loneliness. They are quite different.

The CHAIR: In your report you cite that New South Wales residents reported the highest prevalence in the country, with 29 per cent meeting the criteria for loneliness. Can you explain this a little bit? Is that 29 per cent extrapolated across the population? Was it 29 per cent of respondents?

MICHELLE LIM: Twenty-nine per cent of respondents, but those surveys are actually benchmarked and rated according to ABS profile. I would like to state very clearly that when we look at differences across States there is no significant difference. It's just that New South Wales is reporting the highest, so just be very clear about that.

The CHAIR: When you talk about meeting the criteria for loneliness, can you talk us through what the criteria are?

MICHELLE LIM: There is bit of a cut-off score that we use of a psychometrically validated scale, which is the UCLA Loneliness Scale. We actually have a criteria for loneliness at any given time in the more severe end, so more at the top end, where we found that one in six Australians report severe levels of loneliness but only one in three would report loneliness at any given time. So you can hear that the prevalence is really high. I'm not really concerned very much about the high prevalence because loneliness itself, from an evolutionary point of view, you are meant to feel lonely. It's like you are meant to feel hungry and you are meant to feel thirsty. What I am concerned about is persistent loneliness, right. So we are living in an environment that does not facilitate us having, initiating, developing and maintaining social connection that's meaningful and healthy to us.

In this year we actually look at longitudinal data and I am more concerned that one in four Australians report what we call persistent levels of loneliness. This is actually meeting our minimum criteria of at least eight weeks, up to 16 weeks. And depending on where you look, including the HILDA survey, we also looked at people who met the criteria for one year and people who met the criteria for two years. I'm more concerned about persistent loneliness because we know now with emerging data that, yes, loneliness is bad for our health and wellbeing, but when we have those persistent states or more chronic states, that's where we exacerbate our incidence of high mortality and increase our risk of developing future health problems.

The CHAIR: Throughout the various submissions there is discussion about which age cohort or demographic group experiences higher levels of loneliness. Your research was interesting in that it found it was younger people, 18 to 24. Can you talk us through that a bit? Has there been an attempt to figure out what's going on with that group?

MICHELLE LIM: I would like to state that, depending on the survey that you look at, there will be different age groups. It really depends on the sample. In the international data we have younger people, and then sometimes middle aged and older adults might report loneliness. It really depends on how you measure it. I wonder sometimes when I look at this data whether it is that young people are just more comfortable in reporting their loneliness. Perhaps there is an intergenerational bias, where older people do not allow themselves to use the term "lonely" or have this perception that "I shouldn't be feeling this way". So I would not discount the fact that older people experience loneliness. They certainly experience social isolation, which is a pathway to loneliness. We can't neglect other age groups as well. And of course, the middle age group, as well, does come up quite a bit. Not much research has been done looking at the causes of that in middle age, but some of the hypotheses around that might be that they might be in a parenting role or a caring role. They do not have time to develop and maintain meaningful social connections for themselves, because they're really overburdened by those responsibilities.

Dr AMANDA COHN: Thank you so much for coming to share your expertise today. I'm interested that you're representing a national organisation. You're obviously doing some very impressive work internationally as well. What are the lessons from overseas or other jurisdictions that we should be looking to?

MICHELLE LIM: What we have looked at is different kinds of interventions. We have a lot of investments in interventions, focused on the individual level and some on the community level. I will, of course, advocate that we do need to look at these at-risk communities. However, government has the opportunity to look at population-wide strategies as well. Given that there is a high prevalence of loneliness—at any given time, one in three of us will experience it—what we're really trying to do is to prevent that one in three from going on to develop more persistent loneliness. Only government would be able to have a strategy where we have this population-wide initiative. It could look different ways. It could look like improving community awareness on the national level. We have Loneliness Awareness Week, but that's very much limited in terms of its funding. We can only do so much with very limited funding.

This year, just in three weeks, Loneliness Awareness Week yielded around 286 million media impressions[1]. That's just in three weeks. Two thousand people sought connection. People went to the website to look at how they can help others or help themselves. This campaign is really limited, and it needs to be scaled up,

[1] In correspondence to the committee received on 3 December 2024, Professor Lim clarified the evidence given advising that the correct figure is 589 million media impressions.

but that would be an example of a population-wide strategy. Other population-wide strategies could be things like building the capacity of health and community services to understand, assess or appropriately respond to people at risk of loneliness; implementing workplace policies that provide opportunities for employees to feel included and supported in the workplace; implementing policies to ensure that employees are not overly burdened at work and there is sufficient time for them to focus on their personal lives and building quality interactions; implementing educational policies to children, adolescents and young people where they can learn to navigate social relationships; and incentivising the community to engage and share activities in their neighbourhoods. We can do more. Basically, what we have found is there is a lot of evidence on the individual and community level, but nothing for a population-wide strategy. It actually has been advocated for by the public health sector that we don't spend enough time on prevention. They don't cost much more and they have value for money. But we need to actually do those ones.

Dr AMANDA COHN: The top recommendation that you made in your written submission was commissioning an evidence-based statewide strategy to promote social connection and address loneliness. You mentioned a couple of examples from elsewhere. Which one of those would you see as best practice in terms of other states or overseas?

MICHELLE LIM: We have just recently looked at the global level. About nine countries around the world have a strategy already to address loneliness. Another seven have loneliness included in related policies, so social, community and mental health. We are probably one of four countries around the world that have done economic costings on loneliness, but we do not have a strategy. I think we're a little bit behind in that we need to coordinate efforts. Loneliness is a highly prevalent issue but is not easily resolved because it's an intersectoral issue. Without that coordination and bringing in multiple stakeholders from across different portfolios, and working with government stakeholders, people with lived experience and scientific experts, we need to have a strong foundation to actually base our actions on.

Every country is different. I know, for example, for Denmark's strategy, they commissioned their strategy to experts on the ground. That is an example. Other governments might do an in-government strategy and coordinate their efforts by themselves. What I really hope to see much more, which I notice, is that these strategies are not evaluated and some of them are not implemented. That is a worry because then you have a strategy that just sits around and does nothing. If we were to go down that line, making sure it's implemented well and evaluated would be a very sound approach and a great opportunity for New South Wales to start.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for coming today. I have a couple of questions. The first one is around the definition and whether there are universally accepted definitions of loneliness and social isolation? Could you outline the difference between those?

MICHELLE LIM: Yes, there is. You will see those definitions when the World Health Organization releases its report early next year. In brief, loneliness is subjective. It's a distressing or adverse feeling that comes up when you feel your relationships do not meet your current social needs. Social isolation is objective, so you have fewer social relationships, contacts and interactions with people. Again, one is observable and the other is not. When we think about interventions and solutions, we don't really know the impact unless we ask people, "Do you feel less lonely because of the intervention or do you feel meaningfully connected because of this intervention?" I think we can do a much better job evaluating loneliness.

The Hon. NATASHA MACLAREN-JONES: You mentioned there has been some economic costing around loneliness. How can you measure loneliness and social isolation?

MICHELLE LIM: I think we can have a strategy in New South Wales, for example, of population health surveys, where we can actually validate loneliness measures, or short, brief measures that have been used by the UK, for example. The Office of National Statistics does have a one-item loneliness scale that looks at frequency and also measures well-known indicators of social isolation as well. Some people do use indicators around the amount of social contact that someone has. Other surveys also have related constructs like the living alone status, for example. I would recommend a combination of those. But they can be really easily implemented in New South Wales population health surveys.

The Hon. NATASHA MACLAREN-JONES: I know that Queensland held a loneliness inquiry a few years ago. Only a few months ago the ACT released its report. I am not sure, but I think Victoria is still going through theirs. You also referred to a New South Wales strategy. How important is it to look at it from a national perspective, particularly around a universally accepted definition and how things are measured?

MICHELLE LIM: I think what we don't have—and this is something that we've been trying to do as a national organisation, is to set the consensus definition and to ensure that everyone's thinking about the issue the same way. We talk about specific measurement using a loneliness outcomes framework. We talk about measuring

programs, asking people questions the same way so that we can have a benchmark to compare interventions with other interventions. Because we're not using the same kinds of scales it's very hard to determine the effectiveness of those interventions.

The Hon. NATASHA MACLAREN-JONES: This is more of a health question. We know that there is a link between loneliness and social isolation and poor health outcomes. Has there been more work done to break it down to the psychological and the physical impacts on a person's health?

MICHELLE LIM: Yes. At the moment we are doing some research with *The Lancet*, for example—it will not be launched until next year—but we look at the mechanisms of the pathways from loneliness and social isolation to mortality or poor health. There are pathways, so psychological mechanisms are one, restorative pathways like sleep quality, health regulation behaviours are another, and physiological pathways as well—so brain biology and genetics. One thing that I want to really stress is that loneliness is really experienced in the brain as a biopsychosocial stressor. When we are physiologically stressed out, we will also then have that impact on our psychological health, and we are less incentivised to keep healthy. We are less incentivised to exercise because no-one is nagging you to do those things. We're less incentivised to eat well and live well. Therefore, if we are lonely and we do not address those things properly and we do not have the resources around us to help us, that is when it leads to high mortality and high morbidity of health disorders.

The Hon. NATASHA MACLAREN-JONES: My final question is in relation to your recommendation 3, about evidence-based training programs for frontline practitioners in New South Wales. This was a similar recommendation that came out of the Queensland inquiry. I'm interested to know if you're aware whether Queensland has advanced any work in that space and any examples of some practical programs that are being rolled out, whether it's here in Australia or overseas.

MICHELLE LIM: I do know. I'm not sure if I'm allowed to speak about them, and that's one of my recommendations for the Queensland Government as well. What we don't have—and I would even relate this to a psychology practice; I'm a registered clinical psychologist—specific training even within our mental health sector about what loneliness is and what it's not. Ending Loneliness Together was commissioned to do a series of training in Victoria, for example, and we went up to mental health practitioners on the ground. What we found was that the things that we were teaching around social connection, loneliness and social isolation were new to practitioners. The way I was trained was that we were very much focused on mental health suicidal risk, maybe physical health to ensure that, but we don't think about social health until we try to discharge someone off the books, right.

We need to have a system change in the way we train mental health clinicians. We're doing some work on the ground already on ensuring that people understand the 101 of how we improve social connection. Again, remember, it's not simply connecting people. I think when we connect people, if you feel ambivalent—and I say ambivalent so you're not sure about the relationship—or if you feel negative about the relationship, in which you just gain, you will still feel lonely. So, really, getting practitioners to understand, sure you connect someone, but what is the next step? How do you know they're less lonely? You could connect someone and they actually feel more lonely. Being lonely in a group, for example, lonely in a marriage, lonely within the neighbourhood is something that people talk about all the time.

The Hon. ANTHONY D'ADAM: You've talked about loneliness and social isolation being two different things: one is subjective, one is objective. Which one has the more adverse health impacts?

MICHELLE LIM: They're equivalent. There is no significant difference between the two. In traditional research and medical research, the impact of social isolation on poor health has been researched very well, starting from things like animal models where they actually isolate mammals, for example, and see how their health is and how they interact. But in more recent years, it's not about being alone that hurts our health; it's feeling alone that hurts our health. We see emerging data, even in young people. In a recent study that we did, we could see signs of vascular ageing in young people as young as 22. If they feel lonely, we're seeing signs of vascular ageing early on. They don't have chronic disease just yet, but loneliness has a profound impact on deterioration at an early stage. That is why I talk about prevention quite a bit, because—

The Hon. ANTHONY D'ADAM: Is it possible, then, to be socially isolated without some health impacts?

MICHELLE LIM: My colleagues in the social isolation research would say it's equally bad for you, and the data is saying that, equivalently, we know that if you're socially isolated you're going to have a higher chance of cardiovascular disease as well. So they both are bad for health. If you have one and not the other, that's bad. If you have both, that exacerbates it. They're synergistic—you might put it that way.

The Hon. SCOTT BARRETT: My questions are going to be a bit scattered and not linear. They might also seem a bit obvious, but it's important that we get some of this stuff on the record. My understanding is that there is a chance of progression from social isolation to experiencing loneliness, then to feeling lonely, through to severe loneliness.

MICHELLE LIM: Yes. What we're saying is, again, I guess keeping in line with the current perspectives that we have out here, is that feeling lonely is an innate signal for us to do something different about our social relationships. If we ignore it or if we do not have the resources to manage our loneliness in an effective way, that's when it will lead to poor health. When that's the case is something that researchers have not figured out, and it could be a subjective threshold because, as I mentioned, loneliness is subjective. So we do not know when someone is lonely and how long they need to be lonely for before it leads to poor health and mortality.

The Hon. SCOTT BARRETT: Following on from that, in terms of who is affected by loneliness, could you tell us a bit more about why those reporting financial hardship would be seven times more likely to have persistent loneliness?

MICHELLE LIM: That's a fantastic question, Scott, because that's something that came up for us unexpectedly and, with this climate of everyone being in financial strain, we are concerned about that. When I look at the international data on that, we also see that people from lower socio-economic backgrounds, who are more disadvantaged in terms of income, are disproportionately affected. Even after we account for age, gender, health problems—all of those variables—we still find that people who perceive themselves to be financially unstable or who do not have their financial needs met are almost seven times more likely to experience persistent loneliness. We do not have the detail of why that's the case, but one can hypothesise that being financially strained changes the way, first of all, that we see relationships. It changes our capacity to maintain social relationships—things like time, things like activities. So a population-wide strategy, for example, could be to ensure that there are low-cost or no-cost types of activities for people to engage in. People need accessible and safe spaces in the community to have social interactions that are meaningful and heathy for them.

The Hon. SCOTT BARRETT: I will come to the other ones, because this sort of flows onto your second recommendation. Among other things, it talks about developing a framework to guide and promote social connection. What are some of the things that could help that social connection?

MICHELLE LIM: For everyone's sake, loneliness and social isolation are, according to the World Health Organization, two forms of social disconnection. There are other forms of social disconnection, such as lack of social support. Social connection would mean having less loneliness and social isolation in this space. The competency framework is really focused on training people on the ground across sectors to know how to respond accordingly, what to say and what not to say. We need people who feel lonely to feel safe to actually get the help they need. What we do know is that there is a huge amount of stigma around loneliness. About one in two Australians who do feel lonely actively conceal their loneliness and do not want people to know that they feel lonely. Because they are actively concealing and not getting the help they need, that is where we actually get into the risk of developing persistent loneliness.

The Hon. SCOTT BARRETT: Thank you. You've also put a dollar figure on what loneliness is costing per year. You've got it at about $1,500 per person. Who is wearing that cost?

MICHELLE LIM: I would say the Government. I believe Professor Alan Duncan, who will also be giving evidence, is the lead author on that paper. I think he can give you a really specific breakdown on where those costs lie. I believe some of those are hospitalisation costs. Just to note, I don't believe that the social and educational outcomes have been costed. If there is only a health focus, loneliness also has a burden on other kinds of outcomes, such as education and social outcomes.

The CHAIR: Mr Barrett, do you have any further questions for now?

The Hon. SCOTT BARRETT: I do, but I am conscious that there are others who haven't asked questions yet.

The CHAIR: Okay, we will come back to you shortly.

The Hon. ANTHONY D'ADAM: I have a question about periodisation. What is the evidence in terms of the experience of loneliness in early life versus later in life? Is it the case that there is evidence of persistent loneliness that goes for the whole course of someone's life, or is it something that might be experienced at different stages to different extents?

MICHELLE LIM: That is a great question. I am not entirely across the research on that. I do know that there are a lot of studies on children and adolescents that look at early experiences of loneliness and how that trajectory means that they actually report poorer educational outcomes. But I don't believe those surveys actually

track those children long enough for us to know how far those detrimental effects are. Usually they track them for four to five years and they can see that early loneliness predicts poorer educational and social outcomes down the line.

The Hon. ANTHONY D'ADAM: My other question is about government prioritisation and the relative risk of loneliness in terms of adverse social impacts versus the other risks and other types of interventions that can be made. If you are taking a public health approach, why is loneliness more of a pressing issue than, say, diabetes, or other forms of—

MICHELLE LIM: Over the past 20 years we have had an acceleration of robust scientific evidence that has found negative impacts of loneliness on health. Prior to that, we didn't. If I think about what we've done for things like obesity, we have guidelines to talk about how we can prevent obesity. The detrimental impact of obesity is fairly equivalent, yet we don't have any guidelines on having meaningful social connections. I think it's kind of overdue, and it's an issue that the World Health Organization is trying to reposition. This is not a soft issue. There is enough evidence for them to invest millions of dollars to have a high-level commission around the world. This is also not an issue that's just a high-income country issue; this is also an issue for low- to middle-income countries. It's enough evidence for us to do something about it. What is difficult is about how we do it, where do we start, because there will be a lot of people who want investments in particular types of interventions.

I really think about the value of government being able to widely implement and make a difference across the population, and that's where the power of government is. What I do see is there are a lot of interventions out there that evaluate, or maybe not evaluate at all, and they can't be scaled even if they're effective. That's the issue we have. They're all working in silos. A lot of interventions are really also led by very poorly resourced community organisations. They don't have any support to scale up. They don't have any support to do more. Our efforts are really very limited and very siloed, and this is where government can really do a robust, sound strategy and implementing and evaluating that strategy and thinking about not just what we call high-risk populations but also population-wide strategies.

The CHAIR: I've got a couple of questions. One might be quite quick. In your recommendations you note that your research could be further broken down by jurisdiction. Is that something you already have or is it something you could do? I'm thinking more about New South Wales, obviously.

MICHELLE LIM: Yes, we could do that. I think it's very easy for us to scale up. But it depends on whether you want to use existing datasets, which may not be fit for purpose for the New South Wales Government. But we can easily run statewide populations and longitudinal populations. I'm just going to flag that because we know a lot about what's happening at a cross-sectional level. We know the associations across that. What we don't know is how those things fluctuate over time. This informs interventions; this informs solutions or strategies. I would highly recommend a much more longitudinal approach so that we can make a big difference.

The CHAIR: Regional versus metropolitan—is there anything that can be broken down there?

MICHELLE LIM: Yes. From our State of the Nation survey, we do see higher levels of loneliness in remote/rural areas of Australia. What we don't have is the reasons why that might be the case and what we can do to help our rural communities. I think that we need to really dive into different kinds of methodologies that can actually answer those questions.

The CHAIR: I have one last question—I know we're running out of time—but it's not quite on that point. It goes to the questions you were asked by Ms Maclaren-Jones. You made the point that lonely people are less engaged in physical activity and more likely not just to be on social media but to have social media addiction, I think is the framing. Have you measured this, and could you just explain that a bit more? You read there are some good things about it, but this sounds to be at an extreme end. If you could just explain that a bit more.

MICHELLE LIM: I will just speak to the cross-sectional data that we have at the moment from the State of the Nation report. Just for the purposes of the other members of the Committee here, what we do see is that there is an association of loneliness and problematic social media use. That means one needs to check their social media accounts all the time. If they are not on them, they feel very adverse effects from that, so this is a problematic addiction. What we found was the frequency of use wasn't associated with loneliness, but it was really if you had the problematic use. That's the difference. What we do also see is certain age effects. We don't see that effect in older people; we only see that effect in younger people. It's basically indicating that we may need to think about guidelines for younger people in terms of how they navigate social media use and also not compromising face-to-face interactions. So being skilled and confident to manage the social interaction that's happening face to face.

The CHAIR: I suspect there might be some more questions, but we are almost out of time. Thank you, again, for joining us here today and for your submission. I don't think you took any questions on notice but there are a few questions we might not have got to, due to time, so we might send those to you as supplementary questions. The secretariat will be in touch with you about. Again, thank you so much for being with us today.

(The witness withdrew.)

Mr CHRIS GAMBIAN, Executive Director, Australians for Mental Health, sworn and examined

Ms STEPHANIE TRAINOR, Policy Advisor, Suicide Prevention Australia, before the Committee via videoconference, affirmed and examined

Ms REBEKAH HENRICKSEN, Director of Government Relations, Suicide Prevention Australia, before the Committee via videoconference, sworn and examined

Ms CARLY DOBER, Policy Coordinator and Psychologist, Australian Association of Psychologists Inc, before the Committee via videoconference, affirmed and examined

Mrs AMANDA CURRAN, Chief Services Officer and Psychologist, Australian Association of Psychologists Inc, before the Committee via videoconference, affirmed and examined

The CHAIR: We will begin our next session. We have quite a few witnesses online and I note for their benefit that we also have some Committee members online, so witnesses may also receive questions from them. Thank you for making the time to be here today and for your submissions. Each organisation may make a short opening statement. Mr Gambian, would you like to start?

CHRIS GAMBIAN: Thank you for the opportunity to say a few words today. Australians for Mental Health is a citizen-led social change group dedicated to fighting the root causes of mental ill-health and determined to create an Australia where everyone's mental health can thrive. Loneliness is not, of course, a mental health condition, but the two could not be more closely linked. We know that people experiencing mental health conditions can be at extreme risk for experiencing disconnection and isolation. Likewise, we know that people who lack strong relationships and connection are at a much higher risk of experiencing a mental health condition or exacerbating the symptoms they are already experiencing. The polling we have conducted confirms what others have said: at any given moment, a third of us feel lonely and the experience of loneliness doesn't discriminate by age, gender, class or geography. This is the pandemic that not enough people are talking about, and I congratulate the Committee and Minister Jackson for taking on this important work.

