REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

PREVALENCE, CAUSES AND IMPACTS OF LONELINESS IN NEW SOUTH WALES

CORRECTED

At Jubilee Room, Parliament House, Sydney on Thursday 6 February 2025.

The Committee met at 9:45.

PRESENT

The Hon. Dr Sarah Kaine (Chair)

Dr Amanda Cohn
The Hon. Anthony D'Adam
The Hon. Natasha Maclaren-Jones (Deputy Chair)
The Hon. Taylor Martin
The Hon. Bob Nanva
The Hon. Emily Suvaal

PRESENT VIA VIDEOCONFERENCE

The Hon. Scott Barrett

CORRECTED

The CHAIR: Welcome to the third hearing of the Social Issues Committee inquiry into the prevalence, causes and impact of loneliness in New South Wales. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting 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 respects to any Aboriginal and Torres Strait Islander people joining us today.

My name is Sarah Kaine, and I'm the Chair of the Committee. 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 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 SHARON LAWN, Executive Director, Lived Experience Australia, sworn and examined

Mr JOHN MILHAM, NSW State Advisory Coordinator, Lived Experience Australia, sworn and examined

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

SHARON LAWN: Yes. Thank you. Firstly, I'd like to acknowledge the Standing Committee on Social Issues and its work on this important issue. I'd also like to acknowledge my colleagues in Lived Experience Australia and members of the Royal Australian and New Zealand College of Psychiatry Community Collaboration Committee, who supported the national survey that we undertook on loneliness and mental health with the lived experience communities that we serve. I'd also like to acknowledge the Gadigal people of the land on which we're meeting today and our Lived Experience colleagues.

Loneliness is an embedded social issue and a deeply personal experience: how people see themselves, how they look out into the world around them and view their place within it. It's a social problem, not an individual one, of being alone, though almost a quarter of people living in Australia say they rarely or never see or feel close to others, or have someone to talk to or people to turn to to confide in. Loneliness is harmful and shares space with stigma, discrimination and shame. So solutions must acknowledge these mechanisms. The group that I'm referencing primarily are people with severe mental illness, which has significant impacts on many aspects of their lives, particularly when the internal world is as much a part of their world, particularly if they experience paranoia, extreme marginalisation and isolation.

We heard from approximately 200 people with direct experience and 100 families across Australia when we did our survey. The majority were people between their thirties and sixties, people in the prime of their life. We asked them, "What does loneliness mean to you?" Many people described having no-one who saw them, no-one who heard or understood them. They kept using these words: "feeling quite isolated and not connected to people around them", "struggling with purpose and connection", "feeling like I don't matter to anyone", "having no value as a person, no sense of community". They spoke of being marginalised, stigmatised because of their mental health, and "not knowing what it is that I'm doing wrong, not knowing how to fix it". "There must be something inherently wrong with me," "I must be disgusting," and, "Being amongst others and feeling like I'm never fully there", were some of the comments.

Some carers spoke of loneliness in their role, living in surreal lives, disconnected from others physically and emotionally, railing against losing or already having lost their own identity beyond the caring role. Loneliness was detrimental to families. People described how it tears them apart, that they withdraw from each other. Loneliness, mental health and physical health were enmeshed and inseparable. They are the one thing, a vicious cycle. They bleed into everything you do. It's physically painful, people described. A lot of people were resigned to their loneliness, reflective and emphasised self-compassion and living in a life differently to manage their loneliness. People had a lot of agency. They were very active in managing their loneliness. They had a lot of strengths.

What needs to happen to address loneliness? Address stigma, how we treat each other as human beings. Service providers need to listen, to actually ask people about loneliness. It's the one thing that often doesn't get asked. It's the elephant in the room. To conclude, loneliness is an experience deeply embedded within the experience of mental illness. The two things become the one thing. It's physical, inseparable at times. It aligns with deep despair. People just become accustomed to it. Thoughts of suicide are common, but people get on in spite of that. The relationships are complex and bi-directional. All those issues around stigma and self-stigma are embedded. Therefore our responses need to be interconnected as well. Thank you.

The CHAIR: Thank you very much. I appreciate that. I just want to ask quickly, you gave a general overview of your members or the people you work with but you also said "lived experience of communities that we serve", so there's differences. Could you just briefly describe the different cohorts or groups that you work with?

SHARON LAWN: Yes. We're a national mental health consumer and family carer systemic advocacy organisation. So our community are all people who have experience of mental ill health or mental distress. They may or may not be in contact with mental health services. They may have had past or current or future experience of that, them and their families.

The CHAIR: Thank you very much. Reading through your submission, thank you for that. You mentioned a strengths-based approach to enhance wellbeing is likely to be of benefit. Could you explain a bit more to me? This is a general discussion of what might be of assistance. And you talk about the fact that strengths-

based approaches that enhance wellbeing are likely to be of benefit. Could you explain to me what a strengths-based approach is?

SHARON LAWN: I think, particularly for people with mental health issues, they are already often experiencing embedded self-stigma or stigma, which impacts self-worth, which impact relationships, connections, which hence therefore impact sense of loneliness, internally and externally. So they are often passengers in services. So anything that actually mobilises people's own agency and strengths is going to be exponentially beneficial for them as people and their recovery and their contributions to the community. No-one likes to be a passenger in care. And we had this discussion in the foyer, where so many people with severe mental illness—a lot of the solutions are offered through agencies, through services, so that their friends become the service providers, being the only people who come to the home sometimes or the people that are taking them out to connect into community. It's an artificial sense of friends and connections, and it's like a wall, like a mirror that stops people from participating in communities like everyone else.

The CHAIR: So it's about encouraging individual agency in their own—

SHARON LAWN: Yes.

JOHN MILHAM: If somebody refuses to eat, you can intravenously feed them. But that's not eating. That's sustaining them. All services are sustaining people who are who are dealing with distress that isolates them or keeps them away from some form of connection that's necessary. To be effective as a human being, to be whole and healthy, you have to be connected. So it's useless. We can have all of these drips providing sustenance, but the only thing that cures loneliness is connection. And connection must be coming from the individual involved. So the question becomes, "What services turn on the capacity to connect?" not, "What services do we give them to connect to?"

Because it's the micro-skills of dealing with their own patterns, the micro-skills of just having a conversation or feeling safe enough to actually connect with someone in an environment. There are degrees. People who are habituated to isolation will be very, very difficult to connect to. But, say, in my case, as someone—I'm isolated by circumstance or situational distress. Losing my spouse led me into a place where I was isolated from the world. Illness isolates people—loss of job, which goes down to identity. How do you help them find—strengths-based is finding the identity they have that they can use to actually connect with other people.

SHARON LAWN: We all strive to find our tribe. We don't want to just have mental illness that dominates our lives.

The Hon. NATASHA MACLAREN-JONES: I want to understand a little bit more about carers and the impact of loneliness on carers and what supports your consumers are saying are available to them.

SHARON LAWN: Certainly. I will table this national report. We've got an electronic copy, which I can send. But I'll also send another paper, which was a personal narrative on loneliness from a carer perspective. It describes the surrealness of living in two worlds, where it's a very—what the home environment and what the outward projection of going about your everyday business. Those two things are vastly different things. Sometimes when you're dealing with and living in a house with someone with severe mental illness in particular—other people can't grasp that, really. It's beyond their understanding unless they are a family carer. That's why the informal carer support networks are so important to people. They're often organic. You step in a room as a family carer and you don't have to say anything in those rooms because you can see that everyone else gets it. I think that's an important thing to say around that. Respite puts a bandaid on it to throw you back in, really. It's a very hard one because so much is lived longitudinally because it's not something that services can necessarily fix for people who are family carers, but they can help alleviate the burdens and the stresses of that.

The Hon. NATASHA MACLAREN-JONES: Have you worked with any young carers?

SHARON LAWN: Yes. They have particular struggles obviously because they take on that responsibility so diligently and passionately and lovingly and are so committed to parents that their own sort of development and schooling and education and career development are incredibly torn.

Dr AMANDA COHN: Firstly, thank you for appearing today and the extraordinary amount of work that's gone into this report, which I understand was a collaboration with the college of psychiatrists.

SHARON LAWN: Yes, basically they helped us with the questions—

Dr AMANDA COHN: It's a really valuable resource.

SHARON LAWN: —and then we did the project.

Dr AMANDA COHN: One of the threads that I noted throughout a number of the anecdotes from people with lived experience was the impact that the cost of living is having on people at the moment. Is it something that you've noticed as well? In what way should we be taking the current cost of living into account?

SHARON LAWN: I think the cost of living is just one of many things for people who have many pressures that they just take in their day around the management of their conditions, around other things. But certainly there are many people that—certainly people on benefits who are really, really struggling with small, quality social things, like a colleague who I'm catching up with at lunchtime today. It's a lady with schizophrenia who doesn't get out much. We connect every time I'm in Sydney. We're going for a coffee and lunch. It's cost but it's also there's no-one to go and connect with regularly. How do you get into that rhythm of making friends? So cost absolutely is part of that—cost of coffee, cost of transport, basic costs.

JOHN MILHAM: There's another aspect to consider on that. Situational distress is also responsible for a large degree of isolation and loneliness. So you have the long term, you have people with diagnosable—separating highly impactful situations like mental illness. Then take for instance, say, a family breakdown, so a very common situation in the community where divorce proceedings means that there's a separation in the family. So if there are children involved—even worse, often that there are complications that relate to that process. The level of isolation that relates both to the physical separation and the costs involved—so getting separated from your normal social framework because you're no longer either able to afford it or it's no longer available as a safe space for you. You often have an impact in terms of the lifestyle that you once had, the accommodation, all of that stuff. That's, again, a factor of cost of living.

SHARON LAWN: And just the fact that a lot of people with severe mental illness and other mental health issues live alone. The actual costs of living alone compared to sharing a whole lot of utility costs and other things with others in a household is quite—

JOHN MILHAM: And often separating from your normal social environment—so if you have to move away or you're actually in accommodation that is isolating in terms of its format and design. Those issues can cause a level of loneliness that is just as impactful in terms of your mental and physical health. Yet it's not a diagnosable form; it's a social determinant that has led you into that space.

The Hon. ANTHONY D'ADAM: You mentioned earlier the distinction between services. I wonder if you could perhaps elaborate on the types of services that you think are effective.

JOHN MILHAM: Treating the baseline issues—there are services and appropriate responses for that. There is no holistic approach. If you're in the system being treated for, say, schizophrenia or even stress or anxiety—just even more benign, sort of what they would consider low-level impacts—you are not being asked about your current circumstance. Of course, there's no incentive to offer that because there's stigma involved. The very fact that you feel lonely is actually a challenge to your wellbeing, so you won't offer this. You walk into a GP or into a psychologist or into an ED and you are being treated for the obvious areas or the immediate impacts, but you're being released back into an environment that has led you to have those kinds of conditions.

There's no connection through the services for the whole of impact. As a result, nothing is even directed your way. Many people are not given an option for any kind of social prescription—like a doctor doesn't say, "You need to join a men's shed." Perhaps they should but, even then, that's only a superficial response to something that is more complex and probably best dealt with embedded into the community, where the services don't reach normally. Because it's that consistent availability, the awareness and the recognition. When lonely people say they're not seen, they're not heard and they're not treated as a person, you can't go to emergency for that. You need to have that where you live, available to you, whether you are reaching out and putting your hand up like a lifesaver or not.

SHARON LAWN: And services that are not just about you turning up, because you're all mental health consumers, and you're all—the focus is on that. People want to move beyond that. That's why things like community choirs are so popular, because people can be people, not just sit around and talk about their mental illness, if that makes sense.

JOHN MILHAM: The treatment is connection, and connection is done a million ways. It's interesting because right at this point most people who are lonely need to pathologise their loneliness to get it dealt with. You need to become sick to actually be relevant, to get some form of treatment. That treatment is usually ineffective or inappropriate because it's not dealing with the whole issue, but at least it's something. We're inviting people who are struggling for very normal, very everyday life reasons. We're inviting them to escalate their own illness simply so that they can actually plug into someplace in services. You can't access a psych for months and months, on a private level or on a public level. You have to be bad.

We're inviting an increase in the impact that this has on everyday lives and the community, and we're increasing that across the level of demographics so that more young people who are self-managing these things through social media or peer-based stuff, their level of impact is escalating simply because that's the only feedback they're getting. It's more important to show symptoms and so on to be given the attention when, in fact, we should be just building social structures that—well, that's a complex issue, and you'll have your own commission for that. But the whole pathologising of our loneliness to turn it into something that will actually raise somebody's attention, I think, is probably a really bad approach. We should be cutting it off upstream.