There is a risk that we think about our opportunities to make change in the wrong way. There will be many worthy programmatic interventions suggested and we will support those. There will be more abstract observations about loneliness, and that is understandable. Coming up with a concerted policy response to something as big and indistinct as loneliness is a bit like coming up with a concerted public policy response to the weather or poor dress sense. Some will roll their eyes at what they might think is the ultimate expression of the nanny state. I urge you not to fall into either of those traps in this inquiry. I urge you to consider the modest structural responses that can be the catalyst for meaningful change. By asking local government to consider the opportunity to drive social inclusion and connection, funding it to deliver and holding it accountable for that delivery, we believe that the lives of literally millions of Australians can be improved. No side of politics owns this issue. It's not ideological and it should not be partisan. Tackling loneliness should be a priority for everyone in this Parliament. I thank you for taking these first steps towards that goal.

The CHAIR: Thank you, Mr Gambian. Suicide Prevention Australia, do you have a statement?

REBEKAH HENRICKSEN: Thank you for the opportunity to present to the Committee today. I am Rebekah Henricksen, director of government relations, and I am joined by Stephanie Trainor, our policy advisor, who brings with her lived experience of suicide. Suicide Prevention Australia is the national peak body to provide a collective voice for over 350 members, representing more than 140,000 workers, staff and volunteers across Australia. More than 3,000 people die each year by suicide, and each suicide has a ripple effect through families, friends and communities, emphasising the importance of considering suicide with a whole-of-government and whole-of-community approach. Clear linkages exist between the feeling of withdrawal from social connections and the risk of suicide. This is true across all age ranges. A lack of connections influences the risk in adolescence. Marital status is a strong association. Levels of social integration across men and women have a direct impact. Loneliness can have a lasting impact. Children experiencing loneliness in middle childhood, for example, are more likely to demonstrate suicidal behaviours in their teen years.

Loneliness is a significant issue in New South Wales, with nearly one half of residents reporting experiencing loneliness. In the context of this inquiry, Suicide Prevention Australia is calling for community- based interventions, enhancing research into linkages between suicide and loneliness and suicide- prevention training for key contexts within the community. There is scope to co-design programs and interventions with priority populations to provide the most effective responses, especially when incorporating lived experience to resonate in a way that generalist interventions won't do as effectively.

For people with lived experience of suicide, there are many factors that can lead to or exacerbate isolation. Reconnection with life and the community is a difficult journey. In terms of enhancing research, we know the impacts, but research is needed to better identify effective strategies and services to address loneliness and prevent suicide. The Commonwealth Government funds suicide prevention research at a national level through the National Suicide Prevention Research Fund, managed by Suicide Prevention Australia, which provides a valuable source of world leading but localised research.

Finally, it is a critical moment when a person discloses their distress or suicidal thoughts for the first time and it will often be to a community member such as a pharmacist or a barber. Equipping these people with suicide prevention first aid training gives them the ability to provide vital assistance and sensitivity to help reduce that person's risk of suicide. This passing connection allows for life-changing intervention. The opportunities provided by this inquiry to equip New South Wales with measures to reduce loneliness and suicide risks are valuable and Suicide Prevention Australia thanks the Committee for their consideration of these important issues.

The CHAIR: Thank you. Australian Association of Psychologists?

CARLY DOBER: We thank the Chair for allowing us to share our thoughts on the issue. The AAPi is a leading not-for-profit peak body representing psychologists Australia wide. We advocate for ease of access and affordability so all Australians can get the psychological help they need when they need it. The AAPi is committed to advocating for the mental health and wellbeing of all Australians and recognises the profound impact that loneliness has on people living in New South Wales. We are seeing a significant rise in the challenges associated with loneliness and social isolation, which have become pressing public health issues across New South Wales. Various stressors, including the impacts of urban sprawl, lack of access to social infrastructure, the COVID-19 pandemic and now the cost-of-living crisis have exacerbated these challenges.

While loneliness affects people across all demographics, certain groups in New South Wales are disproportionately impacted. Elderly individuals, young people, people living with a disability and those in rural and regional areas with limited access due to transportation and social infrastructure are particularly vulnerable. Loneliness in rural and regional areas often goes unreported, while urban sprawl and privatisation of public spaces further diminish opportunities for spontaneous social interactions. This intensifies isolation, particularly for those who face already significant barriers to connection. Furthermore, the urban poor face risks with limited access to recreational spaces and social activities that often require financial resources. Loneliness is not only a cause but a consequence of mental health issues, particularly anxiety, depression and stress-related disorders.

For vulnerable populations such as young people, the elderly and people who have experienced bereavement or family disconnection, loneliness can lead to more severe psychological and physiological decline. In young people this can manifest as low self-esteem, increased suicidal ideation and poor academic performance, while for the elderly it can contribute to cognitive decline and a higher risk of dementia. Specific groups within New South Wales, including men of all ages and single parents living with children, face particular risks of chronic loneliness. The lack of adequate social support networks for these individuals can lead to vicious cycles of withdrawal and increased isolation. Access to mental health services remains a significant barrier for those grappling with loneliness. The current Medicare rebate system for psychology services does not adequately cover the costs of quality care, leaving clients with substantial out-of-pocket expenses.

This financial burden discourages many individuals from seeking the support they need, exacerbating their isolation and mental health struggles. Increasing the Medicare rebate to $150 per session for all psychologists would greatly improve access to essential psychological care, making it more affordable for individuals dealing with loneliness and related mental health challenges. We recommend a comprehensive investment in initiatives that will improve mental health outcomes for all Australians, including the introduction of more accessible Medicare rebates for psychological services, targeted funding for services in rural and regional areas, and greater support for communities experiencing heightened social isolation. By prioritising accessibility and affordability, we can ensure that no Australian is left without the care they need to overcome loneliness and build healthy and more connected lives.

The CHAIR: Thank you all very much for that. We will now go to questions. Mr Gambian, before I ask you about one of your recommendations, could you just tell me a little bit more about the poll that you mentioned and is in your submission, just so we get a sense of what that was about?

CHRIS GAMBIAN: Yes. A couple of times we have been running what we called the Australian mental health monitor, which is a poll ostensibly about mental health, and it asks a series of questions related to mental health. People are given a series of statement-based propositions and they are asked to answer yes or no. One of those is, "I have enough connection in my life and I do not feel lonely." Roughly, a third of people are saying to us that that is not, in fact, true for them. It is a higher number in regional areas. If I was more organised, I would have actually brought the specific figures—it might be in my submission—but it is higher in regional areas. Young

people are a surprising cohort of people who are saying that they don't have enough connection, which I guess is ironic, given that stage of life, but pretty consistent with what you heard in the evidence of the previous witness and what is in the common discussion about loneliness.

The CHAIR: Just because we are comparing a lot of research today, in your sample who is it that you asked?

CHRIS GAMBIAN: It's a random sample of Australians. It is a poll conducted by Ucomm. There are about 1,500 responses across Australia.

The CHAIR: We are just dealing with a lot of different research. I want to ask you about your recommendation. One of your key recommendations is about local government. Indeed, in a lot of the submissions, there is a theme about local initiatives. Can you explain why you have put that in as a recommendation and why that emphasis?

CHRIS GAMBIAN: Yes. As I said—perhaps a little bit alluded to in my opening remarks—one of the things that we are very concerned with at Australians for Mental Health are the big structural changes that government can make that can have a flow-on catalysed change. We find that in mental health across the board there are lots of good programs and services, and those responses that in some cases are fantastic should be scaled, should be better funded. We really believe that until we start addressing root causes and start building up new structures that drive new cultures, we won't get to a place where we can really make population-wide change. In the case of loneliness, it is a big, abstract issue in many respects. That is not to say that some of the programmatic responses aren't absolutely fantastic and should be supported, but we see the solution to loneliness as being connection. Where does connection happen? It happens in community. Who is closest to community? Who, primarily, can influence what happens at community? We believe that's local government. And so we, quite specifically, think that local government should be tasked with identifying within its own area, within the idiosyncrasies of that area—recognising that what is good for Broken Hill is not necessarily what is good for Bondi, and vice versa—the prevalence of loneliness and identifying the opportunities a particular local government area has within its own jurisdiction to drive change.

That change could be anything. It could be found within existing budget allocations, just by retooling those spends and identifying and measuring their contribution to social inclusion, whether that is a community centre, a sporting field, a community space or a public library. Maybe it's some town planning decisions or town centre upgrades—things that perhaps are already within the spending regime of a local government area, but adding a lens that considers the opportunity to improve the data on loneliness and then making local government accountable for that. The Act requires local government to provide annual performance reports. We think that social inclusion and loneliness should be added to the Act as one of the specific areas where local government is required to report its performance.

The CHAIR: Thank you. I note that the submissions from Suicide Prevention Australia and the Australian Association of Psychologists both talk about community-based programs. One of them talks about community-driven data collection, which I am a bit intrigued about. I will go to Suicide Prevention Australia first, because you talk about community-based programs and interventions. Could you speak about those? We would also love some examples of programs that you think are working. Then we will go to the Australian Association of Psychologists.

REBEKAH HENRICKSEN: With the community intervention, a really important part about it is to make it relevant and to make it meaningful. It is not one size fits all. It is about drilling down to the interest groups. For example, men's sheds—men's organisations where men can talk to men—are a really valuable resource. Similarly, something that is youth-driven helps to engage youth. There is a whole range of different ways that you can engage community. It could be through a more formal way such as social prescribing, where you have referrals through to networks, and even volunteer work, where you actually get that connection built. Or it could be through using examples with lived-experienced-driven community intervention, so that you're designing programs around what you know to be the risk factors with the experience, so that you can actually build a very tailored, very effective and very meaningful connection for those people.

Unfortunately, loneliness isn't something that just affects one demographic, so you're talking about multiple models. But that's part of the beauty of it, is that you can actually target it. We have many members who run different services for different age groups. For example, we have members who target youth. That can be anything, from a social media-driven program through to a connection in person. It is about finding the right platform for that demographic.

The CHAIR: Thank you. Ms Dober or Mrs Curran?

CARLY DOBER: I would agree with the previous statements by both members today that meaningful connections have to be intentionally planned. It is not necessarily a case of build it and they will come. What I mean by that is, a cafe opening in a rural area where people don't have the financial means to engage and to socialise won't be popular. It must be fit for purpose. Co-design is really important, because if we actually look at the data of who is lonely, again, it is single dads with young children. They're very lonely. But single mums with young children are not so lonely. Single mums with older children are lonely. So there is variance within the data.

I think co-design must be important. I would also place a strong emphasis on urban blue and green spaces—again, third places where people can come together and they don't have to spend money. The data strongly tells us that financial concerns over the last two years are significant and they are also impacting people's mental health. It becomes quite a significant spiral. If we are thinking about data collection, currently the best tool we have for data collection about loneliness in Australia is the Household, Income and Labour Dynamics in Australia [HILDA] survey. However, there is a stigma associated with being lonely or feeling loneliness. I am not too sure if we are fully capturing it in the way that we could.

The CHAIR: Before I pass on to others for questions, I have a quick question about the issue of stigma, which I know you do draw out in your submission. I think we have seen—you guys are the experts—a reduction in stigma generally around mental health issues. I know we've been clear that loneliness and mental health issues are not the same thing, but they're related. Why do you think there is still stigma attached to loneliness when we've made such progress in other areas?

CARLY DOBER: I think with stigma and mental health, we still have a long way to go. Some mental illnesses are more palatable than others. Complex mental illnesses are still not understood very well. If we're thinking about loneliness, there is a social taboo with loneliness. The message that a person who is lonely might feel is, "I'm not good enough. I'm not interesting enough. There must be something wrong with me." I think that it is a cause and consequence of feeling lonely. I think that influences and perpetuates stigma for many people.

AMANDA CURRAN: I think that particularly for young people who might have some financial barriers to inclusion, there is a lot of stigma around that as well. It's, "I'm not the same. I'm different to my peers and I can't get involved in this because I've got no means to join a soccer club or go to a particular social event." There is a separateness and an additional stigma around social economic status there as well.

CARLY DOBER: I want to echo another point: gender. Men cannot necessarily share their emotional world as much as they would like to. If we look at gender lines and gender divides, men over the age of 55 are less likely to share that they are feeling lonely, even when asked. Women are more likely to talk about that.

The CHAIR: Mr Gambian, in your position for your organisation and that question about stigma being different, is there anything?

CHRIS GAMBIAN: I agree and I agree with the comments that have been made. I think the thing about stigma is that it is more acceptable at a generalised level to talk about mental health and loneliness. It is more acceptable and more required to start acknowledging that it exists and the prevalence of these issues. There is a more open conversation. I think those things are all true. I think that is a different thing to when we are talking about a particular individual in their particular circumstance and how they are perceived by their network, whether that's their coworkers, their teachers, their fellow students, people in their families and their broader social network. It is how they are perceived within their own networks but also how they feel about themselves in this context. I don't think stigma is the only problem; I think shame is a really big problem. As others have alluded to, there is the shame of being somebody who is finding themselves lonely, particularly in a situation where you are surrounded by people. We need to disavow the idea that a lonely person is an Eleanor Rigby-type character who is sitting at home by themselves. It is entirely possible to be alone in a crowd. It is entirely possible to be alone within a family environment, within a household or within a relationship. It is entirely possible to feel alone in the context of a busy life and a busy workplace. Those two things shouldn't be conflated.

The Hon. SCOTT BARRETT: Mr Gambian and Ms Dober, you both mentioned and singled out the regional experience. Without asking too many questions, I might ask you both to go into a little bit more detail around why that is a particular concern and what can be done to bridge the gap. Then I'll come to suicide prevention in a moment. If you two could touch on that a bit more, that would be great.

CHRIS GAMBIAN: Do you want to go ahead, Carly?

CARLY DOBER: From a social infrastructure point of view, connection and public transport availability can be more difficult or very poor in rural, remote and regional areas. If we are comparing, say, urban New South Wales, there might be a bus every 10 minutes to half an hour, and for some towns they don't have bus routes that take them to maybe where their friends, community members and family members are, or there are no bus routes at all. I think infrastructure is really important to allow people the opportunity to actually be social if

they would like to be social, because without that it is very difficult. Not everyone drives and Australia is a very car-dependent city.

That cannot be the assumption especially if we are talking about disabled people, young people or people who don't want to drive, or don't have the means to drive, especially again in the context of the cost-of-living crisis where petrol is expensive. Then, of course, if we are thinking about geographical capabilities, some people are just more isolated geographically and maybe community centres might have one opportunity for social interaction a week if they are funded enough, if they are funded adequately, but we are really thinking about the need for opportunity here—that need for being responsive to people's social needs.

CHRIS GAMBIAN: I agree with all of that and just simply the numbers in our limited research bear out that people who live in regional areas say that they are lacking connection more so than people within urban areas. But when you think about it and think about the types of scenarios that we might have, if you live in a small town, getting to see people, as Ms Dober has rightly pointed out, requires transportation and your closest relationships might be half an hour away, an hour away or two hours away. Of course that is a limiting factor. If you don't have great access to communications, like good mobile phone reception or good internet access, that is a limiting factor. If you live in a small town and your relationship ends, what do you do? Small towns famously are places where everybody knows everybody, and that can be a wonderful thing. It can also be a terrible thing when things go wrong.

If you are living in the context of places like the Far West in New South Wales where we are talking about very, very small populations and very, very small groups of people that you can have face-to-face contact with—if you live in a place like Menindee, Wilcannia, Pooncarie or some of those places in the Far West—how do you find your tribe? How do you find your people if your life circumstances placed you somewhere that is inconsistent with the type of community that you are trying to find? Apart from the data that's showing that there is greater prevalence in the bush, I think we have got some really significant public policy challenges in those areas, and it is one of the reasons we think that it cannot be a one-size-fits-all proposition. We have to have solutions that are right for different communities at different times.

The Hon. SCOTT BARRETT: I have one other question, possibly for someone from Suicide Prevention Australia or one of the others. I have heard mention here today of men's sheds and soccer clubs. We have seen a drop, particularly since the late '70s and '80s, in the number of organisations that are out there as well as the number of people that are involved in those organisations. Keeping that in mind and some of the things that I have seen in the Suicide Prevention submission, where there is the need to create more connection for people to have more friends, how do we do that and how concerning is that decline in our associations and association membership?

REBEKAH HENRICKSEN: That is a very good point. A lot of the problem in the regional areas is access to services, whether they are formal ones or informal ones. Part of that is why we are asking for the first-aid suicide prevention training. If someone is in a community leadership role, such as the barber, there doesn't have to be a connection, but if they're trained to be able to recognise distress, whether it is loneliness or suicidality, if they have access to this training they can make that connection. They can say something meaningful and they can act in a way that will actually help that person. It might be by providing a connection; it might be by guiding them through that situation until they are ready to make a connection. It starts with an individual person. If you equip the community through that individual and then you build up, that is how you create the groups, it's how you create the connections, and it's how you can actually get those clubs back to support those people. Does that answer the question?

The Hon. SCOTT BARRETT: Yes. I saw lots of nodding there from Mrs Curran. Would you like to add to that?

AMANDA CURRAN: I definitely agree with all of those points. We see a lot in the construction industry. They are leaders in this area of training up peers within the industry to be able to catch people, because it is those little moments where intervention can happen. Men of a certain age are very unlikely to go and see a psychologist, but they will say something to their mate on the job site and be able to get some assistance there. So I think that peer-led mental health first aid training is really so important. With regard to associations closing down and difficulties with getting enough of those community organisations as well, I think what we see happening is there is a big pressure on families to have two income earners if there are two parents, so we are seeing a lack of ability to volunteer in a lot of those community organisations. Funding those local-level initiatives at a bit of a higher level might be a way to alleviate some of that deterioration in the amount of services that are available. Local community grants, council grants—those sorts of things can go a long way.

Dr AMANDA COHN: I have a couple of questions. Thank you all so much for sharing your experience with us today. My first question is for the Australian Association of Psychologists. I am particularly interested in

your submission about the role that you say social media can play in facilitating meaningful interactions—in the context of us having just had a conversation with the previous witness about how social media use can become harmful or, if used inappropriately, can exacerbate loneliness. What are the ways that social media can be protective? How could the Government support social media to be used in a way that is constructive?

CARLY DOBER: I'm not a social media expert, but I can say that the algorithms currently keep people on social media and that can be a really helpful thing if you are vulnerable, if you are geographically isolated. But that does mean that some people might not go outside and connect in real life as much as they would like to. So I think there could be investment in meaningful local forums or groups where people can meet other people online and talk about mutual interests. They can perhaps join meetups that occur on a recurring basis that might be free or very easy to access, keeping in mind different people and different cultures—a social media infrastructure, if that makes sense.

AMANDA CURRAN: I think there is also a real value in social media based interactions for those with disability. We have meetup groups for people with Ehlers-Danlos that happen. They are able to jump on and talk with peers if they are not able to access community. There are lots of interest groups based on those with chronic illness—spoonies is one that comes to mind. There are also a lot of interest-based ones that someone who is autistic might be interested in joining. There are also some initiatives I have seen recently where interaction might start online and then transition to an in-person arrangement. There is a dads group that I have seen recently where they were gaming online and then moved it to being all in the same room gaming online. It is helping people to engage and get connection, and then moving that to an in-person arrangement where possible.

Dr AMANDA COHN: The Chair asked a great question about the role of local government, which I am particularly interested in, as a former councillor. One of the witnesses earlier mentioned the role of urban planning—actually having the right spaces. Could you go into a bit more detail about what that looks like?

CARLY DOBER: I think when we're thinking about urban sprawl, Australia has a really interesting challenge ahead of us, and New South Wales is no different. People are coming to New South Wales to enjoy all the beautiful elements of being in New South Wales. However, that means that this rapid urban sprawl has led to suburbs and places where, if you don't live there, you've got no reason to go and stop by. We're needing to have urban blue and green spaces because we know that this is really good for mental health—places like public parks or lakes or wetlands that are rewilded so not only biodiversity can enjoy it but also people. These are things that come with no cost for the people who enjoy these spaces but they also invite interactions—casual interactions where perhaps relationships and friendships can occur.

Dr AMANDA COHN: I am also a member of the committee that is looking at the financial sustainability of local government. Certainly, councils, particularly rural and regional councils, are in really dire financials straits. As a devil's advocate, what do councils actually need to be able to do the kind of work that you're talking about in terms of creating spaces for these interactions to happen?