SHARON LAWN: And then, of course, there are people who don't ever reach that level of crisis. I had a call from a lady in her fifties, parents are in their eighties, her brother with schizophrenia, living at home, who doesn't go out and will never probably come to the crisis attention of mental health services. The parents are pulling their hair out, "We're in our eighties. What do we do? What's next?"

JOHN MILHAM: I'm sure you guys have seen the numbers of, say, men and loneliness in men, which is my particular issue. Roughly around 50 per cent or a bit more of men who have suicided are not known to the system. About 50 per cent of those men who are suicidal will actually have issues around social dislocation or relationship breakdown or estrangement. If you look at that, just on a simple number, you're talking about 1,200 to 1,500 men who are dead each year as a result of isolation and loneliness, and that's due to their own hand. That's a pretty significant load that is actually unknown to the system. There's no systemic area of connection for a man to tap into to get support in that circumstance, and it's not an unreasonable response. Being lonely is not an unreasonable response to not having anybody you can talk to or anybody who recognises you. If you've lost your spouse, if you've lost your job or if your friends have moved away or passed away, it's a reasonable—being lonely is a perfectly sensible response to that.

The Hon. ANTHONY D'ADAM: You mentioned those sorts of trigger events. How can we design services that catch people when those events occur? Obviously we know that a loss of a partner or a relationship breakdown starts you on that path towards social isolation. How do we catch people at those points so that they have the services available rather than, I suppose, expecting them to intuitively know to look for those kinds of services?

JOHN MILHAM: I can get onto my soapbox here. I believe it's the old Pareto rule: 20 per cent should be the high end of services and 80 per cent should be in the community. How do we do it? When it's not being done, the community does it already. Organisations that are connected to—there are Lived Experience and community-based organisations that are doing their best right now. Supporting that, finding those assets and understanding what they do and then bringing some structure and support to those, I think, is a hugely powerful way of embedding the upstream services where they need to be.

I understand the problem is how do you work out whether something that takes something away has been effective, but we need to understand—the research is clear that the further upstream we go, the more impacts we have on a range of social issues that all relate to things like loneliness, isolation, suicide, domestic violence and family breakdown. All of these things are coming from a very similar space, which is the social determinants that every day cause people to get distanced, isolated and impacted in their ability to meet their daily connection. All of us go through it. Everybody in this room will have experienced a day when they were lonely, sad, disappointed or depressed. It's not something we should be hiding. The fight against stigma is a deep, long and challenging one, but it starts with these kinds of conversations, I guess.

SHARON LAWN: Pragmatically, there are clearly services and health professionals or other service providers, like Centrelink and GPs, people that must be seeing people—pharmacists, who you'll hear about soon. It's about having the conversation, I think. The asking, as people in our service—people just don't ask me, "Am I feeling lonely? How am I? What does it mean to me at the moment?"

JOHN MILHAM: It's almost an education issue—so micro-skills for just having a decent conversation or just understanding the need. How do I connect with a small group of people in my community or just ask a simple question or get my needs met? Sometimes that has never been demonstrated to somebody, so we can improve those social skills and those personal connection skills.

SHARON LAWN: Local sporting clubs—the local rugby club down the road for me has such a diversity of community members, and there's a place there for everyone.

The CHAIR: Thank you for those particular examples and exploration of those questions, and for your appearance here today and your submission. We very much appreciate it. I think, Professor Lawn, you were going to table a report for us.

SHARON LAWN: Yes.

CORRECTED

The CHAIR: We appreciate that. If there are supplementary questions, the secretariat will be in touch. Again, thank you so much for your time and for all the work that you do.

(The witnesses withdrew.)

Dr ANNA BROOKS, Chief Research Officer, Lifeline Australia, affirmed and examined

Mr CHRIS SIOROKOS, Executive Director, Government and Stakeholder Relations, Lifeline Australia, affirmed and examined

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

CHRIS SIOROKOS: Sure. I'll make a short opening statement. Before I begin, I'd like to acknowledge that we're meeting on traditional lands and pay my respects to Elders, past and present, of those traditional lands. I note that we're meeting at a place that can have a big bearing on future reconciliation in this State. On behalf of Lifeline, I'd like to thank the Committee for giving us the opportunity to contribute to this discussion about loneliness. For over 60 years, Lifeline has been at the forefront of supporting people experiencing loneliness and isolation. Last year, for example, Lifeline received around 1.1 million calls and more than 250,000 texts and webchats from people needing our support across Australia. About one-third of those contacts came from New South Wales. What that means is that in the time we have here today, the half an hour, around 21 contacts to Lifeline will come from people in New South Wales. While only 4 per cent of callers to Lifeline explicitly state that their reason for calling is feeling lonely or socially excluded, our crisis supporters—they're the people who answer the phones—tell us that loneliness is a major factor driving people to emotional distress and crisis.

Many conversations reveal the risk factors present in the experience of persistent loneliness. Significant life changes such as relationship breakdown, losing a loved one, becoming a parent, financial hardship and health conditions all take a toll on people and are clear risk factors for a more isolated life. COVID has also played a major role in reducing social connection. Loneliness and isolation can affect anyone, irrespective of age, gender, race, ethnicity or other such identifying attributes. Loneliness can affect people even when they're not alone. We know that loneliness and a lack of social connection has a big impact on physical health. Among other things, loneliness is associated with an increased risk of cardiovascular disease and high blood pressure, cognitive decline and cancer. It's clear that loneliness is something we can address if we take the issue seriously and work together as a community and work with government, which we believe can do more to address loneliness and social isolation. If we don't do that, we will, in the words of the US surgeon general, "further retreat to our corners—angry, sick and alone".

The CHAIR: We'll go to questions now. Obviously you've put in a submission. We've just heard your opening statements. I want to get Lifeline's perspective on what you think is driving this focus on loneliness. People ask me this about this inquiry: Why are you doing an inquiry into loneliness? Why are we doing this and why is it now? Is it actually that something has happened or that there's an emergency? Why is Lifeline, in particular, focusing on this?