CHRIS GAMBIAN: I take your point that anything that gets proposed needs to be funded. I'd make two points. One is that we are already spending a lot of public money on things that could be contributing to better social connection—things like a local library. These are already places where people come together and they already deliver those programs. But imagine if the local library, in addition to providing its core service of making books available, had a KPI around its social inclusion. Imagine how that would culturally change the way the library is run. Imagine how that would change its strategic approach. Imagine how that would change what it chooses to prioritise within its existing spending. The other great example is Meals on Wheels. We know that it's a food delivery service but it is also a source of connection for both the people who are receiving the food, who are isolated in their homes, and the volunteers who are making the food—the connection that happens in the kitchen when the food is being prepared, in the warehouse where it is being packed and then in the delivery process itself. Imagine if Meals on Wheels had a KPI that acknowledged what it's already doing and it was recognised and supported for delivering that as well as it possibly can.

Then there are just simple things that councils can do that don't cost any money. About a decade ago the then Marrickville council created a policy and a toolkit for locals who wanted to host a street party in their street. It cost the council no money but it culturally sent the message that this is not something that we will allow you to do; it is something that we will encourage you to do. It gave you an easy way to apply for the permits you need and to deal with all the regulatory barriers there might be for the couple of neighbours who had the bright idea to host a street party in their community for Christmas, Easter, Australia Day or whatever they might choose to have a street party for. A lot of these things don't need to cost a lot of money. Some of them will, of course. Let's not be naive. Some will cost money and those funds should be made available. But in many cases what we are talking about it making this stuff a priority and embedding that priority into the ways decisions get made.

Dr AMANDA COHN: Thank you. Those are great examples.

The Hon. ANTHONY D'ADAM: I wanted to ask about social prescribing. Maybe you could just elaborate a bit more on this idea. Perhaps, for medical practitioners, what are the barriers to social prescribing? A follow up on that is: How can a medical practitioner or a health practitioner know what services are going to work?

REBEKAH HENRICKSEN: Thank you. Social prescribing is taking off in some parts of the world, such as the UK, for example. It's about connecting the community. So if somebody comes into a GP office and is obviously lonely and obviously disconnected from society and needs that help with reconnection, that is the stage at which, if they can implement social prescribing, it is about putting them in connection with the most obvious network. If there is a community that has a group—and this could be something that the State Government could help with, compiling the networks and the lists, or local government can do it. But it's having access to that information. It might be a volunteering job. It might be somebody who feels that they have too much time and they're lonely because they're sitting by themselves all day, every day and have no way to make themselves feel useful, and they're disconnecting that way. It might be about volunteering and creating a sense of service and value. It might be about something that is more mental health-based where you have a child who is being bullied and that kind of thing—a lot of the marginalised feeling people.

For example, coming back to the social media side of it where you have got LGBTIQ communities who use social media, maybe social prescribing is good in that instance where you can actually connect face to face. The social media might be the start of it, as somebody said before, but all of these different aspects of it all lead into the same thing of you need that reconnection. In our space, somebody who has lived experience of suicide often needs that help with reconnection too. It's an incredibly lonely time for many, many people and that reconnection helps them to come back into community. In terms of the barriers for it, it is the network; it is knowing what's there. That's what would need to be established. There is nothing else that potentially could stop that from happening. What you are doing is just reconnecting.

The CHAIR: Ms Dober, did you want to answer?

CARLY DOBER: No. I was just saying that I agree with everything that has come before. I think some of the barriers are some GPs or health professionals don't know what they don't know. They don't know about the social prescribing movement as well, and it can also be based on what the person is genuinely interested in, what they used to enjoy, what they used to love before maybe something like mental or physical illness turned their life upside down, or things like divorce or becoming a parent or ageing.

The Hon. ANTHONY D'ADAM: Is there any data about how much of this is occurring in Australia? Are GPs actively embracing this as an approach? Is it the subject of discussion in GP group practices? Do we know whether there is any data on that?

CARLY DOBER: It is emerging. I don't have specific numbers, but the Australasian Society of Lifestyle Medicine is a movement full of GPs that are all about lifestyle medication and lifestyle prescribing. A big part of their work is about social prescribing and bringing that into all Australian GPs nationally. I don't have that paperwork on me right now, sorry.

The Hon. NATASHA MACLAREN-JONES: Thank you very much to all of our witnesses for coming today. I have a couple of questions for everyone. A number of you referred to volunteering. We have seen volunteering drop over the years, particularly post-COVID, and also in younger generations. I am interested to hear from you about any suggestions you have to increase the uptake and interest in volunteering, particularly in light of the fact that the correlation between volunteering does address some of the issues that people raise around loneliness. Do you have any insights on that?

CARLY DOBER: One of the things that I found clinically—and I don't have data to support this, sorry—is that volunteering is expensive. In the cost-of-living crisis, actually getting to a volunteer role when you have to pay for the bus or the train or sometimes you have to put petrol in the car, that is not something that some people can do anymore. That has been one reason that volunteering has dropped. Another reason is that particularly older teenagers, young adults, can't afford to because they need to pick up shifts that they don't necessarily like engaging in, but trying to juggle that and uni has become an all-encompassing issue. If we are thinking of the cost-of-living crisis and how that is impacting rates of volunteering, I think that could be one issue.

AMANDA CURRAN: I think as well that there is a lack of information potentially around what opportunities are available, or the information is out there but it is not delivered in a way that is going to be seen easily by younger people. There is some research around the type of work and volunteer work that younger people are more likely to engage in. I think the indications were that project-based opportunities rather than an opportunity that lasts forever is something that they're more likely to be attracted to. So if there are community organisations that need volunteers, maybe that's something for them to consider—that offering project-based or

limited-time opportunities might be a way to attract some more people in. Once people are engaged, they are more likely to stay.

CHRIS GAMBIAN: I think volunteering can sometimes be one of those things that, on the face of it, makes all the sense in the world, doesn't it? People are lacking relationships. Where could you get some relationships and do some good? Volunteering is the obvious place. When you drill down a little bit and start thinking about where things aren't lining up—you have a lot of lonely people and a lot of need for work that needs to be done, so why aren't those two things coming together?—there are a couple of things going on. One is that, as has just been said, if you're working two jobs in order to pay your rent or pay your mortgage, it doesn't leave too many hours in the day—it doesn't leave mental space, apart from anything else—to go and do a shift at St Vincent de Paul or something. That in itself, I think, is a huge barrier, particularly when you're talking about people with families and that juggle.

On the other hand, and perhaps slightly less obvious, is that for a lot of non-profit organisations that could benefit from having volunteers, the compliance environment that we are now placed in makes it really difficult to have volunteers or to attract volunteers. I remember years ago I was invited to be on one of those food delivery services just for one night, just to get a sense of it and to see how it worked. I was more than happy to do that. But in order do a couple of hours of handing sandwiches to people in a disadvantaged community, I was being asked to do a day's worth of training on the various regulatory requirements to go and hand somebody a Vegemite sandwich. These are barriers. In the social services sector in particular, we have created, for very good reasons—I am not criticising the rationale—an environment where it has become very, very difficult for those organisations to be responsive to where people are at, and to create space for people where somebody can, on their own terms, just come and hang out. That's a barrier.

I think another barrier is the volunteer organisations themselves and how they orient. Sometimes those organises can be cliques. I think we all know examples in our own communities of organisations that, on the face of it, are wonderful community-based organisations, but we also know that they're cliques. And so I think a lot of the challenges we have around connection continue even within a volunteering space. Tackling our ability to just have an honest conversation about that and to navigate what is disconnecting people would go a long way. To chime in on that discussion a moment ago about social media, I think one of the things that social media is doing is eroding our ability as a community to relate to each other, because we are getting very curated content. Our phones are much more interesting than the more difficult conversations we might be part of, and so we are losing that skill. I think, at a population level, we are losing the skill to connect.

The Hon. NATASHA MACLAREN-JONES: My final question is around funding and grants, and whether you have an opinion on the notion of a grant scheme where people can apply for funding for different ideas, programs and initiatives versus a more targeted investment in organisations. For example, it was mentioned before about councils taking a more proactive role in addressing loneliness from an inclusion point of view. During COVID, neighbourhood centres were a point of contact for isolated people. They were there not just for the distribution of RATs, but also as somewhere for people to go to get information. Is it better for the Government to be directing funds towards targeted organisations versus the scattergun approach of grants? Does anyone have a view on that?

CHRIS GAMBIAN: Yes, I have a strong view about that, and that is I think the best community centres are the ones that have block funding. If you're a community centre, you might be called a community centre, but if all you're running is an aged-care program, a disability program or a childcare program, then that's all you're doing and that's all you are. The organisations that produce the best sort of community outcomes are the ones that are funded to do community development. We have less and less of that. We have less of that now than we've ever had. I think that is a yawning gap right now in the make-up of our social services sector.

REBEKAH HENRICKSEN: The beauty of targeted funding is that you actually get to have some meaningful aim in it. It's not a short-team nice project. They might be really, really good, but with a targeted one you are actually getting to the meaning of why you're doing it. You're also allowing the continuity. That allows you to grow. It's about ensuring that you've got the workforces within that funding who can actually skill increase and they can share those skills with the people they're trying to help. It's about building on that work instead of doing a bit here and a bit there. If it's more targeted, you can actually reach the audience you're trying to get, and then you build the skills around growing that organisation.

The CHAIR: If I could go back to the submission of the Australian Association of Psychologists for a second, because I'm reading all of these submissions at the moment, you identify a number of groups that are at increased risk of loneliness. I'm interested in how you determined that and what research you based your submission on because reading different submissions, some research is saying age and gender don't matter, and it's something that is felt across the board, while some are saying it's particular cohorts of women and some are

saying it's young people. Yours is saying that men tend to be lonelier. I am just trying to get a base understanding of what evidence we are relying on for which parts so we can try to decipher that as well.

CARLY DOBER: Absolutely. I think it's tricky because loneliness is a normal human emotion. We all feel it at some stage. When we were developing our submission I looked for peer-reviewed research and looked for things that were specific to Australia and New South Wales. Then I went to big organisation such as the Australia Institute, which is a national, non-partisan think tank that has incredible researchers. The research you're talking about in particular is Dr Michael Flood, who is amazing. He is very well known. I tried to find peer-reviewed research in the Australian context because loneliness is different across cultures and across countries, and then to localise it to New South Wales.

The CHAIR: Okay, so you didn't undertake any empirical research? It was peer-reviewed research that was out there and you essentially brought that in and synthesised that to help us?

CARLY DOBER: Yes, that's correct.

The CHAIR: Thank you. That's very helpful.

The Hon. SCOTT BARRETT: I have a question for Ms Trainor, who has been sitting there very diligently listening to all of this. We have heard lots about the research and how we can fix this. It was mentioned that you have some lived experience that could possibly shed a lot of light on this. I just wondered if, in the last couple of minutes, you could respond to some of the things that have been said. Given the platform, what's something that you would like us to take home as a key message from this?

STEPHANIE TRAINOR: Thanks very much for that. This is my first hearing, hence why I have been quietly observing. I think the reality is that when you've got lived experience, whether that be mental health or whether that be suicide, trying to reach out for support and trying to bridge that gap of loneliness is incredibly hard. The act of reaching out to a friend, the act of reaching out to a GP, the act of going to a coffee shop to have a coffee with somebody are all incredibly challenging behaviours to engage in. When we're talking about the context of what a community can do or government can do, it's actually about what can the support people and systems in the community surrounding the individual do and how can we upskill them and support them in supporting those who are experiencing loneliness. I think a lot of the onus is often on the individual attempting to seek help. The reality is that we need to ensure that we're creating an environment that actually supports that and encourages that and bridges that gap. So when we are talking about social prescribing, when we are talking about upskilling the community, we are really talking about how are we ensuring that we are creating more advocates and creating more diverse support systems that can breach that loneliness gap. That is my two cents.

The Hon. SCOTT BARRETT: Following on from that—you said it is difficult to reach out—I imagine that the longer the time before you do reach out it would probably get exponentially harder to then reach out, suggesting that the earlier the intervention occurs the better?

STEPHANIE TRAINOR: I think to a degree yes, and I can only speak from my experience. That is again when we look at those targeted interventions, recognising that everyone has a unique experience when it comes to loneliness, mental ill health, suicidality. I think the earlier always the better, but the reality is that we need to be equipped at any point. Yes, the longer that we go on or the longer you have that experience, the harder it can be to reach out for support, for connection. But that also doesn't diminish the reality of it: It is hard at whatever stage you are experiencing loneliness. I think it is also actually about advocating for ensuring that there are multiple opportunities at any point and that we are not focused on just the end point of exacerbation where someone has been experiencing loneliness for their entire life, or for years or months on end, but we are looking—I think it is in part that but also in part going, "Okay, how are we at creating ample opportunity at any point when someone is ready, able or in need?

The CHAIR: I just have one last question. We only have a couple of minutes left. Mr Gambian, the submission of the Australians for Mental Health doesn't recommend a specialised Minister in this space, which is counter to what we have seen in other jurisdictions and some of the other submissions. Very briefly, could you just explain that a bit?

CHRIS GAMBIAN: Yes. We really think that the answers here lie across the whole of government. We are very concerned that specifying a Minister, who may or may not end up with a department or any kind of enabling bureaucracy around them, might direct responsibility really at that one person rather than recognising the opportunity every Minister has to deal with this issue. So in the same way that financial issues and any number of other whole-of-government matters need to be addressed, overseen through central agencies, we say that this is the type of issue that every single Minister has a role to play in trying to address, and that if coordination happens it should happen out of a central agency, whether that is the Premier or the Treasurer or the finance Minister.

The CHAIR: Thank you very much. I think that is it. I just wanted to thank you all very much for your submissions, making the time to be with us today and answering so comprehensively our questions. I don't think anyone took anything on notice, but it may be that we have supplementary questions for you following on from your submissions and your evidence, and the secretariat will be in touch if that is the case. Again, thank you all very much for appearing today; we do appreciate it.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms ELIZABETH CLARK, Partner, Policy, Economics and Public Impact, KPMG Australia, affirmed and examined

Mr MARTIN BLAKE, Chairman, Groundswell Foundation, affirmed and examined

Mrs JOHANNA PITMAN, Chair, Research Sub-Committee, Groundswell Foundation, affirmed and examined

The CHAIR: Welcome to this afternoon's hearing. We thank the witnesses for appearing and for their submissions. Just before I get a statement, I note that we have the Hon. Scott Barrett online and we will be taking questions from online. Do you have a short opening statement?

MARTIN BLAKE: Elizabeth is going to start, then we're all going to say a few words if that's possible.

ELIZABETH CLARK: Thank you for the opportunity to provide an opening statement. As I said, my name is Elizabeth Clark. I'm a partner at KPMG in our Policy, Economics and Public Impact team based here in Sydney. KPMG welcomes the opportunity to appear before the Standing Committee on Social Issues as a part of its inquiry into the prevalence, causes and impacts of loneliness in New South Wales. We commend the Committee for their important work that will help policymakers better understand the issue of loneliness and hopefully pave the way for better solutions for our communities. I'd like to acknowledge the Minns Government's recognition of the issue and the potential for addressing loneliness to be a meaningful legacy for this Government.

As the Committee is aware, Connections Matter is a report prepared by KPMG in collaboration with the Groundswell Foundation. It reveals the prevalence of loneliness in Australia. The results were stark. Loneliness impacts over five million Australians and is a significant risk factor for poor physical health, mental health problems and decreased quality of life. Our report found that 37 per cent of young people are lonely. Lonely people have a 26 per cent increased risk of death. The impacts of loneliness are equivalent to smoking 15 cigarettes a day or having six alcoholic drinks per day, and 54 per cent of people are lonelier since COVID-19. Considering this, it's great to see policymakers now focusing on loneliness as a key health priority. It's also an economic priority. As the Connections Matter report found, loneliness has an annual healthcare cost to the Australian economy of $2.7 billion, or approximately $1,565 per person per year.

Mental health issues are closely related to loneliness, including depression. It's estimated to cost the economy over $60 billion annually. Given the economic and health impacts of loneliness, the Connections Matter report recommends three critical action areas. The first is collaboration through establishing clear policy directions across national, State and local levels to raise awareness of loneliness as a priority issue and taking targeted action. The second is to communicate by activating stakeholders from public, private and not-for-profit organisations to embed loneliness as a priority issue into new and existing health and wellbeing activities. The final one is to track progress by building the evidence base for loneliness and interventions in Australia through detailed and dedicated data collection, research and evaluation. Since KPMG's involvement with the Groundswell Foundation, they've done some great work to advance their thinking and refine their focus across those action areas, and Martin will speak to this shortly. We appreciate the opportunity to be here today.

MARTIN BLAKE: In a world of always-on social media and digital connectedness, it seems almost inconceivable that loneliness could become a health crisis affecting one in three Australians. It's a health priority that has almost entirely been overlooked by health regulators and providers in Australia, and it's one that has been certainly been exacerbated by the pandemic. I established the Groundswell Foundation three years ago to bring together a coalition of influential Australians to tackle the growing issue of loneliness and the impact on mental health in Australia. We are truly delighted that the New South Wales Government has announced this parliamentary inquiry into loneliness.

Our aim is to drive a groundswell of initiatives and action to eliminate loneliness. As the Committee would have heard, loneliness is a pervasive problem causing significant personal pain and detrimental economic and health consequences for society. The Groundswell Foundation and members of the reference group also share our sense of urgency to tackle the problem, having seen the worsening data, personally feeling the impact of the pandemic and sustained use of phones and social media. In addition to traditional vulnerable communities which are outlined in the Connections Matter report, we have an entire generation of young people that have a reduced capacity to create meaningful social connections. They are simply connected but disconnected.

We have reviewed all the submissions to the inquiry and note many consistent themes, but unlike most organisations that made submissions, we're not specialists in any one aspect of loneliness and we're not seeking funding to sustain or enhance our operations. In fact, in setting up the foundation, we won't be asking for a dollar from any government in the world. We're raising $50 million to positively impact loneliness, which we are well on track to do. What we're seeking is the New South Wales Government's commitment to harness this moment and for each member of the Committee to recognise this singular opportunity to imprint your legacy on New South

Wales society. As Minister Jackson reflected at a recent RALLY4EVER breakfast in this very room, the inquiry needs to be a springboard of action. The loneliness epidemic is different from most public policy challenges, and we can elaborate on why that is. It is clear tackling loneliness requires an innovative approach that draws on other international best practices and initiatives globally. We just can't tinker at the margins. Our recommendations have one single goal—to ensure that change happens quickly and meaningfully. Our future depends on what we do today. Johanna is going to add a few remarks to that.

JOHANNA PITMAN: As the chair of the Research Sub-Committee for the Groundswell Foundation, we took on board that goal to ensure change happens quickly and meaningfully. So with that in mind, if we could have three wishes, here's what we would look for. First, we'd want the New South Wales Government to create an enduring oversight body to coordinate and monitor initiatives to tackle loneliness. Second, we want to help roll out a public awareness campaign at the conclusion of this inquiry to signal the New South Wales Government's commitment to destigmatise loneliness. This recommendation has been made across and repeated in numerous submissions. But best of all, this would not need to cost the New South Wales Government any money. We have the creative talent and advertising industry poised and ready to contribute pro bono their expertise to make this important campaign happen.

Finally, if we had one more wish granted, it would be for the New South Wales Government to acknowledge that this challenge is like no other public policy challenge we have faced. It requires a tapestry of solutions that are dynamically woven together. Some actions to tackle loneliness will influence the design of places, some will be led by not-for-profits and community organisations, some will be led by business and employers, and some actions will be around getting better data and research on the problem. Whatever the individual components, the New South Wales Government will need to embrace experimental interventions, will need to be prepared to support a range of interventions without traditional constraints, and will need to coordinate across different entities that may or may not rely on government funding. This is where we think the Committee and the New South Wales Government can establish a legacy. Through an enduring oversight body, the New South Wales Government could radically improve the wellbeing of its citizens and provide an exemplar for the rest of Australia and the world.

The CHAIR: Thank you very much. We will go to questions. I have an opening question. You're looking at the effectiveness of interventions to tackle loneliness, particularly in youth, but I'm pretty sure you also note the difficulties in measuring efficacy. I wondered if you could talk a bit more about that, but also, given those difficulties, have you still been able to glean any sense of the levels of efficacy across the types of interventions you categorise in your appendix—direct support programs, activity-based programs and skills building programs? We know that those things are there. They're hard to measure, but given that, is there still anything you could tell us about it?

MARTIN BLAKE: I could maybe start off. In terms of my journey on this, I've really drawn upon the experience of the UK Government who have had a Minister for Loneliness, the inaugural Minister, Tracey Crouch, for some 10 years. Essentially, I made friends with the department on tackling loneliness, and Tracey, and was able to glean those insights. The UK is the jurisdiction in the world that has the most evidence on this, but unfortunately it is lacking. Most of the research on loneliness is what I would describe as enjoying the problem: this many people are lonely, this cohort of people are lonely, they're lonely because of XYZ. That's why we commissioned research with Melbourne University to look at what are the most effective interventions with young people in urban and rural areas. That's currently underway. We will publish that in the first quarter of next year to inform policy decision-making. Johanna might have some other remarks to add to that.