ANNA BROOKS: To answer that question, it's important to acknowledge that organisations like ours and others have been engaged for a long time in trying to promote awareness of not just suicide but also mental health and wellbeing—that sort of broader concept. In that awareness-raising, promoting and trying to help people understand the importance of wellbeing as a concept, what we do acknowledge is that there's a role in the rates of people reporting loneliness in that promotion exercise that we've been undertaking as a nation. Awareness means that people are now, thankfully, more willing to talk about it when they are doing it tough. You do see in the data that that's one of the drivers. It's very difficult for us to eliminate that increased awareness as one of the drivers of the high rates of loneliness that we see across some groups of people. That said, the fact that one in three Australians report being either very or quite often lonely is certainly something that we need to focus on. This is a real issue, and it's one that we, as an organisation, have been tackling for 60-plus years.

Lifeline is all about human connection for people and, through that connection, promoting hope but also addressing people's needs to engage with others as one of the primary factors in wellbeing. With all of that in mind, one of the additional factors that we talk about as playing a role in loneliness in the community these days is our increasingly digital world. Obviously with the connectivity that we're experiencing now, there are a lot of advantages. We can all be connected better with family members and people overseas. There's that immediacy and reach that comes from greater connectivity through the digital environment. But there are also real challenges in how we, as human beings, connect and have meaningful human engagement in that digital medium.

Being able to "like" posts and post yourself or share selfies on social media, there are some advantages to that in some contexts, but it's also a whole new world, particularly for young adults who have grown through this explosion of digital connectivity, in trying to work out how you use that opportunity to create meaningful connection. There's a distinction between having lots of people following your social media posts and actually having meaningful human connection. I think that's one of the challenges that we face as a society in trying to tackle loneliness.

CHRIS SIOROKOS: And I think that is one of the things that comes through when we talk to our crisis supporters who work on the text and web chat lines. They tend to have a much younger cohort that reach out that way. A lot of the anecdotal feedback is younger kids—some of them as young as 10—reaching out because they feel incredibly socially isolated.

The CHAIR: That's really interesting and disturbing, really. You've just spoken about that quite young cohort. How does loneliness otherwise typically show up in the Lifeline environment?

ANNA BROOKS: Chris mentioned that about 4 per cent of our calls are explicitly about loneliness, but I'd also add to that that 40 per cent of our calls are about relationships. That includes the loss of and difficulties in relationships. Related to that, one of the things that we know is a key risk factor for suicidal thinking and suicide is big life transitions, like leaving a job—when people transition out of the Defence Force is a good example—or transitions in personal relationships, like a divorce. Those sorts of big transitions are a really significant psychosocial stressor for experiencing suicidal thinking. One of the things that I'd point out is that key link between transitions in life and the feeling of being disconnected from people and those relationships that you may have had in the workplace or the disconnection that can come from divorce. There's a relationship between loneliness and suicidal thinking more broadly speaking, but we also see it in those call patterns, with relationships being a key reason that people reach out to us.

In addition to what we see in our crisis support environment, we also offer community programs—the face-to-face ones that are offered by centres across the country. Some of those programs are specifically designed to address loneliness. We have volunteers, for example, north of the harbour who provide a service that is located in a couple of different libraries across north Sydney where Lifeline volunteers will make a time and go and have tea and coffee with people who are doing it tough and connect with them. It's not just the immediacy of that human connection with the Lifeline volunteer in the library; it's also then practical support for where they might be able to get support to reach whatever needs that they're expressing to the volunteers from the Lifeline centres. We see loneliness affecting not just the calls, texts and chats that we get but we also try to address loneliness via some of those community programs that we offer.

CHRIS SIOROKOS: I think one of the things we've learnt from the Connect centres on the lower North Shore is that about half the people that go in and have those face-to-face discussions with the counsellors were not born in Australia. Because of the demographics up there I think there's a Mandarin speaker, a Farsi speaker and a Hindi speaker, and their services are very well utilised.

The CHAIR: Did you say that was volunteer based?

CHRIS SIOROKOS: Yes. It's a really low-cost model. They go into a library and they have an agreement with the councils. I think it's Willoughby, Hornsby and North Sydney Council. They go in once a week at a set time. They get a room. There are posters around the library. I was at, I think, the Hornsby council library a couple of weeks ago and there's an announcement over the loudspeaker saying, "Lifeline's here." They're in whatever room and people come in.

The CHAIR: I wasn't aware of that kind of activity with Lifeline.

Dr AMANDA COHN: Thanks so much for the evidence that you've given. I've got a fairly niche question. In your written submission, you're not the first witness at this inquiry who has made a link between loneliness and the built environment. You've cited some really valuable research about how the built environment can be improved. From the people that Lifeline staff and volunteers speak to, how is the built environment impacting people's loneliness?

ANNA BROOKS: From engagement with the people at our centres, there are different factors that play into loneliness, and one of them absolutely is the built environment. With increasingly hectic lives, the incidental opportunities to actually engage with people—a park bench where you might take your dog and other dog walkers are there or people just spending a little bit of time in the park—those sorts of opportunities that we have in the built environment to encourage moments of connection between human beings, especially face-to-face connection, I think are really key opportunities for us to address it. It sounds very old-fashioned, but open spaces where people can gather and have those incidental moments to connect are incredibly important. Through our centres what we are aware of is that people feel like there's less opportunity to do that. People are busier and their environments—they're commuting or, indeed, staying at home to work and those patterns of life are less conducive to having those incidental connections with people.

CHRIS SIOROKOS: Just to add to that, we note and we accept that there need to be more houses built in New South Wales, and Sydney in particular. It's our view that very early on in that planning process—again, at very little cost to government—the relevant authorities make sure that these kinds of things are considered and social connection is considered as part of the broader planning for housing.

Dr AMANDA COHN: You mentioned in your written submission the Lifeline Connect centres that are already operational in Far West New South Wales. Can you tell us how those operate?

CHRIS SIOROKOS: Sure. Do you want to kick off on that one, because they're a slightly different model? Or I can start—whatever. The centre in Far West New South Wales is a physical centre. It's staffed by Lifeline paid employees and volunteers. It's there and anyone from the community can just wander in. They kind of serve a similar purpose to the centres we have, that Lifeline Harbour to Hawkesbury has on the North Shore. People just go in if they have an issue or if they just want someone to talk to. I know that there is one person who goes in on a regular basis. One of the staff members makes them a cup of tea and they talk, and that person leaves very happy. They cover a wide range of topics. Someone might walk in and want to raise a financial distress issue, they just might want to have a chat or they might want to talk about domestic violence. The centre also has very good referral pathways as well. I don't know, could you call it like a triage centre maybe?