JOHANNA PITMAN: It is ongoing research that is underway there, and we're at the point where we are surveying a wide range of young people about those interventions. But in terms of the efficacy, there are a couple of things. One of the first things that we discovered was the range of interventions. Setting up that nomenclature for it is quite important—to say, "How do we distinguish all these different interventions?" The second part is you can have the intervention, but how you get someone off the couch and taking up those interventions is just as important. The intervention might be effective, but you can't get the people who need it most there. That's the way we're looking at the two aspects of it. The follow-on piece of research is about barriers to taking up interventions. It is a bit early to say. In fact, the survey—we expect to have results in December. We'd be happy to share emerging results as soon as they're available.

The CHAIR: That would be great. If you could take that on notice, it would be extremely helpful. We would appreciate that. Ms Clark, we've had some questions and some discussion about loneliness being distinct from mental health. I note in your submission you make that distinction, but in your introduction there seemed to be less of a distinction. I wondered if we could go back to your submission and you could explain why you were so clear that you were making that distinction.

ELIZABETH CLARK: The report articulates really clear definitions of loneliness specifically. There is a lot of attention around mental health and mental health issues broadly, but I think what we're really focused on in this report is loneliness itself. We felt it was really important to clearly articulate that definition of loneliness up-front and highlight, really, the point of difference from broader mental health challenges because it's different from a drivers point of view and it's different from a policy response point of view. That's why we felt it important to isolate that definition.

MARTIN BLAKE: If I could add to that. Every human being in the world has an expectation of the quality of relationships they'd like to have in their life, irrespective of age, gender, ethnicity. Loneliness is the gap between those expectations and the reality, and that's why young people are disproportionately impacted by loneliness because they spend so much of their time on mobile devices. They're connected but disconnected. That's why it's such an important issue. But loneliness is absolutely not mental health. It's not socialisation either. It's very specific. In the Connections Matter report it is quite clearly articulated. I think there is a growing awareness around that.

The CHAIR: You have mentioned social media. Today already we've had some discussion around it with ideas that it does enable some connection, but what about the quality of the connections. I wondered if any of you or all of you could add a bit more around that. I also note in the KPMG submission there was the idea of using AI and tech and how it might be harnessed in different ways. If I could put that to you.

ELIZABETH CLARK: In the report, definitely, we looked at social media and the fact that social media is almost a driver and a consequence of loneliness. It can drive loneliness in the sense that you're not having meaningful connection, but what we also found in the report was that loneliness can actually cause problematic use of social media as well.

JOHANNA PITMAN: I'd add to that that it's not just the nature of the social media and how you use it or how it's being used but, particularly in young people, how it is causing them to lose that ability to have face-to-face interactions. We've all seen that and we see it in different degrees. But, really, anyone who has grown up with a phone is going to have a reduced capacity to make those social connections in person unless they work on it. Rather than seeing social media as the problem, it's seeing the deficit of face-to-face interactions as the problem. Maybe social media can be harnessed. Within the research on interventions, we are looking at how important it is, particularly for specific subgroups, to connect virtually with people like them. It's very important, but it's the absence of face-to-face connections that we can't overlook. To look at that positive side, how do you increase face-to-face connections to build those skills so that people can have that personal connection with others?

MARTIN BLAKE: Another dimension to this is artificial intelligence. One of the businesses that I founded, which is based in London, is the leading business in the world to unobtrusively analyse corporate culture with the two leading professors in the world from the London School of Economics. It's called Above Board. AI is moving so fast; in fact, it is doubling capability every six months. In fact, technology solutions, avatars, can be very helpful in providing companions for individuals, for old people, for young people, for different people in different groups, migrants, LGBTI and First Nations people, who all have mobile devices.

It's both. It's a double-edged sword because, as Johanna said, in many cases it's problematic—the extended use of social media—and it's fantastic that federally we've got some new direction in terms of use of social media with young people. But also it is an important part of the solution because during COVID, during the pandemic, I certainly enjoyed connecting with friends all over the world, having Friday night drinks. It can really enhance connections. It is a double-edged sword, but it is a little bit like a bushfire in summer. It's really a little bit out of control and it's very reassuring to see the Federal Government is trying to put some freedom within boundaries, and some fair boundaries around that.

The CHAIR: I have one more question and then I'll go to Committee members. Groundswell in particular makes recommendations, or one of your recommendations is to support business-led initiatives. Can you talk us through some of those and what you've seen implemented and be successful. I guess there are categories of what could be done if we support this, what has been done and what has worked. That would be great.

MARTIN BLAKE: This is what I would describe as triple-strength leadership. This is combining the organisational and intellectual capabilities of the public service, of higher education and business. We've worked very closely with Bran Black in terms of developing the initiatives within the Groundswell Foundation, the priorities, and we've certainly drawn on global expertise and experience in terms of successful initiatives. Certainly in Europe, specifically in the Netherlands, there have been some very successful initiatives around introducing slow queues into supermarkets with the idea that for many elderly people, the only time they get out

of home is when they do their weekly shopping, and if they've got an automated electronic payment system, they don't have the opportunity to interact with anyone.

That's been enormously successful. I've certainly proposed to Bran that he promotes that within the Business Council of Australia. Obviously we've got some challenges with the oligopoly that we've got in supermarkets with many people charging at them with spears. This would be a very effective way of positively contributing in the community to tackle loneliness and build trust in the community. What is very evident from the UK is that the most effective interventions in loneliness are using the convening power of existing community assets to bring different cohorts of people together to make meaningful connections.

Interestingly, the two most trusted institutions in communities in Australia are libraries and pharmacies. Libraries in New South Wales—we have 264 of them and the New South Wales Government have increased funding for libraries by 50 per cent in the last five years. Under the leadership of Mike Pratt, the former Treasury secretary, who is a member of the reference group, they funded free wi-fi in those libraries, which has made the libraries a honeycomb for vulnerable people, homeless people, people suffering from domestic violence, migrants, LGBTI, different interest groups and youth groups. To use the convening power of libraries in a different way to reimagine their role in the community to positively tackle loneliness, I think, is an inspired thought. I'm certainly working with Caroline, the chief librarian, on initiatives.

Pharmacies as well reimagined themselves during COVID. That was principally because the pressure on the health system was so extreme that they got a mandate to engage in the community in different ways, particularly in terms of dispensing COVID vaccinations. They are trusted in the community. There are 35,000 pharmacists and there are 5,000 pharmacies. One of the members of our reference group, Jenny, has got an initiative up with the Pharmacy Guild to run an education program with pharmacists, which is accredited. They have I think 30 learning points each year that they have to get, and this would contribute 10 learning points for strategies to identify and positively tackle loneliness and social isolation in communities.

In the UK, one of the most successful things that they did was to have an alliance leadership pledge by the largest organisations across both the private sector and the public sector to positively tackle loneliness. If you go to our website, I've written a short paper on what executives can do in the workplace to positively tackle loneliness, and then creating space within shopping centres to foster social connections. I live in Mosman and they've got an initiative around having a particular seat and table in cafes to encourage people to chat and socialise. There are some really quite practical things that can be done in the community that are not going to cost the New South Wales Government anything, but they have an extremely important role in providing that enduring oversight to understand the different initiatives, the effectiveness of those initiatives and also where the gaps are.

Dr AMANDA COHN: Thanks so much for coming and for the very extensive submissions that you've made. In your written submission you wrote quite a lot about leveraging place-based investment. There's a particular comment about how planning policies can deliver greater connection and access to green space as well. Do you have any suggestions on how that should be done or examples of where that's being done well?

JOHANNA PITMAN: I think we've relied on the input from the Loneliness Lab in the UK, which has done a lot of research around how place can really be leveraged to design out loneliness instead of institutionalising loneliness. In terms of the specific planning policies, I think we'd need to look at—there has been work done by the chief architect there which has been really relevant and looking at the specific rules. We note that the quality of green space is not the same as the quantity of green space, and the quality of shared community assets is not the same as the quantity. That's an area in which the planning policy could incorporate that, but it's probably more in the field of expertise of the chief architect or someone within Planning.

The Hon. ANTHONY D'ADAM: Which is more important, quality or quantity?

JOHANNA PITMAN: From what we're seeing is that the quality of that—for example, the example is given that if you have a new development and they say it must have X square metres of public green space, you could have some green space there, you could have a certain tree canopy and you could have a swing set in there. That swing set is not going to be well used by young people. The space is, therefore, not designed for young people and it's also not really designed for old people, so how do you make sure that that same square metreage could be better designed? You see that people maybe have a quiet area within a park, maybe a more communal gathering area. It's about how that public space is used, or that green space is used, versus saying, "It's all created the same." Whether the planning policy could incorporate those recommendations or best practice—that would be one area to look at.

MARTIN BLAKE: Professor Thomas Astell-Burt is one of the members of our reference group. He is recognised as being one of the leaders in the world in understanding the connection between green space, loneliness and mental health. There are studies that he has undertaken, and also Professor Feng, around this. They

talk a lot about what they call lonelygenic environments and green space, which is really associated with the social environments connected with space and the ability to build meaningful connections within that space.

Obviously with the focus of both the Federal Government and all State governments around Australia on housing and with the new legislation promoting medium-density residential housing, particularly around transport hubs, this is a wonderful opportunity but also a potential risk because if not carefully managed by both the State Government and the local councils, then we could actually institutionalise loneliness. So this is a very real risk, but it is quite well documented in terms of the Connections Matter report. Thomas Astell-Burt is a world leader on this; he is recognised as such. His work in terms of the impact of nature—he talks about more trees and fewer tweets—is really quite groundbreaking and fresh.

The Hon. ANTHONY D'ADAM: Taking up that question about third spaces, it strikes me—and we heard evidence earlier—that one of the advantages of third spaces is they're free. This suggests to me that perhaps loneliness is actually just symptomatic of socio-economic disadvantage—that it's actually about class disadvantage in society—and those who are socially more disadvantaged are obviously more vulnerable to experiencing loneliness. Would you like to offer some comments about that?

ELIZABETH CLARK: I've written on the cohorts.

MARTIN BLAKE: Yes, you comment on the cohorts.

ELIZABETH CLARK: In the Connections Matter report we highlight I think it was around eight different cohorts who had a higher prevalence of loneliness. Definitely those who were of lower socio-economic advantage were one of those cohorts, but they were one of many. There was a large number of cohorts: young parents, young people, Aboriginal and Torres Strait Islander people. There was a really large number of cohorts. This is not just an issue for those who are economically disadvantaged; it is an issue for a really large number of cohorts of people. I guess the responses for each of those cohorts needs to be targeted at those cohorts. What you put in place to respond to loneliness for older people looks very different to new parents, looks very different to young people, for example.

JOHANNA PITMAN: I'd add that third spaces are the starting point. If you have a third space, it's how it's activated that really matters. For example—and there was a submission made by RALLY4EVER—it's a very simple concept but using the third space of a tennis court. As you know, they're often not being used. It's bringing along volunteers to provide free coaching. It's weekly, at the same time every week, and therefore it gives someone a routine. That's a very different activation to something like in a library, which is fantastic third space, that might have a mahjong session or kid's reading session.

Whatever it is, those activities, I think the key things to avoid the socio-economic barriers would be what are they costing for the individual and are they targeted properly? Is mahjong happening in a place where people have an interest in mahjong? Getting that balance right in the activation of those third spaces is what's really important. It could be a park with one yoga instructor that provides free yoga every Wednesday lunchtime. It could be something very different, but it's how the third spaces are activated, how that activation is communicated and how well people know about what's going on. You often see things where they're underutilised, and so making sure that it's activated and marketed to the right population groups—a focus on third spaces is important, but there's those next two steps that are equally important.

MARTIN BLAKE: I was just going to say, interestingly, the experience in the UK is they started off—this was over a decade ago—with their initial campaign to tackle the stigma associated with loneliness, and they had a very broad campaign. Whilst it did raise some level of awareness, it wasn't that effective. What they've done is focus their various campaigns—the campaign last year was called "Let's Talk Loneliness", and it was specifically targeted at young people. It was very effective in terms of targeting young people because it's much more specific in terms of those particular cohorts. All these initiatives that we talk about, they are very helpful, but there is no one initiative. There's no silver bullet solution. That's why we are strongly encouraging you to think about creating this enduring oversight body which really coordinates and monitors these initiatives, because you can look at the effectiveness of these initiatives and see what works and what doesn't work and what is helpful for different cohorts in the community.

The Hon. SCOTT BARRETT: There's a lot of talk about these green spaces. Apologies I'm not in the room. I'm in Orange, which might give you some indication of the line of questioning I'm about to go down. The green spaces you're talking about, I'm just wondering what impact drought might have on them and the flow-on effects for regional communities as far as social connectedness from drought.

MARTIN BLAKE: I think one of the very significant issues that's been surfaced in regional communities is transport and access to transport. As transport services have been rationalised and improved, particularly an issue for older people in terms of mobility when they can't drive and things like that is to actually

be able to travel around and meet with people, cohorts of people, and make those meaningful connections. Droughts per se, I haven't really seen much data on droughts, but certainly where there's a crisis situation that can be very helpful in drawing the community together in the immediacy of that crisis. I think we've seen that happen very effectively in different communities across New South Wales and nationally. But actually the long tail to that is in terms of where people are displaced, not living in their original dwelling, as they may have lost their home through fire, or they may have problems economically with drought and the impact on the economics of the agriculture industry. It's that displacement that can create an environment for loneliness to flourish.

ELIZABETH CLARK: If you'd like me to add, what I think many farming communities have seen is the impact of drought. The cyclical nature of farming has seen kind of an erosion of the profitability leading to aggregation of farms. You've got less families because you've got larger farms. Where there might have been five families before, there's only one. So that's five less families in the community, and so less opportunity for social engagement. That's one of the consequences of the economics of agriculture.

The Hon. SCOTT BARRETT: You touched on it before, combining the green spaces with organised activities like yoga and that sort of stuff. The types of interventions you mentioned were the activity-based programs like the sports leagues, volunteer groups et cetera. We've seen a massive decline in those clubs and organisations, and also involvement in them. I just wonder what levers you think can be pulled to strengthen that activity-based program that could assist with the earliest possible intervention as far as the decline into severe loneliness.

JOHANNA PITMAN: This is part of one of my key interest areas. The importance of participation in local activities through a public awareness campaign to say that social connections matter, they're good for your health, they're good for your wellbeing, they're good for your productivity—through this sort of campaign that's saying do you belong to as many organisations as your parents did. The stats are you don't. Most of us belong to fewer organisations than the generation before. Through that awareness campaign we need to pose that question but also have the resources to make what's available near you a bit more accessible. So one of the things we see is "I don't know where to start. I don't know what to go to." It's all finding these reasons why not to join.

If we can destigmatise the fact, or actually make people feel more motivated—they know why they need to participate because they know it's good for their health and they know, "Actually, I don't belong to many organisations. What are organisations could I join?" Maybe you're making that behaviour more likely to happen. But getting more people to join organisations, and giving those organisations the young people to sustain their operations—because what we're also seeing is, if we think about a bowling club, great assets in the heart of town have often got a very ageing member base. How do you make those places more vibrant? You need more members. How do you get more members? You need people to know it's in their best interest to become a member and there's actually broader benefits to it.

Dr AMANDA COHN: That's very related to what I was going to ask about. We've heard all morning about very structural and systemic barriers to people connecting, whether it's physical environment, transport, cost-of-living pressures, families with both parents working et cetera. So I'm really wanting to home in on this suggestion of a public awareness campaign. The last question that was asked, the answer was that they were very effective at targeting people. My question is whether there is evidence that an awareness campaign is actually effective at reducing loneliness given the other systemic barriers. I suppose I'm interested if there is evidence of it working as a sceptic that the missing piece of the puzzle—sure, people would love to join more sporting and community groups if they had time and access and income et cetera.

MARTIN BLAKE: In the UK they have a very disciplined process of reflecting on the goals that they've set and the effectiveness of the initiatives, both from the public service but also other organisations in the community that tackle loneliness. What they've found is that the campaign they've done to raise awareness around loneliness, and specifically deal with the stigma associated with loneliness, has been effective. That's on their website. But that's not dealing with loneliness per se; that's tackling the stigma associated with loneliness. But to be honest with you, at ground zero, you've got—if I go to work and Johanna's my boss, and it's Monday morning and I ring up and say, "Johanna, look, I've had a tough time this weekend. We've got this going on with the family. There's some issues. I'm feeling really blue", then Johanna would absolutely support me in saying, "Here's the employee help line. Have as much time as you like and we'll check in with you in a day or two."

But if I ring up Johanna and say, "Look, I've had a really tough weekend. I feel really lonely and I'm not coming into work today", that would have a very different reaction. So there is a real stigma associated with that, particularly in young people. There's really next to no support for young people in that. I'd strongly recommend you just google or dial in to the UK and have a look at what they've done in terms of both the public awareness campaigns and the effectiveness of it. That is absolutely on their website.

JOHANNA PITMAN: Can I add to that in terms of measuring the effectiveness. It's always going to be one of many, and that's why I really like that idea of a tapestry of solutions. It's attacking it at one level. If we think about the "Slip-Slop-Slap" campaign, that was highly effective. There's been other awareness campaigns and we can't remember them. But there was the never quit quitting, to try to stop smoking, just keep trying to quit—that was quite effective at that targeted group. We have to try something because those campaigns have not happened so far. There's been mental health awareness raising campaigns, but we have to start, and we have to start by really saying, "Okay, which target group are we going to go after?" I think whether it's a highly effective campaign or a moderately effective campaign kind of doesn't matter because it's getting the ball rolling, and we're going to learn from that. Are we targeting the right group? Well, it's not going to be one and done. There will be multiple organisations, and that's certainly come out from looking at the submissions.

All the different vulnerable groups that we're talking about—for us, it's youth that we're very passionate about because we see them as the productivity engine of the State, the country. We see the increasing urgency around doing something there, because the figures are only getting worse and the ability to make connections is reducing over time instead of getting better. So I think how effective it's going to be will depend on the quality of the creative concept that someone comes up with and the rollout. But we can measure it and improve on that. I think what's really reassuring is that the advertising industry wants to contribute to that. They're willing to provide that service, and I think that's a really important thing that we should harness.

The CHAIR: Unfortunately, our time has ended. I think you did take on notice your research results, which we would love to have. If there are further supplementary questions, the secretariat will be in touch about that. We thank you very much again for your interest in this space, your submission and being here today.

MARTIN BLAKE: I would encourage you to have a look at *The Weekend Australian* tomorrow because there's a special feature on loneliness.

The CHAIR: We will. Thank you so much.

(The witnesses withdrew.)

Ms ELISABETH SHAW, Chief Executive Officer, Relationships Australia NSW, affirmed and examined

Dr STEPHANIE HODSON, Chief Executive Officer, Relationships Australia Canberra and Region, affirmed and examined

Mr GREG JENNINGS, Chief Engagement Officer, Beyond Blue, before the Committee via videoconference, affirmed and examined

The CHAIR: Ms Shaw or Dr Hodson, do you have a short statement?

ELISABETH SHAW: Thank you, Chair, for the opportunity to appear before the Committee. We're both going to be speaking on behalf of Relationships Australia. For our organisation, we witness the profound impact of loneliness every day. We all know that it's a complex issue with far-reaching consequences for individuals and society, and it is marked by a lack of good enough relationships. People can be lonely and socially isolated but, equally, they can be in relationships and experience intense loneliness. Research that we've carried out within our national network says that nearly a quarter of Australians report feeling lonely, a figure that we're observing growing since 2022. Already vulnerable communities are at greater risk, including the elderly, unemployed, those in remote areas, CALD communities, members of the LGBTIQA+ community, and victim-survivors of domestic and sexual violence.

It's an obvious truth to state that the antidote to loneliness is social connection. This is best demonstrated by the 85-year longitudinal Harvard Study of Adult Development, which still continues today, which demonstrated that, regardless of participant backgrounds, those with the strongest personal relationships were not only the happiest but also enjoyed the best overall health and lived the longest. Strong social connections were demonstrated to provide emotional support, reduce stress and increase feelings of happiness and belonging, which in turn has beneficial effects on physical health and promotes longer and healthier life.

Equally, of course, poor relationships, separation and estrangement are inextricably linked with loneliness, and are one of the key reasons for suicidal ideation. We all know that key transitions in life, such as leaving school, changing workplaces, relationship breakdown, moving interstate for work, having children, leaving the workforce, children leaving home, retirement—these life transitions all involve loss as much as they involve opportunity. Single parents, particularly single dads, experience higher rates of loneliness, for example. Those who manage transitions well will be able to hold on to, and build, connections to see themselves through. Not everyone can do this, for a whole range of reasons.

Relationships Australia's services therefore play a crucial role in supporting people facing the sort of issues that result in social isolation and loneliness. We've submitted a number of recommendations that are already before you about how to address the issues, but I just wanted to highlight three for opening purposes. First of all is to speak to the whole issue of service design, which is about community and health services being designed around whoever is presenting as the symptom-bearer being treated as a relational being. That goes well beyond just asking them, "Do you live at home? Do you have anyone in your life?" but actually conceptualises them within that network and looks at how they can be part of the journey.

So it involves all the audience of others, which could be family, friends, carers, workmates who could be part of the service response, who are wise guides and people with good ideas and information who may be part of the solution. But we know that carers themselves can be in higher need as well. Our community, and the cost of community care, will depend on people autonomously being able to move forward with their lives. Those familial and friendship networks, we rely on them as a community to carry forth a service once they are independent of organisations such as Relationships Australia.

I will just give you a very quick vignette of this. For example, a young man in his twenties experiencing his first mental health crisis presented to his first community heath appointment. His parents, who were key carers with whom he was living, attended with him but they just sat outside the room while he was taken in—no role to play. At the end of the appointment, despite their fears about his wellbeing and safety and the role that they could effectively play, they were given a fact sheet and sent on their way to just drive him home, feeling very bereft about how they could have played a part. They were a sitting resource who could have been part of an action plan.

Secondly, we know that workforce is a big issue. What we would recommend is that in every health and community service, as part of a multidisciplinary team, if not a core skill set, there are, say, couple and family workers or people who are trained in family intervention as well as peer and lived-experience workers who can forge connections and take people from one relationship to another. It's not enough to make a referral. We know that people fall down in the gaps. We need those who can be the hand-holders. We also need those family workers to see the situation differently.

Another quick example is that a young woman with considerable gambling debt presented for assistance. She was given support around addictive behaviour, including financial advice. What was not unearthed until much later was that her family, with great intentions, were taking their lonely daughter to gamble at the casino with good intentions to help her socialise, thinking, "We're taking her out and we're doing something together." When this was discovered, they came to a family appointment and talked about how to be a better support and how they could all potentially do things differently, but more importantly, to focus on their worry, which was that she had no friends. We were able to help her, therefore, build her social network autonomously of the family, but it takes a family-focused worker to even spot that and move to intervene.

Finally, funds need to be provided for the establishment of services that promote community connections such as social hubs and peer support networks. I heard your previous presenters refer to that. We talk a lot about social prescribing but we need to bear in mind that just making a recommendation or putting people in a room together is not always the end of the story. Not only do we not have enough services but also if someone is shy, in transition, lacking confidence or just has never built those social skills, being in a room with others can be an intensely lonely experience.

We need to think about people requiring skill building so that they can make most use of those group activities. Otherwise, they actually could make them feel worse. We could measure attendance but still not be measuring change to loneliness. In order to look at some of these community hubs, we would also recommend the Government's own commitment to fund community services to a minimum of five-year contracts because people who are lonely need reliable supports that are there year in and year out. We are very grateful to have our chance to talk about our particular angle in the issue of loneliness and look forward to more questions from you.

GREG JENNINGS: Beyond Blue thanks the Committee for recognising the serious public health risk that loneliness presents to the people of New South Wales. The need for connection, the need to belong, is a basic psychological need. It's a foundational building block for mental health and, put simply, we cannot be mentally healthy while we're experiencing loneliness. The relationship between mental health and loneliness is twofold. First, loneliness is a cause of and a contributor to poorer mental health outcomes like anxiety, depression and suicidality. Second, experiencing a mental health condition can be, for many, a lonely and isolating experience. Loneliness is a key challenge for many people living with a mental health condition.

At Beyond Blue we are increasingly concerned about the prevalence of loneliness in the community. We recently commissioned a nationally representative survey that found one in three people stated they experienced distress due to loneliness over the past 12 months. The impact of that experience was clear. People who felt lonely were over 1½ times as likely to report anxiety compared with those who weren't lonely. They were nearly 2½ times as likely to experience depression, and even more concerningly, lonely individuals were five times as likely to report suicidal thoughts and behaviours compared with those who weren't lonely. Data from the Mental Health Commission of New South Wales also indicates that the inverse is true. People experiencing poor mental health are 4.4 times as likely to experience loneliness as those with moderate to good mental health.

Loneliness and social isolation regularly feature as the reason people from New South Wales contact the Beyond Blue support service. We also know that loneliness and social isolation are significant contributors to many more calls from people who interact with our support service. So the evidence about loneliness is clear: it's prevalent and it's damaging. It's a complex problem that requires a comprehensive response, including action at the individual, community and social level. At the societal level, we support the development and implementation of a national strategy complemented by State-based approaches. We are also excited by promising initiatives like social prescribing and we support the call for a large-scale rollout of social prescribing, given some State-based trials are yielding really promising results.

At the community level, it's critical that we continue to leverage existing initiatives to build social and emotional skills both within individuals and in the settings in which they live, learn, work and play—building social and emotional skills in those settings like workplaces, schools, local communities, local sporting clubs and in homes. Finally, for individuals we recognise the need to promote social participation so that might be things like organised sport or for social activities like volunteering, many of which are in decline. But for people who are experiencing persistent loneliness or those people who are experiencing mental health conditions and are feeling alone, they would benefit from earlier access to effective supports—things like the Beyond Blue support service or digital initiatives like the Beyond Blue online peer support forums, which we found can be really helpful with enhancing connection. We know that loneliness is a major issue with significant health implications. The economic consequences are in the billions and we strongly believe that an urgent response is required.

The CHAIR: Dr Hodson, did you have anything to add or was that the opening statement?

STEPHANIE HODSON: No.

The CHAIR: Excellent. I didn't want you to think we hadn't considered you. I will ask a research question first of Ms Shaw or Dr Hodson. In your submission you indicate that there's further data from the 2024 Relationship Indicators project that will be published in coming weeks. Is that available and can we have it? Is there anything that is relevant for us?

STEPHANIE HODSON: It has actually shown that—yes, and we can now give it to you. The report was so close to coming out, but we can actually provide you with the report. The bottom line is the results have increased. Especially those who say they strongly agree that they are lonely, there has been a 3 per cent point increase in loneliness between 2022 and 2024. That has particularly been in the emotional loneliness increase in social and emotional loneliness. There was a slightly higher increase also in social isolation. So very happy to give you that report. I think the other thing that's really important, what's very valuable about that set of research, is that the Relationship Indicators talk a lot about who is it that you talk to? Who is your significant other that actually makes a big difference in your life?

Thinking about relationships, it's men who seem to be the group that have the least people talking to them. Sixty per cent of couples will say, "It's my other couple." Then it's mothers and daughters that people talk to. The last people that get talked to if you have a problem, you don't go and talk to your dad or your son—it's a smaller group. That just goes to show the risk we have with young men and the risk we have with men in our society, which is also coming through in our suicide rates.

The CHAIR: It's really interesting. I'm pretty sure it's in your submission, but it did strike me that men in particular were quite vulnerable. Can I just confirm too, when you compared the data is that actually a longitudinal study or is that just a percentage comparison we are looking at?

STEPHANIE HODSON: We've actually replicated it, so the questions have been done two times.

The CHAIR: But not with the same cohort.

STEPHANIE HODSON: No. It's the same panels, yes.

The CHAIR: You are drawing from the same sample but not longitudinal.

STEPHANIE HODSON: Yes.

The CHAIR: We've got a lot of research and we're trying to make sure we know which one is testing what. Thank you for that. Mr Jennings, you noted the frequency with which loneliness or isolation is raised as an issue with your support service. What happens? When that's raised, what do your people do about it?

GREG JENNINGS: We provide a brief intervention service. If someone calls us we support them with the feelings of loneliness that they're experiencing, and any consequences of that as well in relation to their mental health, whether they're experiencing social anxiety, depression, low mood, or anything really. Our counsellors and coaches provide cognitive behavioural therapy or whatever intervention is most suited to the client to support them through those feelings and to connect them into other supports that might be beneficial for them as well.

The CHAIR: We heard a bit today about stigma and loneliness. Mr Jennings, Beyond Blue's submission really says that's quite a significant barrier to accessing support. There are two parts to that question. How have you determined that it is a barrier—we've been talking about barriers as well—and what then are your recommendations to lower that stigma?

GREG JENNINGS: Stigma is absolutely an issue here both in relation to help-seeking but also in relation to the way that people experience loneliness or mental health issues. What we are seeing and hearing in relation to mental health is that while there's greater awareness of mental health, certainly some aspects of stigma are actually on the rise, in particular, self-stigma. A feeling of shame around your experience of a mental health condition is actually increasing, according to our research. I know Ending Loneliness Together's research obviously found significant issues around stigma relating to loneliness. But what we're actually seeing is cumulative stigma. People will be experiencing stigma or shame around feeling lonely, or as we see it, around financial distress as well, and feeling stigma or shame around their mental health concerns, so it starts to build up and create a cumulative effect.

That self-stigma and that shame is something we're particularly concerned about. In relation to what can be done about that, we found that normalising the experiences of loneliness or of mental health conditions is a really effective way of addressing stigma. Contact-based intervention, people sharing their experiences—at Beyond Blue we have lived-experience speakers who go out and share their stories of experiencing a mental health condition and their recovery journey to break down that stigma and normalise the experience of a mental health condition. I know that there are similar interventions around loneliness as well, sharing your experiences with others so they feel more likely to be able to open up themselves and seek support when they need it.

The CHAIR: Ms Shaw and Dr Hodson, do you have any responses to that stigma issue as a barrier?

ELISABETH SHAW: Just to say that certainly, to reinforce what Stephanie was saying, we know that men are much more likely to go quiet than to speak up. There's some early research in my career that talked about women are four times more likely than men to have discussed their issue with a friend or someone else before presenting it to a therapist. They had more practice talking about issues and might have fielded those concerns earlier on. I think at the moment, what we're hearing anecdotally from many clients—because we do a lot of work in the men's behaviour change space around domestic violence—is that men are more reluctant to come forward because they feel so implicated and the cause of everything.

If there's a relationship breakdown, there's a stereotype. It would be the man who has let the relationship down or who might be targeted as perhaps a dangerous person. At the moment we're hearing more men seeking services later and then feeling more worried about being judged from the beginning. All of those are very obvious barriers and are the perverse outcome of the narratives that are in society at the moment, which are understandable but are not easy for help-seeking behaviour.

STEPHANIE HODSON: What I would probably add is one hundred per cent my background is as a psychologist working primarily with men. One of the biggest challenges around whether it's loneliness or getting help is their own belief, their own self-stigma: "I should be able to cope."

We do have within our systems, though, touchpoints where people will come and touch—Relationships Australia is only one part of the system. For one-third of Australians, unfortunately, marriage will separate. That is a touchpoint where we know they're going to suffer grief and loss. It's a moment where there's a chance of an intervention; there's a chance to touch them.

We do a lot of that primary health work within the health system and we are very much supportive of the recommendations by a number of agencies—to say, just like the GPs do a K10 which looks at anxiety or depression, we could simply be having a couple of questions which are about "How are you feeling in terms of loneliness?" We could be seeing this as part of our primary screening protocol. My experience has been working primarily with military veterans and military populations. They're never going to put their hand up for help. You have got to find those moments where you've already got a worker with them. There are many workers in the system, so it could be someone going in to get a licence, making sure that across the whole system every time you might have something to do with the New South Wales Government there might be that little brochure that is sitting there, or the sticker that is sitting there, about "Have you made contact with someone today?", or something like that.

If you're going to get around the stigma, you've just got to have the touchpoints where people already come. We were listening earlier. I think the challenge is always, though—and I've done a lot of work where you've had the person that you, as a psychologist, are desperately trying to get from your office to that support group. They've always kayaked, they've gone through a terrible part of their life, and they've stopped exercising and going out. I think lived experience, as Beyond Blue highlighted, the ability for someone in the system to be able—and Elisabeth said it too—to sometimes walk alongside to be able to be that peer support. You don't want the peer supporter to go to kayaking for the next 20 years for that person, but sometimes it takes one person to get them from your office to the kayaking group.

The other piece in all this that is so important is the micro skills. Not all of us know how to start a conversation up. Not all of us know how to rock up to someone. The thing that happens in counselling is you teach a whole heap of micro skills, but then you don't get the chance to practise them. That's where social prescribing comes in. But sometimes you actually need to have the fat in the system to have someone come and do the peer piece to get the person from where they are to where they could be. I think it's really interesting too because our churches don't have quite the same role they used to have. Around Wagga we work with the Presentation Sisters, a whole group of nuns who just went out in community and would help especially older Australians, older members in New South Wales, actually get to events.

For the last few years they've contracted us just to provide some counsellors who can be out in the community with some of those lonely individuals and do some of that—get the person from where they are to the knitting group or to the cooking class. You don't stay there, as much as my teens would love it; you actually go along and it's just making that connection and helping them do that warm transfer. What I'm very aware of is those groups are moving on, too. Those nuns are much, much older and they won't be there. The work that they were doing in the community is no longer there the same way. It's been a real eye-opener being in rural New South Wales and realising there's some social glue that's not there anymore. I think that's something that we should be really thinking about.

The CHAIR: I'll ask one more question before I pass on to my colleagues, and that is about social prescribing. You've mentioned it but it also features in the Beyond Blue submission. I note in the Beyond Blue submission you talk about the pilot in Queensland and social prescribing. I have a question about what we know about efficacy. One of the things when I listen to this is, yes, you can go to the doctor and you can include the questions in the K10, but it's exactly that point: How do we know that that's actually translating into the activity that's being prescribed? I'll start with Beyond Blue because you do include that particular pilot in your submission. If you could let us know what has been found.

GREG JENNINGS: Absolutely. We have seen positive results from social prescribing trials both internationally in the UK and in Queensland and in Victoria there are some early promising results. I think, Chair, you're right, that more research is required, and social prescribing would benefit from further high-quality studies, randomised controlled trials and ongoing monitoring and evaluation, to ensure that social prescribing is achieving the outcomes it is intended to achieve, both in terms of loneliness and then, more broadly, in terms of social participation, mental health and wellbeing, community cohesion et cetera. We have seen that some of the early results in from Queensland have indicated positive results in terms of loneliness, but not necessarily extending that to some of those broader issues. The feedback we've had from Victoria has been anecdotal so far, so I haven't seen any published results in that space yet. But certainly internationally we've seen some of the results of these studies published. I think it's promising, but we don't think it's a simple solution here. We think it's part of a broader, comprehensive solution, all of which need robust monitoring and evaluation to determine their efficacy and ongoing efficacy.

The CHAIR: Any response to that?

STEPHANIE HODSON: In our submission there's the social campaign which is Neighbours Every Day.

The CHAIR: Yes, I wanted to ask about that.

STEPHANIE HODSON: We've done a bit of a review with ANU in Queensland. It is about primarily getting in with councils and creating events where people can actually go to them. Importantly, it's also about—my favourite one is the tips to achieving belonging, those micro skills that I was talking about. At these events also having the opportunity to have those conversations with people. I know that in Canberra we did it at Giralang and I know that the councils here in rural New South Wales also do them. It's a chance to bring people together in a fun way as a sort of family event, but while you're there you actually begin to do some of that education. The work with Queensland and ANU actually showed, and we could give the Committee the report—

The CHAIR: Yes, please.

STEPHANIE HODSON: —that it reduced the levels of loneliness when compared with the general population. Those reduced levels of loneliness have positive impacts on people's health and it increased their quality of life. I'm not going to pretend that I understand quality-of-life measures. However, the researchers identified the campaign cost about $4,000 per quality adjusted life years. That's actually really good because, typically, these sorts of measures cost about $28,000. So for a value of $4,000 you get really good outcomes. There's actually been some of that, "Is this value for money compared to some of the health interventions we could be doing?"

Dr AMANDA COHN: I have a very narrow question coming from the very broad questions that have been asked, but you covered most of what I was after with social prescribing. Relationships Australia, in your submission one of your recommendations was:

> Ensure efforts to address loneliness in NSW complement gambling prevention strategies by ensuring the links between gambling and loneliness are well understood.

Is that something you could expand on a bit more? What are the links between loneliness and gambling?

ELISABETH SHAW: What's really important is to look at what are the sorts of things where people feel they can go out with a legitimate activity to join in with other people. Gambling, we know, there are a whole lot of charges one gets out of that, including the idea that this might be hope over despair. Although it's a lucky moment there's also a certain amount of excitement. It's also something that even if you are very alone you can go and sit with others and do. There are a whole lot of draws on people psychologically to gamble. Also, as we know—we've heard a lot about this in recent times—there is a lot of pursuit by gambling companies to seduce, inveigle you to keep gambling. There's a sense of being wanted and engaged.

A lot of that is coming from, "This might be my only activity and they're ringing me up and saying they miss me"—the kind of language that I've worked with gamblers who are having those sorts of calls. "We want you back. We haven't seen you lately." We can see that, for the person who is vulnerable and perhaps living in an

environment where they're still hoping, they're quite despairing of their social situation, it pulls on them in a whole range of ways. It sets an example of that. Any other addictive behaviour is also implicated, such as drinking for people who are lonely. There's that sort of thing. You can go and sit at a pub and have a drink by yourself, or you can drink alone at home. I think we need to look at all the things that people do to make themselves feel better. On the point of social prescribing, I think we have got to be very careful, in our western medical conceptualisation of services, using a term like "social prescribing". Because we're used to other sorts of prescriptions, it can just sound like someone makes a referral to the kayaking. An organisation like us could say, "Well, we made five referrals. Our job's done." But if the person has lost confidence until they've got there and they say, "I know I should stop gambling, but it's the only activity I have got," then we're going to have to ask more questions and understand people's experience.

We have got to be careful that a term like "social prescribing" does not become glib. We haven't stopped to really unpack it and understand it and to bear in mind that the sorts of services we'd like people to go to, first, don't all exist and, second, people won't go if they haven't got the confidence. They know often full well what they would like to do, or they'd prefer to do. We need to ask, "What would you like to do and what would stop you doing that?", which are the sorts of things we need to get into. It has always been my worry as a psychologist picking up a medical term like "prescribing" because I don't know if we're thinking relationally about people's experience in the world. It could become another transaction that an expert does with a vulnerable person, as if their job is done, handing them a referral: "Off you go." It's not actually what you do with loneliness.

STEPHANIE HODSON: Another comment I'd make is that there has just been a piece of research that has come out of ANU that is really looking at the fact that online gambling, I think for the first time ever, has reached 50 per cent, if it has not gone over, being most of the gambling harm, in their particular piece of research. What was concerning in that is the young mums who are at home and who are socially isolated. Gambling has now entered our personal spaces and entered our bedrooms. You are sitting there and you're by yourself looking after the kids and it becomes easy to start to gamble. Around our social media, the use of phones and online gambling, there's a real issue here around what it means for people who, for whatever reason, are not as connected. It might be a period of grief. It could be a period just because you're looking after the kids and you're home by yourself. That's where I know that ANU is doing some really interesting work in this space and they are very happy to send the Committee the reference.

The Hon. SCOTT BARRETT: I did have a line of questions, but given the sense that there seems to be a certain level of regional expertise in the room, I might head down that path. Can we touch on why there is a difference between regional and urban areas. So I don't have to keep coming back after being out of the room, can I also ask about what are some of the programs that have worked or you think could work in addressing loneliness specifically in regional communities?

STEPHANIE HODSON: Having worked in both metro and regional, I think the issue always is the ability to actually—if we're looking at interventions and workforce, as someone who manages a headspace in Wagga and trying to get support and services out to Young, it's just so hard to get workforce out in our rural and regional areas. Having boots on the ground is tough in our regional and rural areas. I look after the South Coast a lot and I do a lot of work down there. Again, trying to connect people and having boots on the ground to do community engagement activities is tough work because we're looking for workforces. I am going to be really honest: A lot of that has got to do with housing. China has enough housing. Even if I can find someone, I cannot necessarily find the person on the ground to be working with young people on the coast because we might not be able to have housing.

I think a very complex set of factors make it hard to deliver community services in rural and remote areas at the moment, especially around how we pay our workforce and access for the workforce to be there. Having said that, I do see every single day amazing people that are there in those communities and doing this work, but they're very stretched. When I talk about doing that wraparound work, when you see someone and you want to get them to the group, I think sometimes it is our more regional groups, my workforce, that would be more likely to give up their Sundays to take someone somewhere, but that's burning your workforce out as well. I think sometimes we don't have as much capacity out there. I don't know if that helps at all, but those are some of the things that I face in trying to support, through a community service, getting services out to these groups. I must admit, though, that our workforce out in the regions are—the Henty field days, the ability to be at the shows. They're the first ones to volunteer to be out there on the ground having these conversations with people, trying to break down stigma and volunteering to do the work that they can get out to the communities. But it is tough at the moment to have a big enough workforce to do even what we are already funded to do.

ELISABETH SHAW: Just to add to that, we had a whole raft of services that we were providing around community resilience-building and preparation for climate-related disasters. What we were doing, on a fairly cheap model—about $35,000 per LGA, so a substantial coverage—was actually working with the community

leaders to resource themselves. It's a different model, but it wasn't reliant on workers. It was reliant on workers to get this happening, but it was the communities themselves identifying local community leaders which could be the local person who runs the school tuckshop—people who don't realise they're leaders—and building a community activity that the community themselves said they would value. We've got the stereotypical sausage sizzle, but whatever it was—it was fixing the school hall, getting the community to rally around that and to have conversations together on that activity. That was a way to bring people in, not because they had a mental health concern, but they might well have a mental health concern. It was building the community up to be self-resourcing and then the workers pulled out. Those are the sorts of models we could look at. But we can't say we're running a booth on loneliness at Lockhart, because they're not coming.