ANNA BROOKS: Yes. It essentially operates as wide-open front door and it's a connection hub. If people are looking for human connection, they can go there without an appointment; you wander in. But then also there's the capability from that centre, as Chris mentioned, to provide referrals to ongoing support. It can just be a cup of tea. It can be that the Lifeline person is then connecting that person into financial counselling services. I think the key element to it, like our crisis support service—the one people know us best for: 13 11 14—is that it's that wide-open front door concept. Even if people aren't sure if they qualify for support, they can go into the Connect centre and have a chat, and if the need is there then there will be those practical, ongoing supports provided. But if not, it will just be that opportunity to connect with the Lifeline staff.

The Hon. ANTHONY D'ADAM: Is it specifically funded, that centre? How is it funded?

CHRIS SIOROKOS: I will double-check, but I think the local Lifeline centre funds it. I'll double-check and we can take that one on notice and come back to you.

The Hon. ANTHONY D'ADAM: So it's not a beneficiary of specific government program funding?

CHRIS SIOROKOS: I don't think that one is. Some Lifeline centres do get specific government funding for specific services, like GambleAware. I think that one is funded locally, but I can confirm that or not.

The Hon. ANTHONY D'ADAM: What led to it being established?

CHRIS SIOROKOS: I think the local Lifeline organisation saw a need. It was responding to community need.

The Hon. ANTHONY D'ADAM: In your submission you talk about the importance of place-based services. I think that's probably a good example of having those very locally based, responsive to the specific needs of communities.

ANNA BROOKS: Yes.

CHRIS SIOROKOS: That's kind of how those Connect centres and libraries were established as well. The local Lifeline member up there saw that there was a need for that kind of thing and they just started talking to the local councils, who agreed it was a good idea. I guess pharmacies is also another one. We're going to start talking to pharmacy associations, because they are a place where people go. Oftentimes they tend to be older people, and that is a key cohort in this space as well—to see if there's anything we can do with them.

The Hon. ANTHONY D'ADAM: The previous witnesses raised the idea of those services that facilitate connection. From your experience in the program on the North Shore, are those kinds of connective services available for the people who are coming through, having those consultations and needing to be referred on? Is there an adequate provision of those types of connective services, from your experience?

ANNA BROOKS: I would say that we can always do better. The thing that's often a factor is that people aren't sure whether they qualify for getting support. I think one of the key advantages of things like the Connect centres but also digitally our crisis support service—and, again, referring to that wide-open front door approach—is that we're trying to reduce the barriers to people actually engaging with someone. Having a local centre where you might know the people who provide the cups of tea—anything we can do to make people feel like this is a regular sort of behaviour and it's not something that's way outside of what you do in your normal everyday life is advantageous for us to really try and support more people earlier. The more we can do to reduce the barriers, the better. In terms of whether there are enough connection services available, I would probably argue it's more about making sure that what we do, we do really well. That includes thinking about how we meet people in the ways that they're going to be most likely to engage. We have various different models to try and really keep the barriers to engaging with an organisation like Lifeline very low.

CHRIS SIOROKOS: With the Connect centres and the libraries, they are incredibly low cost. The startup costs were minimal. I think it was about $50,000 or $60,000 to get these things going. They're staffed by volunteers. We have made a submission to the Treasury, I think, for half a million dollars to see if we can roll out more across the State, because at the moment we're only doing them on the North Shore of Sydney. We think there are areas of need that could benefit from these sorts of things, particularly areas where you have big CALD communities that are very difficult to service.

The Hon. SCOTT BARRETT: Being online, what I might do is just say some things that I'll try and plait into a question to get a response to later on. I might ask, though, as we go to the break that the last group before the break maybe repeat that number that you just gave out for anyone that might be listening online. You said that Lifeline is all about human connection. The previous witness spoke about the further upstream we can get the better it's going to be, essentially stopping them from coming to Lifeline. I wonder how much or if you lament the loss of opportunities for human connection we've seen through a breakdown of things like our clubs and organisations, be they churches, union organisations, the footy club et cetera. What impact do you feel that is having? Are you seeing any trends that might have evolved out of that in the calls you're taking at Lifeline?

CHRIS SIOROKOS: I might talk a little bit about economic insecurity, if I may, because we know that about 13 per cent of calls to Lifeline relate to financial distress, housing and homelessness or employment. We know that people who don't have financial security or whose financial circumstances fluctuate wildly are at a much higher risk of things like suicide. We get frequent callers and, looking at who those frequent callers are, oftentimes loneliness is a driver for those calls. A lot of those people might be disabled or unemployed. I guess the other thing tied in with economic insecurity—and, Anna, I might hand over to you to talk about this a bit more—is it's really important that people have a sense of purpose. If you do have economic security, you can then volunteer, you can join your local surf club, you can join the army reserve or the CFA, or whatever it is, and it's a really important thing to give people that opportunity to have that purpose so that they can connect. I don't know if there's anything you want to add.

ANNA BROOKS: That's a really good summary. Broadly speaking, having those opportunities to connect is key, and that can take different shapes and sizes. But everyone's preferences are different, so having varied opportunities, and sporting clubs are a great example. Volunteering in any sort of capacity is a really great example as well because through the volunteering you get both of those things Chris just mentioned: a sense of purpose but also the opportunity to connect with other human beings. Anything we can do to expand the opportunities for people to connect is a good thing.

Just sort of harking back to my previous point about sort of lowering barriers, how we offer those opportunities is really key. It has to be in ways that are sort of low barriers and that people are willing to engage in. That's one of the primary sorts of things I'd suggest we need to think about when we're trying to address—think about how policy wise, for example—how we better support people to not experience loneliness. On Chris's point about financial insecurity, we do know there is a really strong evidence base that financial insecurity puts people at increased risk of experiencing suicidal thinking and death by suicide. The relationship between financial security and the opportunity to engage, to go and have coffee with people, is really important in the suicide prevention efforts that organisations like ours engage into.

The Hon. NATASHA MACLAREN-JONES: I just have one question. Before, you were talking about some of the programs—the library program. I'm interested to know if there are any specific programs that you run that target young people. I noticed in your submission you said they're actually the higher cohort now, the 15- to 24-year-olds, so I'm interested to know whether you have programs or also access to other services and supports for them.

ANNA BROOKS: We are not a youth-focused organisation. Our crisis support services, for example—people can use those services without telling us how old they are. We do have young people using our services, particularly our text-based service. If you do a comparison between our voice-based service and our text-based service, the text-based service receives a lot more interactions or contacts from people who are young. That's a good example, in fact, of us providing a service that actually gives different groups of people the opportunity to engage in a way that works for them.

The other thing that we do—we do support children incidentally through our services, but what we do try to do in order to help meet the needs of children and young people is to have really good connectivity into organisations like Kids Helpline and headspace. As a member, we try to make sure that our services are plugged in to those youth-focused services—for example, our self-support toolkit. From resources that are available that people can self-navigate to in our self-support toolkit, we're able to then refer them into those youth-based services where it's appropriate. We're playing an important connection role for children without being a child-focused service provider.

CORRECTED

CHRIS SIOROKOS: About 60 per cent of the contacts that come into Lifeline by phone and, I think, text and chat are referred to other organisations. We would refer young people to Kids Helpline or to headspace or wherever we think they need to go.

The CHAIR: We're pretty much at the end of time, but I just wanted to give you one last chance if there was anything you wanted to particularly highlight to the Committee with regard to the key things you think the Government should be considering in this space and in addressing loneliness. If you could wrap up with that request.

ANNA BROOKS: From our submission, you'll see that one of the things we called out was consistent data. I'm a research person, so it's very important to me but also, more importantly, to all our endeavours to make sure that the services that we are providing actually work, to draw from the evidence base. When services are funded, making it a condition of funding that those data are shared back so that we can see what works and focus resources on that—on the programs that do work—is really important.

CHRIS SIOROKOS: Just going back to one of the things I mentioned in my opening statement, there are lots of low-cost or no-cost options for government, particularly looking at things like early-stage planning for housing developments, things like supporting those connect centres that don't cost much money but do have a big impact over the long term in terms of people's feelings of loneliness and social isolation.

ANNA BROOKS: If I could just add one more thing too in terms of promotion and awareness raising, one of the things that I think is a really important message is that human contact, human connection and wellbeing. One of the things I like to say is that it's one of the foundation stones. Getting good sleep, getting good nutrition, exercise and connection are fundamental to wellbeing as humans, and I think the more that we promote that message, hopefully the more impact that we can have in getting people to take loneliness seriously.

The CHAIR: We thank you very much for your evidence and submission and for the work that Lifeline does. I think, Mr Siorokos, you took something on notice from Mr D'Adam, so the secretariat will be in touch with you about that and also if there are supplementary questions. Thank you again very much for your involvement today.

(The witnesses withdrew.)

(Short adjournment)

Mr PHIL McAULIFFE, Founder, Humans:Connecting, affirmed and examined

Mr JONATHON LAWLESS, Investment Manager, Humans:Connecting, affirmed and examined

Mr PAUL DOLBY, Founder, Spoke International, affirmed and examined

The CHAIR: I acknowledge we have two different organisations here. Would you like to begin by making a short statement, maybe, Mr McAuliffe?

PHIL McAULIFFE: That solves the conversation that Paul and I were having of rock, scissors, paper about going first.

PAUL DOLBY: I thought it was age before beauty, and I lost on both counts.

PHIL McAULIFFE: I firstly just want to say two things, very simply. One is I'm very grateful to be here. The reason that I started Humans:Connecting is very personal and speaks to a lived experience of loneliness and not knowing how to respond to it. I've been working on loneliness and human connection and social disconnection now for over five years. One of the things that is incredibly challenging and frustrating at times is being heard. I'm very grateful to you and to the standing committee for giving us a voice here, through providing a submission and providing evidence.

One of the things about working on loneliness and social disconnection is that there's furious agreement that it is an important issue. It affects so many people. There's data, there's statistics, there's research, there's analysis and there's reports that all point in the same direction. Fundamentally, though, loneliness and social isolation and loneliness and social disconnection is a life experience that we want other people to have. When it comes to sitting with it, we are in the uncomfortable position of having to reckon with the state of our own connections, and that can be deeply uncomfortable. Loneliness is an experience that we're happier for other people to have rather than ourselves. It's for that reason there is an ironic loneliness to working on loneliness and social disconnection. Being given a voice here and given an opportunity to have a conversation to answer your questions is something that we at Humans:Connecting are extremely grateful for, and thank you for your time.

The second thing that I wanted to finish on in wrapping up my opening statement is a repeat of one of our recommendations to please be bold and please be courageous. Many governments—national governments and State and Territory governments here in Australia and globally—are wrestling with the enigmatic problem of loneliness and social disconnection in their communities and within societies. There have been many great things, but sometimes what has been recommended is a variation of the same thing. Being bold and being courageous is, we feel, what's needed to help citizens in jurisdictions feel that they belong, feel that they feel seen, feel heard and want to make a positive contribution to places and spaces where they are. Thank you.

The CHAIR: Mr. Dolby?

PAUL DOLBY: My lack of understanding of my own story, combined with my inability to listen to my loneliness, led to me attempting suicide in 2018 and again as recently as October 2023. Following a brain tumour diagnosed in 2014, I lost my career, my marriage, my identity, my security and my purpose. The combined load of my physical and financial challenges saw me transition from transient to chronic loneliness. I now listen to my loneliness in a different way on a daily basis. We live in an overcomplicated world, a world where we're moving rapidly away from the behaviours and patterns that have sustained us as a species for thousands upon thousands of years. Feelings of loneliness are on the rise, in my opinion, because our human instincts know that we are living in a way that is in conflict with how we are designed. To thrive, we need to be truly connected—connected in a way that our ancestors were connected. We were not created to be individuals. We were created to thrive in small, physically connected groups. Modern humans can apparently spend as much as 35 per cent of their waking lives in a work environment. Much of this time is spent operating in what I would call high-volume, low-value connection.

My personal experiences of loneliness within the workplace, within the family unit, during a critical, life-changing event, whilst trying to understand a diagnosis and whilst living with a disability, all led to interactions with healthcare providers, insurers, employers and government bodies including the ATO. Those ongoing interactions continue to give me a terrifying insight into just how broken our society is becoming. It feels like we're losing our most fundamental human skills. Spoke is built around the metaphor of the wheel. When your spokes are strong, the wheel can turn effectively. If your spokes are broken or weakened, the wheel will struggle to move forward. We believe that upstream early intervention is where we can help in this overall process of changing how we listen to loneliness. Leonardo da Vinci said, "Simplicity is the ultimate sophistication."