The CHAIR: Mr Jennings, I see that you would like to contribute on this.

GREG JENNINGS: Yes, please. I think the Relationships Australia team have articulated some of the challenges, particularly around workforce, really well. Three points from me. Firstly, there is absolutely a need for and a benefit to these local place-based approaches to combating loneliness. Again, Relationships Australia just articulated the benefit there of co-designing those with community to ensure that they are going to resonate with the community that you're delivering it in. We're seeing that in a variety of ways, including in relation to suicide prevention and suicide safe spaces—really co-designing those with community, in community and being led by community. The second point is we won't always have capacity to be everywhere. So complementing those local place-based approaches with more population-based digital programs can provide reach and scale that we may not otherwise be able to achieve by being in community.

So, ideally, you have a multi-pronged approach here. Digital offerings like online peer support forums, for example, provide access to a certain cohort in the community who will get benefit from it, while other cohorts would prefer those local place-based approaches. The third point is tying into our existing infrastructure right across Australia, including in regional Australia—so tying into schools to develop social and emotional learning schools early in life. Relationships Australia referenced multiple times the importance of developing these skills: micro skills, social skills. The earlier we can do that in life, the better we equip children and young adults to practise social and emotional skills. So tying into schools, tying into workplaces and tying into other local community infrastructure that we already have to deliver some of those skills-building and other interventions.

The Hon. SCOTT BARRETT: Mr Jennings, earlier you lamented the loss of or the decline of our community groups and organisations. I wonder if you could talk more on why you think that's important and what role they can play, not necessarily once someone has become lonely, in preventing that slip down that pole.

GREG JENNINGS: Absolutely. Again, to one of Relationships Australia's earlier points, social prescribing is all well and good if we have the avenues to prescribe or to point people towards meaningful, enjoyable activities where they can connect with others, build a community and build a sense of belonging. We have seen a decline in community participation in a variety of areas in terms of volunteering, in terms of participation in local clubs, in terms of participation in religious activities, in political activities, in unions. So all of these formal organisations where people used to find a sense of belonging or a tribe we're seeing participation rates decline. We absolutely see a role for those sorts of groups to provide that place where people can go to sense make, to find a sense of enjoyment, to find social support. But they need to obviously be prioritised and people need to see the value that they can derive from those groups.

The Hon. SCOTT BARRETT: I wonder if someone can touch on maybe what this space would have looked like 30 or 40 years ago and why I presume that loneliness is increasing? Why are we seeing that increase?

ELISABETH SHAW: I think the things that Greg was talking about, I think society has changed enormously and there are a lot more individualistic ways that people move. Work has taken up a greater role in people's lives, so the time and the emphasis on life outside of work has changed. A lot of space is taken up with work. I think we see the stressors and the lengths that people go to just about keeping themselves going economically. I think what space you have left over for yourself, or even thinking about yourself and your mental health, it's a smaller space. If we think of some of the past activities such as the role the church had, you were also compulsorily required to turn up to something once a week, whatever that religious activity might have been. So there were ways in which you fitted that in as a routine and as a requirement.

I think there are a lot of those sorts of things that were built into how one lives that are quite different now. We often talk about sport playing a role. An awful lot of people don't play sport or have never played sport. I think in Australia we overemphasise sport as a way forward. But I think what we're thinking about is what would be team-based. What's a way that people get together? We have to start to think about community activities that speak to people's hearts and interests. That's where we're seeing the emergence of other forums such as community gardens, or volunteer efforts of people looking after their neighbourhood where they're turning up to work on the

local school garden. A lot of those things that have purpose and meaning and result in a common activity seem to speak to people more now, but they need someone to lead. They need someone who has the idea to rally behind.

The CHAIR: Mr Jennings, I can see your hand up again.

GREG JENNINGS: I think Elisabeth from Relationships Australia has made a fantastic point there. The other point that I'd make is, particularly in recent years, the complexity of what the community is dealing with is really challenging. We're now at a time where it's extraordinarily volatile and certainly complex and ambiguous. What we're seeing and what we're hearing, for example, in our support service is that people are approaching us around multiple complex and compounding issues. Using the cost-of-living crisis as an example at the moment, people are telling us that one of the first things they cut back on when they're experiencing financial distress is connecting with others. They're retreating into themselves. That might be because they're embarrassed, that might be because they don't have the same financial means to connect and to go and participate in activities. But they're telling us that they're kind of withdrawing and looking much more insular than they have in the past. I think one of the things that has certainly changed is the state of permacrisis that we're all living through at the moment and the state of polycrisis that we're all living through at the moment as well.

ELISABETH SHAW: Just to add, we're seeing a much greater rate of loneliness with single parents and particularly single dads. Everything we've all just said is amplified for single parents who may have very few resources, don't always have family around them and are impoverished. But single dads in particular, I think, because there's such a limited, if not completely absent, cohort of peers that they might be able to relate to. Certainly in my practice I see single mums who don't have anything left over emotionally, timewise or financially to do anything for themselves, much as they would love to.

The CHAIR: Could I jump in with a question there about risk factors, just because we're starting to talk about particular cohorts again. In your submission you talk about loneliness as a risk factor that increases vulnerability to abuse—for example, domestic violence. You talk about victims of domestic and family and sexual violence are at higher risk of social isolation and loneliness. Can you talk us through the risk factors there?

ELISABETH SHAW: I think perhaps everyone would know that keeping a victim-survivor isolated is a very common coercive behaviour in domestic violence. If you also look at all the things that flow from that—which is not just about the control and isolation; it's often a gradual erosion of the person's self-confidence, self-worth and their identity. As they become both divorced from their social networks and also shamed perhaps with what's happening, even when they might leave the situation they're cut off and shamed by what's happened. So just leaving the situation doesn't immediately open doors for recovery and confidence. I think the whole cycle of abuse is in itself going to increase not just the isolation but all the things that lead to that being a legitimate way to live, or argued as a legitimate way to live. Women particularly that are emerging from that can take years to recover their sense of self.

We also see this after relationship breakdown generally, not to dismiss the effect of violence, which is staggeringly significant. Also for a lot of people their confidence is really rocked about their worth, their lovability, their place in the world. A lot of people do still feel shamed by separation and divorce itself, let alone violence. You would think it's so ubiquitous, the amount of separation and divorce, but for many people in more conservative communities, and more broadly, I think relationship breakdown and all its consequences can have very significant ramifications for children and for adults.

The Hon. SCOTT BARRETT: I do have another question, but I think you led to one there and I might pick up on something that was said before. When these children are seeing that loneliness, and experiencing that as a family, what impacts does that have on that child as they grow and develop?

ELISABETH SHAW: If you think about how children are living with violence—it is often the sense that we don't tell anybody what's happening in the house, we can't bring anyone home, I cover up, children learn to cover up what's happening. So after a while their ability to just openly connect with friends is limited as well. If children are living with an isolated and lonely parent who maybe, for a variety of reasons, doesn't have social connections, doesn't pursue them or is afraid of them, they're not always enthusiastically encouraging their children to have those skills or know how to offer those skills for them. The whole family unit can become very isolated and also almost become each other's friends and social support. That can be a very collusive and limiting experience in itself. What you find is, if you have a parent with mental health vulnerability, then the carers around them, whether they are children or older parents, tend to be implicated around their mental health as well. The world of the whole social group can get smaller.

STEPHANIE HODSON: We have a program called Women's Choice and Change which comes out of— particularly Elisabeth's team actually developed it. It is about bringing women together and then learning skills together. Whilst group programs are harder to do, they take a little bit more resource, they are inherently

able to—if you can be with other people who've got the same experience, you don't feel so alone anymore. So we do find the group programs very powerful.

We do have men who want to change, and we have men who then form a group and will actually support each other. I think there's a lot to be said for thinking about what are the programs—Elisabeth and I were talking about this before we came in. There are programs where if you said, "Come in for a program to deal with loneliness", you're less likely to have the people come in than if you put together a program that's about "Be the best parent that you can." In reality, what we're doing is teaching those microskills. We're helping them deal maybe with their own intergenerational traumas and then helping the next generation actually do better.

There's a whole piece in there around really good focus on especially young parents and bringing them together. I've done couples' groups. One of the nicest things that ever happened to me as a psychologist was to, years later, be sent a photo. There'd been a couples' group. They'd only spent six weeks together, all these couples sorting out their issues together, but they felt less lonely because they all were in the same boat. They went up to Thredbo, and they used to have a gathering, and they've been having that gathering for 30 years. That formed a social group that no-one else could actually understand because they'd gone through a similar experience.

There's a lot to be thinking about with these group programs where we bring people together with similar needs, whether it's a vulnerable group in the community or parents that need to learn at the same stage together. We all know that mums who go to playgroups together sometimes form lifelong friendships. Sometimes it's about having these opportunities. It's where we started. Where are the natural touchpoints where you put that extra bit of effort in? Group work is harder, but group work also forms friendship groups that can last decades.

ELISABETH SHAW: Just to really emphasise that, we're about to start a new dads' group. That group of dads, it might be the only time they've ever sat and talked together. They'll come to a new dads' group; they wouldn't come to loneliness group. Family life, there's lots of opportunities where you can get people in because the topic is perfectly normal and understandable to turn up for.

STEPHANIE HODSON: And not stigmatised.

ELISABETH SHAW: Not stigmatised. The secondary gain is the connections.

The Hon. SCOTT BARRETT: It's almost like camouflaged mental health support.

ELISABETH SHAW: It really is.

The Hon. SCOTT BARRETT: Mr Jennings, talking about the clubs and organisations—and I will come back, Ms Shaw. I certainly don't just mean footy clubs and sports clubs but crochet clubs or whatever they might be. I wonder also if there's the once-removed benefit. If a group of people are together talking about their community and they say, "Have you seen Greg for a while? He's started to drop out a bit", that has an impact for that person as well. It's not just the members of those clubs and organisations that benefit, but other people they know. So there's that once-removed benefit for the community and for loneliness.

GREG JENNINGS: Absolutely. The ripple effects of those sorts of groups, and the connections that are formed, can't be underestimated. That is a really positive side effect of those sorts of groups and clubs coming together. They form communities, and they give people a chance to practise social skills which then they take into other aspects of their life. The positive aspects continue to ripple out. I think that is why they are such a valuable avenue to promoting social connection and, as you mentioned, a source of social support. That is again something that can't be underestimated. We know that before someone speaks to their GP, before they call the Beyond Blue support service, people are most likely to turn to family and friends in times of need if they're struggling with their mental health or dealing with a life stressor. Having those helpful support networks is so critical for our mental wellbeing.

ELISABETH SHAW: I should note too that groups are a comparatively cheap intervention. Compared to one-on-one work, groups are really good bang for buck. You have more people in it who might actually say, "Let's keep meeting on our own", so they're autonomous of us. We've currently got 700 on our waiting list for group programs. We don't have enough funding to actually run them, but that's how appealing they are. That's a hell of a lot of people that could be connected to each other if only we could have the resources. So they're very appealing and very worthwhile and value for money.

The CHAIR: We are at the end of our time for today. I want to thank you all for coming and for your submissions. Also you kindly took some things on notice that you'll provide for us. The secretariat will be in touch about that and if there are any supplementary questions. Again, thank you so much.

(The witnesses withdrew.)

(Short adjournment)

Dr NANCY KONG, Senior Lecturer, Centre for Health Economics Research and Evaluation, University of Technology Sydney, affirmed and examined

Dr LILI LOAN VU, Research Fellow, Bankwest Curtin Economics Centre, before the Committee via videoconference, sworn and examined

Mr CHRIS TWOMEY, Senior Industry Fellow, Bankwest Curtin Economics Centre, before the Committee via videoconference, affirmed and examined

The CHAIR: Thank you, witnesses for appearing. Welcome to the afternoon session of the hearing today. Before we begin with questions, would you like to give a short opening statement?

NANCY KONG: Over the past seven years I have been actively engaged in academic research focused on the social economics of health, social economic determinants of health, particularly paying attention to the economic wellbeing among vulnerable populations. My co-author and I have conducted research trying to better understand the relationship between loneliness and physical isolation such as living under lockdown and rarely seeing each other. We find that being alone does not equal being lonely, except for those who are young adults and those who are extroverts. How we did this is that we used the longitudinal data, national representative panel data, from Household, Income and Labour Dynamics in Australia that tracked more than 70,000 Australians.

Every year we asked the same question, "From one to seven, how do you rate the following statement which is, 'I often feel very lonely'?" Tracking the same people over time could help us understand how changes in circumstance would affect the feelings of loneliness. We compared those changes in loneliness levels with an individual between those who had experienced extended lockdowns and those who had experienced little to no lockdown. What we find is that physical isolation, represented by the number of lockdown days experienced by each individual, did not significantly affect loneliness.

We counted for many factors, such as working from home, health status, job industry, household composition, dwelling types and things like that. Including those factors do not change our results. We also looked at the long-term effects and find that two years after the COVID lockdown the loneliness level is still quite stable. We also wanted to find out how this relationship could be changed according to the sub-population group, including different income, age, gender, ethnicity, personality, living arrangement and remoteness. What we find is that young people and extroverts do experience a heightened loneliness level. This calls for targeted policy towards this population.

We also looked at how people may anchor their feelings to their friends and families who do not experience lockdown. We do not find that those who live closer to the borders—that is, had more friends next to those neighbours that are not currently in lockdown. This distance does not matter. That means that people do not anchor their feelings of loneliness according to their peers' experience. Those are our null result findings, but we do find that people who have higher community satisfaction, those who stay in touch with friends and family more, have lower levels of loneliness.

Interestingly, merely having access to the internet does not reduce loneliness. It's how you use the internet. We looked at how, during lockdown, people do spend more time doing household chores, playing with kids, and just spending less time commuting or running errands. Those factors increase relationship satisfaction and could explain how loneliness does not actually increase during lockdown. In the end, our study challenged the idea that being alone and being lonely are the same thing. We found social interaction and a support network are crucial.

CHRIS TWOMEY: We've agreed I'll make a brief statement on behalf of both of us. I'll keep it short so we can go to questions. Our submission to the Committee was based on our 2021 report, *Stronger Together: Loneliness and Social Connectedness in Australia,* which looked at trends in social connectedness and assessed their implications for development and wellbeing. The timing of our report meant that we were one of the first who were able to actually look at the impacts of COVID-19 on people's sense of connectedness, their social capital, sense of identity, solidarity, trust and belonging. Not surprisingly, the larger States, Victoria and New South Wales, had the greatest declines in social contact, and these were linked to declines in life satisfaction and increased loneliness. One of the things that stood out was that there were particular cohorts or groups in the community who were at greatest risk of loneliness and isolation.

We looked at what were the drivers of loneliness, what were some of the factors that can mitigate it and how that can add to our resilience and sense of inclusion. One of the things that stood out was that young people aged 15 to 24 were the most at risk and showed the greatest decline in their social connectedness. Interestingly, the decline was strongest in young men. However, we also saw during COVID it was young women who reported that social isolation from their friends and family was the most difficult thing. Both of those findings sit on top of

a much longer trend that we've seen in declining wellbeing and sense of belonging among young people, both in Australia and also internationally, over the last decade or more. But we then saw that particularly the impacts of isolation during COVID tended to boost that.

One of the things we're looking to in the future is to do some follow-up research to see how the COVID recovery process has gone, how well people have bounced back, and really to look at what are the factors that have helped people to recover versus those that have tended to get a bit more stuck. One of the other things that came up quite strongly was the vulnerability of people who were particularly experiencing life transitions. So you've got young children starting school, one at-risk group. Young people who are moving from school to work are another group who are at great risk. Another factor that stood out strongly was poverty contributes to social isolation and those in the lowest income decile were more than twice as likely to report being lonely.

There are also strong links going both ways between poor health and loneliness. People with poor health and those living with a disability are more likely to be isolated and that contributes to worse wellbeing outcomes. But we also found those that were lonely are also likely to be less healthy and that loneliness tended to contribute to people not looking after themselves as much and more likely to undertake risky health behaviours like drinking, not exercising, smoking and eating badly. One of the things we highlighted in our report was that we did some analysis around the economic costs of loneliness. We estimated that as coming in at around $2.7 billion per year, or an average of $1,565 per year for each person who became lonely. That was at a national level. Pro rata, based on population for New South Wales, that would have been around $848 million per year.

We looked at some of the impacts around technology and social media. The results suggest that the impacts can vary but that social media is less helpful for young people who are already feeling lonely. Again, this is one of these issues that's really important for us to revisit to see how things have emerged. It's probably worth having a look at the work that we did in there around developing a social connected index and it highlighted four different domains that interacted: social interactions, which is contact with friends, family and community; social support, which is actually people that you feel you can lean on and confide in; your sense of interpersonal trust for those around you and in your community; and socio-economic advantage also had a big influence on people's ability to do things, get out and to get connected.

That's pretty much it. The other thing I did want to acknowledge in passing is that I noted that you'd also had evidence from Professor Michelle Lim. I wanted to acknowledge the great work that she's done with Ending Loneliness Together and endorse the work that they've been doing. It's very clear that she has been a leader in this field internationally. We continue to follow her work and look forward to working with her. I think that's it. We're happy to go to questions.

The CHAIR: Thank you very much for that introduction. I have a couple of questions to start with about the research method itself. With regard to your Focus on The States series, was that self-reported or was there a validated scale that you used? What was the method for that? That's for the Bankwest Curtin crew.

LILI LOAN VU: Basically, in the report we used data from the HILDA survey, which is the Household, Income and Labour Dynamics in Australia Survey, and we used data from 2001 until 2019. It's the nationally representative survey. We got observations from the whole country, and then also used the sampling to represent a measure of loneliness for the whole country as well and for the State. In terms of the measure of loneliness, there is a particular question in the survey asking the respondents, "How often do you feel very lonely?" The responses ranged from one, indicating strongly disagree, to seven, indicating strongly agree. The individuals are considered as very lonely if they selected numbers five, six and seven. That's how we measure loneliness in the survey and how we deal with the sample.

The CHAIR: So it was a HILDA analysis using HILDA's methodology. There wasn't a separate validated scale or self-reports. You were using existing data, which is the same as Dr Kong, who spoke earlier. Thank you for that; that wasn't particularly clear. While we're on that, Dr Kong, I think in your submission you talk about other data and scales that would be better to use. I wonder if you could just explain a bit about that. Is there any research in Australia that has used those things? The HILDA stuff, which is widely available, hasn't been developed specifically for this, so can you give us a sense of what else is there?

NANCY KONG: I have to say that I am not the expert on this, but I did look up some papers for this question. Basically, in my submission, I cited a paper, Maes 2022, which talked about the measurement of loneliness. Loneliness is widely defined as when people perceive a discrepancy between their actual and desired social relationships. Usually you would measure what's the actual and what's the perceived. In this paper they evaluate eight different scales, so not just one single measure as in HILDA, but eight or 10 questions. Those questions usually cover emotional and social loneliness items. Social is what is your perceived network, while emotional is internal, like how you feel.

What they did find, strikingly, is that most of the scales, or more than half the items, are not actually about the discrepancy between the perceived and actual. What they suggest is quite new research talking about we need to update it to make it better. In terms of Australia, whether we have this or note, my co-author Jack Lamb, has done a lot of loneliness research—he is a sociologist, whereas I am an economist. I believe he has used some other loneliness scale that is not from HILDA, firsthand data where he actually collected the data himself.

The CHAIR: This might go to Bankwest as well, more as researchers than your actual submission. Dr Kong, in your submission, you talk about the need for ensuring cultural and demographic relevance. We get these surveys, we get this information, but is any of this sensitive to different demographic or cultural needs or interpretations?

NANCY KONG: In my research, because I was particularly looking at how physical isolation impacts loneliness and I didn't look for immigrants versus non-immigrants and those who are native speaking, like English was not their native language, I did not find particular difference but that's specific to physical isolation. What I did read is Curtin's submission. I think they have done more on the origin of the country, and I really enjoyed their graph as well, so I think I'll defer this question to them.

LILI LOAN VU: You want me to go first?

CHRIS TWOMEY: Yes, you can go first if you like.

LILI LOAN VU: HILDA is a very rich dataset that includes information on the country of birth of the respondents. So we use that information to identify where they are from and then we compare the prevalence of loneliness among different people coming from different countries. Then we found that people coming from cultural groups different from Australia—for example, Asia, Africa or the Middle East—are particularly at risk of social isolation and loneliness compared to people coming from the UK or New Zealand, or people who are Australian and born in Australia. That's from the report.

CHRIS TWOMEY: Just a couple of quick comments, if it's helpful. First, going back to your previous question, in terms of someone developing a particular survey of particular scales, Michelle Lim has done that work. She's had both one robust question that can be put into other surveys plus the scale with several questions that dig around the issues. Coming to the cultural issues, one of the things that we didn't look at in the research but that came up in some of the discussions we've then had afterwards with key stakeholders has been particularly around the links to community, culture and land when it comes to First Nations and the experience of being isolated and being off country. From what we've been told anecdotally that is something we want to look into because people say that that really impacts on their wellbeing and hence their sense of connectedness and belonging. I think that's a really important issue to consider.

The CHAIR: I have more questions but I'll pass over to my colleagues and we can come back.

Dr AMANDA COHN: For Curtin, I was interested in your written submission, which was really extensive, and the number of submissions that you made around reducing poverty. I'm interested if you could speak to the connections that you found between poverty and loneliness.

The CHAIR: Mr Twomey or Dr Vu?

LILI LOAN VU: Chris, do you want to go first?

CHRIS TWOMEY: Yes, I'm happy to jump in there. It was one of the things that did come through quite strongly. Yes, I mean, a number of things. We ended up putting in four or five different recommendations in response to it. Certainly one of the key factors simply came down to people not having the resources to feel like they could get out and engage. This also comes through very strongly in a lot of the interviews with young people when they talk about not having the resources to participate when it comes to school or social activities. One of the other things that we were then concerned about was the interactions that you had between poverty, loneliness, health and wellbeing and the cumulative impacts of that. I'm just having a look around to try to see. I know that we had a very good section on that. Have you got stuff you want to jump in with there, Lili?

LILI LOAN VU: Yes, thank you, Chris. In terms of the association between poverty and loneliness, we found that the people from the lowest income decile are more than twice as likely to report being very lonely compared to those people in the highest income decile. The loneliness gap between the richest and the poorest remains significant, even when we control for all the other factors. So imagine that we just compare between identical populations.

All the other characteristics, like education, family structures, all things like that, are identical. We just compared between people with low income and high income, and we found that people with low income are much more likely to feel lonely compared to people in the high income. We also found that single parents are more

likely to feel very lonely compared to the other family structures—for example, couples with children or couples without children.

One more thing that I want to find out is the link between poverty and loneliness. Even now, what about the cost-of-living crisis. You can see people right now have to spend money on so many different things. They have to prioritise groceries or housing, so they must spend less money, for example, on going out with friends, having social interaction or even participating in community activities. I recommend more research about this issue with more up-to-date data, up to 2021.

CHRIS TWOMEY: There was a report that came out just last week that I shared with the Committee earlier in the week that was done by the Australian Unity Wellbeing Index where they looked at wellbeing during a cost-of-living crisis. They found a strong association there between people who were struggling with the cost of living, having to go without, and their feeling of social connectedness and social isolation. That information is really good to look at. It also found that the lowest personal wellbeing scores came from those who were unemployed, relied on disability support or had household incomes below $33,800 a year.

Dr AMANDA COHN: That was really helpful. You made a number of recommendations around disaster preparedness and recovery and looking at social infrastructure. Could you speak to how that came out in your research?

CHRIS TWOMEY: Yes, happy to do that quickly. Part of that is it's been an overlap with some of the other work we're doing. With my WACOSS hat on, we've been involved in a lot of the Western Australian disaster preparedness work. We're doing a project at the moment that's around peak vulnerability for particular groups in the community, including seniors, people living with a disability, pregnant women and young children during heatwaves, and what the response is. One of the concerns there—particularly in the discussion that we'd had around people's responses during the recovery phase of COVID—was that the interaction between being in a crisis and being lonely tended to be more likely to impact on people's wellbeing. So that sense of social connectedness during a time of crisis is something that comes through really strongly. As Lili was saying, the link with single parents is another example of that, where, for people who are facing adversity, simply the feeling of having some kind of solidarity and support can make a great difference to them. Otherwise, the feeling can often be that they're finding a lot of things to be overwhelming, and that tends to reinforce their sense of social isolation.

Dr AMANDA COHN: When you recommend building and recovering social capital—I know things like roads are always front of mind for people after a disaster, but what sorts of things should we be considering in that space?

CHRIS TWOMEY: There's a few key things there. One of the things that's been interesting is there's been some work in the past where we've looked at what happens in the disaster recovery period. Often a lot of those small local community service sector organisations and voluntary organisations play a really critical role in recovery. But the flipside of that is that we've found over half of them, if they're directly impacted and they lose buildings and they lose resources, they disappear and they don't come back again.

Part of the thinking is we actually really need to be looking at our community resilience and preparedness and making sure that we're looking at those things. That is so we're not just thinking about the physical impact but that we're ready there to support people, particularly through that crisis and beyond, and use it to help build a sense of solidarity rather than to help people find themselves feeling overwhelmed. Certainly we've had some quite concerning stories recently from some cyclones, for instance, we had in our mid-west where a lot of people lost their houses and it's taken them a very long time to recover. In some of those communities people have become very isolated and in some of them a lot of people have simply left because it's become too hard and too traumatic for them.

The Hon. SCOTT BARRETT: Can I pick up on that? Dr Cohn, you nearly took my question word for word, so it means I can dive a little bit deeper into this. It's interesting that you say there is isolation after a disaster. One thing you often see after a disaster—I know we have seen this Molong, Cudal and Eugowra et cetera—is that the community really comes together. I wonder if you can touch on, possibly through stages of grief, what that means further down the track when they've come together after this incident. I suspect we then see a waning of that togetherness that leads to the loneliness that you might be talking about.

CHRIS TWOMEY: Yes. That's a really good point. I suppose it also depends on the type of disaster and how concentrated or widespread—certainly the ones where everyone's in it together—and then you get to a shared process of crisis response and recovery. But I think in some of these stories we were looking at where we had cyclone and storm impacts that were spread over quite an area where the communities themselves were quite smaller, relatively isolated. It only took a few people who were having trouble with insurance, having to leave the community or something, for people to suddenly drop below a threshold where the communities were functioning

well. Certainly I think deliberately thinking about what are we doing during that recovery period to make sure that we're helping and supporting community participation, that there are things there to help and support people to volunteer, but also then that there's outreach to people who might find that more challenging, particularly if they're seniors or they've got limited mobility as well. I think they're just some of the things, but it's a really important question.

The Hon. SCOTT BARRETT: What you're saying maybe in a disaster event—I'm thinking specifically of floods—is part of the problem that that support infrastructure breaks down because, one, they're doing other things and, two, as you mentioned before, they've lost their building et cetera, so Meals on Wheels, for instance, might stop because they don't have wheels anymore?

CHRIS TWOMEY: Yes, exactly. Certainly in one sense, an event like a flood tends to be more concentrated in levelling in the way that it has the impacts across the community. But absolutely there's that problem that you'll often find if you've got shared community infrastructure from a voluntary organisation that gets flooded and destroyed. It probably took fundraising over many years or many decades to get to that point and they may not necessarily have the insurance or they may not have the resources or the backup. So I think it's really critical that there is some thinking about how does government step in during the recovery period to make sure that there is active support that's not just about the physical infrastructure, but it's thinking about that social infrastructure at the same time.

The Hon. SCOTT BARRETT: If we're talking about disasters that happened in, say, a drought scenario, rather than a quick incident, it is a longer erosion of those support networks, I would imagine that's more likely to lead down that loneliness road as people slowly slip down the pole?

CHRIS TWOMEY: Yes. We've certainly seen some of that, particularly in the northern wheatbelt in WA, where basically we've had land becoming increasingly marginal. A lot of farms are having to be scaled up and so you're reducing the number of farmers per community because they're working over much larger areas. You reach a certain point where you no longer have the numbers for the local footy club, or shops and cafes in town start closing, and so on. That's where it really starts to get cumulative.

The Hon. SCOTT BARRETT: I wonder if you could touch more on that local footy club—extrapolate more than just the footy club but those organisations and clubs throughout the community. As we start to lose them in, say, a drought scenario, what are the ripple effects from that?

CHRIS TWOMEY: I think that's a really good question. It's been one of the things that we've been very concerned about in some of our regions. Disasters have been one thing. Another of the challenges that we've had in some of our north-west communities has almost been the opposite because we've had an economic mining boom and we've suddenly got a huge fly-in fly-out or drive-in drive-out workforce and we get to the point where your local community leaders can no longer afford to retire in town. They're moving down to the big city when they retire and suddenly there is nobody to run those clubs. That's where you then see a real hollowing out of the community. Often those things seem a bit intangible, and you wouldn't think they were that important, but having a social life in the community is what helps people stop from being isolated and have a sense of coming together to do things. When there is a disaster or something, you'll reach out through those networks that are your local footy club or whatever as your first point of contact for finding other people or offering or receiving help.

The Hon. SCOTT BARRETT: I have a couple more specific questions. The $1,500 per person cost of loneliness you're talking about, who is wearing that cost?

CHRIS TWOMEY: The short answer is that's more or less the increased cost to the community of the direct impacts on health and wellbeing. Basically if people are lonely and more isolated and they're not looking after their health as well, that's one of the direct impacts. But I'm interested to hear from Lili if she has got more she wants to say on that. She may have a better idea than me.

LILI LOAN VU: Thank you, Chris. I just want to add some more points about the methodology that we use to estimate the cost. Basically we estimate the cost based on the impacts of loneliness on different risky health behaviours like smoking, alcohol consumption and less physical activities. We basically compare between two different subgroups—people who feel lonely and people who don't feel lonely—and we compare the number of GP visits between the two of them. We can see that people who feel lonely are more likely to visit GPs or present at the hospital. That's why we can estimate the cost based on the cost for GPs and we do the same thing for alcohol consumption, for less physical activities and for drinking.

The CHAIR: That was part of the question I wanted to ask. Your costs are strictly health costs?

LILI LOAN VU: Yes, it relates to health.

The CHAIR: Just health. You didn't do anything with regard to modelling? Dr Kong, being an economist, you didn't do anything about productivity loss?

LILI LOAN VU: No.

The CHAIR: Just health?

LILI LOAN VU: We also take into account the number of sick days that people who feel lonely and people who don't feel lonely take annually. That's come from the sick days as well. It is a bit related to productivity but it's not totally about productivity.

The CHAIR: It's only implied; you didn't test any of that. Dr Kong, did you look at that at all? Did you look at costings with any measure against them?

NANCY KONG: No, not so far. But I did read their paper and I remember they talk about sick days, which I think is quite standard in considering productivity as well.

The CHAIR: Is there any other work, research or estimates out there which perhaps use a broader idea of cost? Health costs are helpful because that's very tangible and governments understand health costs, but productivity costs? We had someone earlier today say it was also the cost of people not engaging in education et cetera, which I guess is less tangible. Do you know of any studies anywhere that have that broader cost lens?

NANCY KONG: Not off the top of my head, but can I take this question on notice?

The CHAIR: Yes, please, that would be great. Curtin people as well?

CHRIS TWOMEY: Yes, we'll have a look as well.

The CHAIR: That would be great. Thank you very much.

CHRIS TWOMEY: One of the things attached to that discussion around loneliness and health that we also looked at was the work in the UK around social prescribing. This is deliberately tackling the health impacts of loneliness by actually having doctors, registered nurses and so on deliberately prescribing to people that they are treating. This is particularly around seniors or people who are socially isolated within the community to directly go and engage in voluntary community organisations or activities in their local community. There's a similar program in New Zealand as well where they do a kind of green prescribing stuff where they suggest people go out and get involved in local community, bush care groups and stuff like that. So this idea that you can actually look within your health system and you can recommend to people what are some physical activities that you can do that are going to help your level of activity, but are also going to get you directly connected with your community to build your sense of connectedness and wellbeing so you start feeling better and you start looking after yourself more and you live longer and better.

The CHAIR: Could I maybe replicate my last question and say if you have any studies about efficacy, cost benefit or social prescribing, that would also be very useful. We've been talking about it today and that would be very helpful for us from Dr Kong, Dr Vu and Mr Twomey, if you can find any.

The Hon. SCOTT BARRETT: Maybe again on notice, I noticed the maps that Bankwest Curtin has in its submission. This is obviously a national study. Is there a chance we could get a more focused New South Wales map for that? I know you have Sydney in there but we if we can see a little more detail around the regional areas and see if you have any detail with that, any trends or regional areas versus metro areas or things that we need to be aware of on that front?

CHRIS TWOMEY: Yes, I think we can send you a better copy of the map. We'll check up on that and send through what we can and then see if we need to follow up to do some more work to get a better one. But we can certainly dig out what we've got and blow and scale it up so you can see things clearly.

LILI LOAN VU: I just want to highlight that the map we produced using data from 2001 until 2018, so if we want more data update, for example, in 2020, we may need another separate study to update data and produce a more updated map for New South Wales.

The CHAIR: If we could just start with what you've got, that would be helpful. I had the same thing; I couldn't actually see. Even with my glasses on, I couldn't really decipher what the map was, but it did lead me to ask a question. Dr Kong, you spoke a bit about the New South Wales experience, but you used the same data which is the HILDA data, and there wasn't all that much in the Bankwest Curtin submission about New South Wales. Likewise, if you do have anything else that's pertinent in what you've already got, as opposed to a new study, that may come at a later stage. But now we'll go with what's there. That would be really helpful as well.

NANCY KONG: Sounds good.

The CHAIR: Noting, of course, Mr Barrett's request about anything regional as well, that would be greatly appreciated. Thank you all very much for your work, your submissions and your evidence today. You all have kindly agreed, after we harangued you a little bit, to provide us with some information on notice. The secretariat will be in touch about that as well as the supplementary questions. Again, we appreciate you coming along and giving evidence today.

NANCY KONG: Thank you so much for the opportunity. I really enjoyed it. It was my first time.

The CHAIR: Excellent. Careful what you wish for, Dr Kong; we might call you back.

(The witnesses withdrew.)

Professor VIVIANA WUTHRICH, Director, Lifespan Health and Wellbeing Research Centre, Macquarie University, affirmed and examined

Dr ROSANNE FREAK-POLI, Senior Research Fellow, Monash University, before the Committee via videoconference, affirmed and examined

Mr ACHAMYELEH TESHALE, PhD Candidate, Monash University, before the Committee via videoconference, affirmed and examined

Dr HTET LIN HTUN, PhD Candidate, Monash University, before the Committee via videoconference, affirmed and examined

The CHAIR: Thank you for joining us today for the last part of our hearing this afternoon. Would you like to begin with an opening statement? I'll start with Professor Wuthrich.

VIVIANA WUTHRICH: Building strong social connections in which people feel valued and supported are important for our social, emotional, cognitive and physical health across the life span. Investing in strategies to build these strong social connections at a community level is likely to prevent and reduce social isolation and loneliness across all age groups. But simply encouraging people to engage more in social activities is not enough. Social activities need to be high quality and they need to facilitate connections between the participants that make them feel valued, supported and connected. Practical and psychological barriers to building social connections are common in all age groups and populations and these barriers, therefore, need to be identified and addressed at the local level to ensure high-quality social activities are available to all people.

Whilst building a community framework to build and support social connection is important, there is clear evidence that simply providing opportunities for social participation is not enough to treat loneliness. Instead, to overcome loneliness people need both access to a variety of social activities as well as access to evidence-based interventions that target those psychological factors that cause and maintain loneliness. This includes a need for practical strategies to overcome unhelpful thoughts about the availability or unavailability of support, by reducing avoidance of social activities that might be about reducing anxiety, building self-confidence and problem solving an individual's barriers to participation.

In order to make a meaningful impact on community-level social isolation on loneliness, we also need to invest in more research to develop more potent scalable interventions. Our submission was based on a large body of research being conducted in our centre where we focus on understanding these underlying factors that cause social isolation and loneliness and to develop new interventions for these conditions. This includes several National Health and Medical Research Council clinical trials that we are currently running where we are looking to evaluate the clinical and cost-effectiveness of these interventions for treating social isolation and loneliness in a number of different groups.

Based on our submission, we have some very practical recommendations for you. One is to establish a framework for integration of approaches across all areas of government and community. Two, invest in a public health messaging campaign to inform people about the importance of frequent social participation with both a variety of people and groups. Three, design cohesive neighbourhoods that facilitate both incidental and deliberate social interactions. Four, increase social access to social activities and social groups that provide regular contact with the same people so that connections can be developed over time. Five, identify and target barriers and facilitators to establishing those high-quality social connections and participation, particularly in the vulnerable groups. Six, make evidence-based interventions to treat social isolation and loneliness inclusive and accessible to all. Finally, seven, invest in research to improve our knowledge of the causes of social isolation and loneliness and how to best treat these conditions.

The CHAIR: Would one of the Monash team like to make an opening statement?

ROSANNE FREAK-POLI: Our research focuses on how social isolation, social support and loneliness impact chronic diseases from an epidemiological perspective. We consider loneliness and social isolation as social determinants of health. Social determinants of health is defined as the non-medical factors that influence health outcomes. They are the conditions in which people live, grow, are born and age, and the wider set of forces and systems shaping the conditions of daily life. Our research has utilised longitudinal databases from Australia and internationally. In summary, our research demonstrates that social isolation and loneliness are separate yet interconnected concepts. Loneliness and social isolation are not only about the individual but also the wider community and social environment that supports the individual. Social isolation can increase the risk of loneliness, and vice versa, loneliness can increase the risk of social isolation.

Loneliness disproportionately affects older adults. Loneliness and social isolation can be viewed as elements of human nature in the sense that we are all likely to experience them at some point during our lifetime. However, long-term persistent loneliness and isolation are both concerns as they negatively impact mental and physical health through separate mechanisms. There is an abundance of evidence that people with positive social health are at lower risk of developing serious chronic diseases and death. For example, we have demonstrated that older, healthy Australians with poor social health are 42 per cent more likely to develop cardiovascular disease and twice as likely to die from cardiovascular disease over approximately 4½ years of follow-up. We have identified that older, healthy Australians can engage in activities to reduce their risk of chronic diseases that are social specific, and we can detail these in question time if you're interested.

We have some recommendations. First, we recommend addressing other social determinants of health simultaneously to facilitate socialising and prevent or mitigate loneliness. Second, we recommend that healthy Australians aged 70 years or more 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 care-giving at least once per week—for example, this could be babysitting, childminding or looking after someone with illness or disability; and have contact with four or more relatives or close friends per month. This could be in person but also includes email, phone, videoconferencing and text messaging.

Also aim for three or four relatives or close friends with whom to discuss private matters with or call for help. Note that only two people are required for benefits in health if they fulfil both discussing private matters and calling on for help. Recommendation three is, 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. Four, we recommend social prescribing as a solution to prevent and mitigate loneliness, social isolation and unfavourable social determinants simultaneously.

The CHAIR: If I could just put a question which has been—"vexing" is probably a bit strong, but on my mind reading these submissions and today through the evidence is the difference in cohorts that we're being told are the most at risk. We've had quite a few anyway. We've had young people, we've had women at a certain stage of their life and we've had men in certain circumstances. I think, Monash, your submission says older people. Am I to take away that we're all in it? I get that there's a part of that as well, but in terms of groups more at risk, how do we make sense of this? I might go to you first, Professor Wuthrich.

VIVIANA WUTHRICH: I think you're being told different things because that's what the literature tells us. Different studies do find different things, and I guess it depends for each group on what's going on for that particular group at the time. We know that poor physical health, for instance, does get in the way of people participating in social activities and is associated with loneliness, so it makes sense that often older adults come up in these particular surveys. At other times, and certainly since the pandemic, we've seen this change with younger people now reporting more loneliness.

In studies prior to the pandemic, we didn't see such a strong effect with young people. That has now become more prevalent since the pandemic. So I think there's a difference in who studies what, when they've studied it, what cohort, what time. The point is that loneliness and social isolation does impact on all populations. It can be those with low SES, or those with low transport options, those in rural communities. I think that it's hard to say that one group is more vulnerable than another. I think any disadvantage really puts someone more at risk of social isolation and loneliness.

ROSANNE FREAK-POLI: We agree that it's really about how the sample is collected and how loneliness is also measured. In our submission we have a figure that demonstrates the prevalence of loneliness by age among an Australian representative sample of people living in their own homes. It's from the HILDA study—the Household, Income and Labour Dynamics in Australia Survey. This was for the data collected from 2001 to 2017 for everyone aged 18 years or more. It showed that people over the age of 75 years were most affected, and we're currently undertaking an updated analysis which we're happy to share with you when it's available.

Just to point out that these are people in their own homes. I have noted that some samples have collected data from people active in the community—for example, going to shopping centres. In those samples they report higher prevalence of loneliness from young adults. It is just important to think about who's already interacting in society, and the difference between social isolation and loneliness here is coming out as well. Another example would be from some work that I'm involved in that's funded by the Department of Aged Care, evaluating their aged-care visitors scheme. My preliminary findings demonstrate that people receiving aged care, whether it be in home or residential, are more likely to be lonelier and socially isolated.

This is critical because it is a vulnerable group of older people that is expected to increase in coming years, given the ageing population and social demographics changes concerning lone households as well as smaller families and kinless people. Then to the point of how it was measured, in with that HILDA survey it is,

"Feeling lonely often, yes or no," are the responses. So it is a direct, single question with a binary outcome which forces people into those categories. If you have a look at the scales, there are different scales with either one or multiple questions. They then do a calculation with subfactors that are more related to social loneliness or emotional loneliness, so it can get quite complicated.