Rather than relying on technological or pharmaceutical solutions, once loneliness becomes a problem, wouldn't early intervention through conversation and connection be best to respond to our human emotion? We

are currently working in partnership with the Campaign to End Loneliness and Sheffield Hallam University based in the UK, led by Professor Andrea Wigfield, the author of *Loneliness for dummies*. I will give her a little plug here. It is an amazing book, which I turn to on a regular basis. We are working on a project combining research with stories of lived experience to try and inspire a different narrative around loneliness. Through early intervention and a shift towards individual responsibility, we believe we can have significant impact in reducing upstream incidents of disconnection and the associated risks and consequences. We may even be able provide a competitive corporate advantage.

By examining how loneliness manifests and evolves in workplace settings, this process will generate actionable insights and evidence-based recommendations to support healthier, more connected working environments. The ripple effect back into the attendee's private and community lives, we believe, will be resounding. In November of 2023, due to a combination of my physical and mental condition, I suffered a nervous system failure. I was admitted to Ramsey health clinic in Cremorne, just around the corner. It was a three-week period that changed my life forever. It confirmed to me that, along with so many others, I was suffering from what I now call suppression. A lack of understanding of my own true story and my family pathology had led to me living a life based on thoughts, not facts.

Our mission is to change the language of loneliness through the sharing of lived experience stories and a collaborative life journey approach. With the help of committed corporate partners, we want to work with the few, not the many. We believe we can create authentic ripples of change. We know we will be just one spoke in the wheel of this broader solution to a huge problem, but we are absolutely committed to being game changers for current and future generations. We know that the right corporate and political partners can help accelerate positive change. I heard in previous submissions as well that loneliness will speak to everyone at some time or in some circumstance during their lives. It does not discriminate. It is not there to hurt us; it is there to help us. We need to learn to listen to loneliness. As a species, we are moving away from what has sustained us: Human connection—face to face, in person. We aim to reverse that trend and empower the individual to make positive change. Thank you so much for taking the time to listen.

The CHAIR: It is very powerful when people with lived experience join us, so thank you both for that. I've been reading all these submissions and having these witnesses, and many of you speak about early intervention and conversations and connection. That seems obvious, except it's not happening. What is it that you recommend—and this is to all of you—that actually creates those opportunities? Yes, okay, conversations and connection. But what are the policies? How do we get to those conversations?

PHIL McAULIFFE: I think that's the million-dollar question, Chair. For us at Humans:Connecting, in a similar way to how Paul said with Spoke being upstream—I'm sure you've heard this in previous oral submissions, in evidence—loneliness has such a stigma to it. The stigma prevents us from talking openly about it because, if we do talk openly about it and we admit our loneliness, we risk judgement. We risk the thing that we fear, which is further rejection and to be thought of as broken and somehow not worthy of love and belonging. That's a very big thing to admit and, because we don't talk about it openly, that feeds the stigma. But, sooner or later, we all have that reckoning within ourselves. When we do have that reckoning, it can be very tough because we don't know how to talk about it as a society.

We don't have the language of loneliness, as we call it, and so we don't know how to talk about it. We don't know how to sit with other people's stories of loneliness without wanting to fix it, because, in fixing it, we can reduce our own discomfort, because someone, as we say at Humans:Connecting, coming out as lonely holds up an uncomfortable mirror to someone receiving that news. They might actually then have to sit with the discomfort that their connections aren't great either. Chair, you've heard me say this before: We want to talk about loneliness "out there", and talking about loneliness out there keeps it clinical, keeps it clean, keeps it something that other people have. In a similar way to what Paul said, empowering people to own it, to listen to it, is the only way—and it is fantastic—for people to harness that power of loneliness, even if they don't know what words to use, even if they feel really yucky, feel really uncomfortable, they don't know how to describe it, they don't know how to ask for help. That for us is key, and we do that by talking openly about loneliness at every opportunity.

PAUL DOLBY: I think before Phil said it, I've written down here—it's like one of those quiz shows—"language of loneliness", and I think that's really, really critical. If we're ever in a position to do a campaign, I think it should be around that, to really lift—I'll say about listening to my loneliness, and Phil was part of this journey as well, that conversation around loneliness actually being very similar to hunger or thirst, and then the decisions you make as a response to that feeling. You can make a decision, if you're hungry, to head down to McDonald's, or you can go and get a salad, and you know there'll be consequences, knock-on effects of that—no different to loneliness. I've absolutely been guilty of this in the last decade, where I'll look for that high-volume, low-value connection. It might be going down and drinking alcohol and having high-volume, low-level conversations. Does that really fix that? It may be a short solution, but it's not a long-term solution.

We had a really good conversation the last time I was back in Sheffield with Andrea Wigfield, who's the professor I mentioned earlier, about the language of loneliness and the fact that it's called the Campaign to End Loneliness and that we have Ending Loneliness Together here. It creates that initial opinion that you need to eradicate it. We don't need to eradicate it. We need to understand it and embrace it. If we can in some way lift that language and the lightness of that experience, that would be a huge change for people. To acknowledge it as something that is human and normal would be significant in my opinion. One other final thing there as well is around reaching out and connecting, having been through my own journey, whether this is at the critical end or purely in loneliness. When you've dropped into those deep levels of that, it's too late to reach out to those connections. You need to create those connections prior to that, because you're not comfortable. When you're in a critical situation, you're not comfortable, because you think of yourself as a burden, or the stigma then. So we need to lighten the load. We need to lighten the language of loneliness. I think that would be fantastic. Thank you.

The Hon. TAYLOR MARTIN: Thank you to the three of you for making time and for your submission and for your work in this field. If I could run through a hypothetical scenario, and I'll ask each of you, starting with Mr McAuliffe. Hypothetically, you wake up tomorrow and you're the Premier. What would you want to implement to see movement in this space?