The CHAIR: Yes, it's an interesting one, and part of it is just being an uninformed researcher. We have had several researchers and research groups come in, having analysed the HILDA results, and give us different prevalence, which I presume is the subset you are using within HILDA. But it's absolutely fascinating to see how the same dataset can be approached in different ways. It is no criticism; it's just an interesting thing for us to unpack as to what we use.

ROSANNE FREAK-POLI: Before you move on, I think Htet Lin would also like to add some information about the gender question you had around prevalence.

HTET LIN HTUN: We were using this healthy older Australian cohort from nationwide Australia, which is from a clinical trial that is called ASPREE, and then we used a subset of the Australian population from that cohort. What we have found was the prevalence of loneliness is higher in older women compared to men. But the thing is, our population is 70 years at the baseline, so it means that when we calculate their birth cohort, it's going to be around the 1940s, so that means that the cultural difference may be influencing the loneliness as well. That means that men may not report loneliness, although they may feel it. There might be some concealment of it. Currently we are seeing a higher prevalence of loneliness among older women compared to men.

The CHAIR: That is a useful thing to point out; I appreciate that. I will go back to Professor Wuthrich. In your submission you talk about your research into treating social isolation and loneliness as "novel". Can you tell us why that is the case and what is different?

VIVIANA WUTHRICH: Yes. I think I also point out in the submission that when you pull apart what is being done in loneliness, there are not that many studies that have actually targeted loneliness per se. Often there have been a lot of studies that have tried to improve social connections and social participation. I think it was really thought that if you just got people together, that is how you would fix loneliness. It is really only now we are starting to, as has been described, understand the different constructs, but it also means that they require different sorts of treatments. When we start to think about what is it—we know that you need to have some contact with other people, but what stops people from having contact with other people?

That is when we started to look back at the theoretical models we have around loneliness, but also our own perceptions as clinicians and psychologists and trying to understand what is it that lonely people do and say and think. We spent some time talking with lonely, older adults participating in a trial, and we realised that there was a lot of what we call cognitive misattributions. Basically it means ways of thinking about their circumstances, ways of thinking about their social network that were really getting in the way of them then being able to go on to participate in things. So, in fact, with these theoretical models we do see that this cognitive component is actually a really important part of what maintains loneliness. People start to believe that they don't have people available to help them and to support them who might come and be of aid to them if they need it.

In some situations that's true, but it's often a perception. Sometimes that's not an accurate perception. We also identified that there are barriers that stop people from participating—social anxiety, for instance, avoiding of social interactions and just not even knowing how to go about joining a social group. For an older person who has lost a spouse, their family has moved away, it is all very well to say, "Go and join a social group." But for these people they might not have made a new friend for 40 years and this actually becomes an incredibly daunting experience, a lack of confidence. We then applied cognitive behavioural therapy skills to say, "How do we address those psychological barriers?" I think we are the only ones to have really drilled down in that space.

We are spending a lot of time understanding what those underlying cognitions are. We have developed a scale and we are validating a couple of samples now to detect what are those unhelpful thoughts that people think to themselves. We have now done some experimental work to identify how we can change those thoughts and the resulting impact to improve loneliness, and we also have some behavioural strategies which we are using as well. In fact, we have just finished a clinical trial where we're looking at this, so very shortly we will have the results to show whether or not we have been successful in actually making a big difference to loneliness in older adults.

The CHAIR: That is really interesting. In your submission you talk about interventions that target social isolation that have an effect on decreasing social isolation but don't automatically lead to a reduction in loneliness. While a lot of the submissions and the evidence we have received differentiate, at the beginning, the theoretical difference between social isolation and loneliness, it seems they conflate the solutions.

VIVIANA WUTHRICH: It does.

The CHAIR: I am hearing that, yes, those interventions work on social isolation, but you're suggesting that the loneliness aspect is a more individualised thing that will need other interventions targeting individuals.

VIVIANA WUTHRICH: Correct. In fact that is what the literature tell us, too. When you look at interventions that have been successful in targeting loneliness, so far they have been psychological interventions that use some sort of way of targeting changes in behaviour and changing cognitions in some way. Others haven't really drilled down on what the fundamental cognitive basis is in the way that we have done, but we know that those sorts of strategies—those cognitive behavioural therapy strategies—have been applied in a couple of different formats: some of them digital, some of them face to face, some of them group. They're the ones that we are seeing actually have an effect on loneliness.

The CHAIR: Those results which you said are soon—how soon is soon?

VIVIANA WUTHRICH: Within the next four weeks we will have the final 12-month assessments done for that clinical trial. I can try to put a little bit of action on the analysis for that.

The CHAIR: That would be great. Even just preliminary analysis would be really helpful. We would appreciate that.

Dr AMANDA COHN: I have another question about measurement and data because we've heard today very clearly that social isolation and loneliness are two separate but related things and that social isolation is a risk factor for loneliness, but that they are separate and need to be measured separately. When you look at interventions—and we've had a really broad variety of things recommended to us today—what is the best practice for measuring the success of an intervention? Are you aware of anyone measuring the impact on loneliness as opposed to only measuring the impact of interventions on social connection?

VIVIANA WUTHRICH: Yes. I think a clinical trial is the best way for us to establish the true effectiveness of an intervention. Clinical trials randomise participants to an intervention versus some sort of control condition. We do that because that is how we tease apart what the active ingredient is. What is the thing that's making a difference? In terms of studies that are measuring changes on loneliness, yes, our study is one of those, but of course a number of projects are happening right now as part of a targeted NHMRC call, which was to target loneliness in people with chronic conditions and to examine the interaction between those things. As part of that, at least two of the groups are actually evaluating an intervention for loneliness in that population of people with chronic conditions.

Dr AMANDA COHN: We are open to a comment from Monash too, if they want to answer the same question or not.

ROSANNE FREAK-POLI: I did hear that you are, first of all, interested in the difference between social isolation and loneliness. I was unable to include it in our submission because it is under embargo, but I have written a chapter on social isolation and loneliness for *The Cambridge Handbook of Loneliness*, which I can share on notice confidentially if you are interested in the definitions and the theoretical frameworks underpinning these two, and how I see them impacting health differently through different mechanisms. Your question was more about how we look at that in terms of interventions. I guess the way I see it is that it's something like social prescribing, which is what I mentioned earlier. It has the benefit of improving both as well as increasing health equity.

Social prescribing is defined as a means for trusted individuals in clinical community settings, like a general practitioner, to refer a 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. There are different models. We advocate for the link worker model because this gives enough time at the individual level, which is I think what we are both saying here. We need to have individual level interventions where personalised plans can be developed between the link worker and participant that are tailored to the person's specific needs and interests. Another key component of social prescribing is that it can also have benefits in offering services to overcome social determinants, so social structures that are preventing someone from interacting with others that may not be addressed by other interventions.

Dr AMANDA COHN: I was also interested, Monash, in your written submission. In your opening statement you made some very specific recommendations for healthy older people, and I say "very specific" in terms of the numbers of relatives or contacts that you are recommending. Could you explain how you arrived at those really specific numbers for contacts?

The CHAIR: Yes, my question exactly.

ROSANNE FREAK-POLI: Yes, of course. I am going to let Htet Lin and Achamyeleh discuss some of the finer details, but I will just point out that most of this research is undertaken in the Australian subcohort of

the ASPREE study, which is the ASPirin in Reducing Events in the Elderly trial. It was a randomised and full trial of low-dose aspirin, and it had no effect on the outcome. All of our outcomes were adjudicated, meaning that we had a very strong measurement in cognitive decline, cardiovascular disease in a healthy sample at age 70. I will let them both go into details.

HTET LIN HTUN: We were using that cohort study to follow up these healthy older Australians for around 10 years. So I am looking at the dementia estimates outcome—we were studying beyond loneliness actually. Loneliness was one of the exposures that we measured, and then we had the additional 24. So in total we had 25 social connection activities. Social connection is one of the umbrella terms and loneliness is one of the terms included under social connection. So, for example, you will see babysitting and childminding because we consider them as social connection activities. Then we have found that men who did babysitting activities actually reduced their dementia risk by about 25 per cent, which is significant for us. That is how we arrived at some of the specific activities and numbers over there.

The CHAIR: Thank you very much for that. Professor Wuthrich, I am just picking up on some of the themes that we have had throughout the day and getting some responses. You spoke in your opening statement about high-quality connections. We have been talking and asking questions about social media, online engagement today. I just wanted to get your thoughts on the role of social media and how that intersects with this idea of high-quality social interactions.

VIVIANA WUTHRICH: I just want to preface that by making two points. In fact, maybe I was meant to say I was tabling some recommendations. I don't know if you saw that. But anyway, they're just some really practical things that spoke to some of those other recommendations. I guess the first point is there is a whole piece that can be done within the community just about building social connections in general. This is going to help get the population in a good place and build connections that are probably going to protect them. We have been talking a lot about how we treat loneliness. When we think about digital platforms, I think digital platforms have a great role to keep continuing these social connections. It is good for people who have connections; it keeps them connected to other people.

When we look at interventions that have actually tried to reduce social isolation, yes, that works, because they might learn, they have more frequency of social contact. We know that interventions that have used digital platforms to treat loneliness have been successful when they have used those psychological strategies I was talking about before. They are therapy groups to target loneliness by targeting those thoughts and getting them to change their behaviour, so we know it works when it is delivered digitally. Again, I think it depends on what the use of the digital platform is for. If it is again just about saying, "Let's pop you into a community group and get some people together," that may or may not work to treat loneliness, unless people feel connected to the group, valued and supported by the people in the group where they feel like there is a shared sense of identity with those group members.

You will see that I have made some recommendations in here where we've thought about how we might be able to think about how we can train community leaders or have options for training for people who run groups within communities to give them some strategies and tips about how do you help your members in your group. Whether it is the men's shed, the Country Women's Association or the soccer group, how do you help people build those connections in a way that they then go on to feel and build these high-quality connections.

The CHAIR: I guess that goes to my next question. I think you mentioned scalable interventions in your introduction or one of your answers. One of the things we are hearing a lot about is the importance of place—local things—which makes complete sense, but I worry about the fact that we are a State Government. What is the role in that? When you're talking about scalable interventions, and you just mentioned they were some things, can you talk a bit more about what you mean?

VIVIANA WUTHRICH: Yes, so one of them is about that. It's about saying, "How do we upskill what's happening in the community?" There's great stuff that happens in the community, but we might be able to make that better by making it more accessible to people. Lots of people don't know about what's in their communities, so we can scale within the local environment by just actually making it known what is around and helping to develop those quality interactions within those local groups. But I also thought that scalable can relate to digital. Once we have developed digital interventions to treat social isolation and loneliness, we can make them accessible through one of the many available platforms we have—MindSpot or other sorts of groups. At the moment I don't think we have any that at least have been evidence-based, that have been evaluated, but I don't think that would be a hard ask to do something and to generate some data around that.

The Hon. SCOTT BARRETT: I have been listening in. Sorry that I've been a little disengaged as I've been travelling. Dr Freak-Poli, you mentioned before some really practical, almost KPIs that quite excited me. I just wondered how you landed on those in particular?

The CHAIR: Scott, I think Dr Cohn might have asked that question, but we'll have a quick recap. You are talking about the two people, the four people—that kind of thing?

The Hon. SCOTT BARRETT: Yes, I'm really sorry. If that's been answered, that's fine. My follow-up question was then going to be: How troubling is it to you to see the decline in the organisations you are referring to, such as the clubs and organisations and the volunteering groups? They have drastically declined over the last 20 or 30 years. How concerning is that in the loneliness context?

ROSANNE FREAK-POLI: This is more of a personal opinion in the sense that I feel we need more equitable resources. At the moment there are options for people, but often they cost money. If we could find a way of subsidising so people could afford socialising—people can't even afford the transport to get to places. We are talking about a huge inequity to socialising in that respect. That is where I would think part of the way I feel that the social prescribing model could go would be to alleviate people of the cost of joining some of these social groups. Also, the link worker can work towards finding ones that are less expensive or free, which are available, but sometimes can be hard to find.

The Hon. SCOTT BARRETT: What about their role in the prevention of loneliness? Before someone is going down that track and needs to be referred to one of these organisations, if these organisations are there and are strong and people are involved, do you think that could then somehow stop more people becoming lonely or having that social disconnection?

ROSANNE FREAK-POLI: I think what my research has found is that you don't need a lot of people to feel socially supported and reduce loneliness. First of all, I noticed that earlier in one of your sessions you were talking about social isolation and it is seen as an objective measure, but actually we do have some subjectivity around that with comparing ourselves to other people and thinking that we need more friends. If we understood that maybe we only need one or two, two or three for our health, that's a really important message to get across first. Sorry, could you just repeat the question?

The Hon. SCOTT BARRETT: Yes, the role that it can play as a prevention.

ROSANNE FREAK-POLI: Yes, sorry. I lost my track of thought there. First of all, we only need a few number of friends, but the thing is that over our lifetime our friendship groups will change over time and this is natural. We need to have avenues of refreshing our friends. If we do social prescribing or interact in our community we find these more easily, is how I think about it. That, in my mind, makes sense to reduce loneliness, but I haven't seen any data around that. It just makes sense. But I would like to ask my colleagues if they would like to add anything specifically.

HTET LIN HTUN: No.

The CHAIR: If not, I might pass back to Professor Wuthrich who may have some thoughts on that as well.

VIVIANA WUTHRICH: No, sorry. I have forgotten the question. I was busy thinking about something else I was going to say.

The CHAIR: The preventative potential of the types of organisations which we might socially prescribe to after the fact.

VIVIANA WUTHRICH: No, I think so. There is lots of evidence showing this association. The more frequently people engage in things the less likely they are to experience social isolation and loneliness. We know that the best predictor of wellbeing in later life is actually the size of your social network when you are younger. So having lots of friends in your forties actually sets you up for life. I think really these sorts of clubs and activities actually set everybody up throughout their life span to have the support they need, but to also have friendships that they are going to lean on down the track. For older people they often end up lonely because they rely on friendships from 40, 50 years ago—people they literally did those community activities with. I actually think a huge piece here is that is re-engaging everybody in these sorts of community activities.

Now obviously we need to have more community activities which are low-cost. It can be a burden for a lot of families when it is expensive, when they have to transport their children or their teams or themselves, and finding time to get there. In our submission one of the recommendations we made here was a lot around thinking about the built environment. There is a lot of research that shows that having the right sort of built environment actually fosters more social contact and reduces loneliness, where there are people and people can just go and hang out. They don't have to be just cafes because cafes are expensive for people who don't have money. But it's the parks, the gardens, the equipment, the free chess sets—any sort of activity. But they do need to be those regular activities because, remember, we're not just trying to have market days or one-off days; we need people to be

reconnecting with the same people where they are building those strong relationships. So when they're in need they get to turn around and ask for social support.

The CHAIR: I have a related question. We haven't heard a lot about loneliness and the workplace, and what role work potentially has in prevention or mitigation. If either group has thoughts? Professor Wuthrich, why don't you go first and then we'll go to Monash.

VIVIANA WUTHRICH: I don't know a huge amount other than that it is a problem and there is some research showing that, again, reducing loneliness in workplaces occurs if you have structured social activities, so regular, whatever it is, Friday afternoon teas, regular lunches, and often if it involves free food that attracts people out of their offices or attracts them in for the day. It is not that different to what we see in the outside community—that we have to put some structure in place for some people.

The CHAIR: Monash, do you have any comments on the workplace side of things?

ROSANNE FREAK-POLI: I know that it has contributed to the cost of loneliness, the fact that loneliness in the working adult population contributes to absenteeism and productivity. But also, when someone leaves the workplace and is going through that change in their lifetime, it is a time of increased loneliness. There is certainly a relationship there.

The Hon. SCOTT BARRETT: I have one random question. Is there such a thing as generational loneliness? If a single parent is lonely that then gets passed on to the kid who doesn't pick up those skills?

VIVIANA WUTHRICH: That's a great question. I don't think we know, but if I had to take a guess, if someone is lonely they tend to interact less with others. Loneliness is associated with social isolation. So if a parent is becoming more socially isolated, we would predict there's a pretty good chance that the kids are having less social interactions because mum, dad or whoever is not going out. But it is a good question—a research project.

The CHAIR: I was going to say that someone's PhD is just sitting there waiting. Any comments, Monash, on that one?

ROSANNE FREAK-POLI: We have looked at spousal loneliness and that impact on relationship together in the same household using the HILDA study as well as on their death outcome, but we can't share that at the moment because it is under embargo. I can share it privately on notice if you would like.

The CHAIR: That would be great, thank you very much. With that we are at the end of the session and at the end of the day. Sorry, Professor Wuthrich?

VIVIANA WUTHRICH: I just wanted to make one comment. I was listening before and you were talking about social prescribing.

The CHAIR: It has come up a lot.

VIVIANA WUTHRICH: It has come up a lot. I think actually the Monash team will have a little bit to say about this too because I know that one of them published a systematic review and meta-analysis on social prescribing for chronic conditions, I believe.

The CHAIR: I'd love that too.

VIVIANA WUTHRICH: In preparation for this I actually went and spent a little bit of time searching the literature because I knew this was going to come up. You know it's a very popular concept and it has been rolled out regularly through the UK. When you look at the literature, there have been a number of what are called systematic reviews and meta-analyses. They compile all of the research in the area and say, basically, in summary, does something work, and the meta-analyses will then be comparing the size of the effect against some sort of active control. It is a little tricky and lots of people won't want me to say this, but the results are often not that great. But I think the problem is that social prescribing is quite broad. The name of it suggests that we prescribe social activities, but not necessarily. People can be prescribed to receive lifestyle interventions to deal with a chronic condition. It is actually hard to then go away and work out what happens if you are picking someone who is lonely and you are trying to connect them in with social activities. I think there is some hope. There are some reviews that suggest at least social prescribing that combines nature. There is some evidence for that.

There is a trial that was done at the University of Queensland; it was an Australian Research Council funded intervention in the Mount Gravatt area. There is a preliminary report available. It wasn't an RCT—they didn't randomise people—so it is just a pre-post evaluation. They report significant benefits in loneliness—I think around an 11 per cent reduction in loneliness. You would probably need to talk to that team from the University of Queensland, but I know they spent a lot of time using that link worker but actually trying to overcome some of

those barriers I was talking about before. So I think the evidence is mixed. If it was to be used, I think it needs to be used carefully, in terms of for certain sorts of conditions with certain sorts of prescriptions. Again, if we could make sure that people are trained who are delivering it to identify what those barriers are and to overcome some of those psychological hurdles, I think there's great promise because it sort of does what we think it does, which is connect people in their communities to social activities. As long as we can bolster their skills, it's probably helpful. I'll let the Monash team comment because I know they've done some stuff in this space.

The CHAIR: I think in a previous session we asked the witnesses for any evidence on efficacy.

VIVIANA WUTHRICH: I can send you the systematic reviews. There are about six of them that I was reviewing in preparation for this.

The CHAIR: That would be really helpful. I will let Monash respond if they so wish.

VIVIANA WUTHRICH: They'll probably disagree with me. That's okay.

The CHAIR: The Monash team.

ROSANNE FREAK-POLI: I don't know where to start. I think I want to start on the point where I agree with you, and that is that social prescribing is a very broad term at the moment. This is where there are different models that are considered social prescribing. I would really hope for people to stop using the words "social prescribing" when a healthcare professional says, "Hey, I've got this great group activity that I would like you to do," and they give them one option. That currently could be considered social prescribing, but that is not the optimal version. The optimal version is someone sits down and gives them one-on-one support to think about what their needs are, what their interests are, and also to determine if they've got any social determinants that are preventing them from socialising.

I am currently evaluating two pre-post-analyses, so they're not randomised controlled trials. One is in the mental health space and one is with people with chronic diseases. What we have found is sometimes that first link worker appointment to remind them of their prior interest is enough. They don't need necessarily a social prescription. It is sort of like permission—"You're allowed to go and engage in these things. Have you looked up this website?"—and showing them. Just sparking it is enough for some people. They seem to have just as good outcomes, whether or not they have seen the link worker once or many times in that 12-week intervention period in terms of loneliness, wellbeing and quality of life in these evaluations that I'm doing preliminarily. I would say that from my research I have seen benefits in the models of social prescribing using the link worker with the one on one, if that helps with how we are seeing it.

There is another model called the Frome model. They won't call it social prescribing, but it's another way of increasing the social fabric. This is where they have sent people on a little bit of a course, like hairdressers, podiatrists—just generally people in the community that like to talk to people. They do a little session to find out more about how they can promote activities and they do it to everyone they talk to, and they try then to get people going to places that they are going to and invite them. There are different models. That model might not take into account some social services that some people may need, but it is another way of building social fabric, I guess. And again, that is not necessarily called social prescribing, but it's another way of increasing awareness.

The CHAIR: Thank you very much for that last intervention. That was really helpful, given the evidence that we have received and are still going through. With that, though, we are calling this session to an end and saying thank you. Again, we will follow up with the secretariat on the things that you have very kindly agreed to provide on notice for us, and there may be supplementary questions. Thank you, once again, for your research, your submissions and your appearance here today.

(The witnesses withdrew.)

The Committee adjourned at 17:35.