PHIL McAULIFFE: For me, pulling levers of government—and this is in our submission. The issue of loneliness and social isolation is so gnarly, so complex and complicated and unique to each individual in New South Wales. But we all have our own ways in wading into the loneliness pool. There are many different characteristics, but there are so many similarities to that. Because of the stigma of loneliness, the kind of force field around the concept and the word, we need to come at it from another angle. This is something that we suggested in our submission, and that is putting belonging at the centre of decisions—given the same weight in briefings from the public service to Ministers, given the same weight as other considerations in Cabinet submissions, about how does this help the people of, in this instance, New South Wales feel that they belong to their community.

That is a much more positive sort of approach to take, rather than "How can this stop people feeling lonely?" Nothing will stop people feeling lonely, because we're meant to feel lonely. It's an important signal that we're meant to connect. But humans who feel that we belong feel connected and, when we feel connected, we don't feel lonely. So, for us at Humans:Connecting, it's focus on how do we make decisions that help people feel that they belong and put that at the centre of planning, put that at the centre of budget considerations and the like—so focus on belonging.

The Hon. TAYLOR MARTIN: Thank you. Anybody else?

PAUL DOLBY: It's incredibly complex. I think for me that lightening the language on loneliness would be fantastic. If there was some sort of campaign, we can start that conversation around lightening this language and how we do that, but then trying to find and genuinely create authentic collaboration between politicians, corporate leaders, academics and lived experience, and bring together—I said in my submission there's a danger here. Having spent eight to 10 years in the mental health crisis end of things, where these things—everything starts with great intentions. But these things ultimately end up becoming—it becomes an industry. I think this would probably be the same with loneliness. It would very quickly become an industry, and then it becomes political, and then it becomes difficult. So I think it has to be collaboration, has to be like-minded people. We're just literally one step at a time, individual direct conversations.

Myself and the lived experience perspective, I can only in fact—I've always been fascinated by this idea of the influencer that's been happening recently. I've got a friend whose daughter is making ridiculous amounts of money as a 20-year-old publishing information on a site and people subscribe. I thought, "How is she doing this?" So I went to look at what she was actually selling and realised quite quickly. I know her dad very well. I said, "I realise what she's doing." She's taking all the information that we would—I have an 18-year-old daughter. The information that I would give to my 18-year-old daughter—she will not hear from me. This 20-year-old has realised, "I can recycle that information and deliver it to people two or three years younger than me and I'll be a guru and they'll pay for it." I think it's this thing of it's not what you hear as much as where you hear it from. I think by putting the right people in front of the right audiences with a similar message is where we need to go. I think I have a certain audience. Phil has a certain audience. My daughter hopefully has got a very different audience. It's complicated.

The Hon. TAYLOR MARTIN: Thank you. That is a great insight.

The Hon. NATASHA MACLAREN-JONES: I've got a couple of questions. They're probably more for Mr Dolby in relation to your submission. It's on the third page in, in response to the terms of reference, paragraph (a). I wanted to understand a little bit more about the work that you're doing with the UK to collect "relevant information pre-, during and post our corporate (and community) events." What are those events? How

are you collecting that information? I think one of the things that has come through from this, all the submissions, the inquiry so far is that actually being able to measure and understand loneliness is a challenge in itself.

PAUL DOLBY: It's incredibly difficult. I think from my perspective—again, having been involved in that critical care and the mental and the suicide prevention end of things, I was really conscious that I wanted to make sure that anything I was doing was authentic, sustainable but also could evolve. I literally reached out myself two years ago to the Campaign to End Loneliness. Then they basically were absorbed into Sheffield Hallam University. I made the connections. Really, from a learning perspective of my own, I wanted to have good people around me. Absolutely, there are some amazing academics and they have these challenges around funding. I have this belief that the corporate world needs to stand up and needs to be involved, but I didn't want to be in a situation where I become another workshop and box-checking exercise—that I go in on certain days of the year and I'll do my "Mind the Gap" talk, people are elevated and share stories, and then move forward. There needs to be something more persistent around it.

I've been working with not only the guys in Sheffield Hallam but also Dr Sarah Wright in New Zealand in Christchurch around how do we do something that's—we can give the corporate enough of an insight into what we're trying to do to then feed back to them that there's genuine need for further activity. Historically, the workshops I've been doing would be—we'd collect anecdotal evidence and you'd share stories afterwards. But then what was next? What we've decided to do in this instance is really do a pre-questionnaire of anybody that will attend the workshop around their perception of loneliness. We then go in and we run the "Mind the Gap" conversation with some of that information. Dr Sarah Wright in New Zealand has created a workplace loneliness scale, which we're looking to adapt to also be not about just your workplace loneliness but loneliness within your personal environment as well.

We can then gather that information, the idea being that, once we have that, we'll then start to move to the next phase of having people commit to a more detailed interview process, which will establish themes. But what we really want to do is have the corporates involved as well. So it's not just a prescriptive research project; it evolves based on the themes that we discover. It really at the moment—it's small datasets that we're then looking to move to interview. The ultimate aim of Spoke is that we'll be in a position where—the idea is that we find what we call spokespeople inside, say, an Ernst and Young, for example. We'll go in, we'll start that process, we'll find stories of lived experience to the research and we'll then enable them to become the spokespeople in their organisation. Because, going back to my original point, I think if you're hearing a story that's relatable to somebody that's been through your organisation or lived in your organisation, it becomes even more relevant. We're in relatively early stages of this, having just done the ad hoc workshops. I was just determined to build something that's more sustainable and informed, if that makes sense.

The CHAIR: Mr McAuliffe, I understand Humans:Connecting also has a suite of tools. I know you also have a workplace focus as well. I wondered if you had some supplementary ideas, suggestions, comments following Mr Dolby.

PHIL McAULIFFE: Thank you. In a similar way to Paul, we have partnered with Annecy Behavioral Science Lab in France. That's headed by Dr Hans Rocha IJzerman, who is also chair of—I always forget the exact name of the school but at Oxford as well, and one of the world's leading academics on measuring loneliness. We connected because of a mutual frustration. We know we want to make an impact. We know that it's important to measure that impact in that pre, during, post phases of interactions with us, whether that's personal or whether that's in a workplace. But the current measures are bad and are from the '90s and aren't accessible. ABSL are global leaders in creating a new, more inclusive—including the developed world and the Global South about what it means to feel disconnected as a human and what it means to feel connected as a human in a much more nuanced way.

The product that we're developing and provide allows businesses to tap into that research as it's happening and come up with something that is bespoke, tailored to their organisation. It's fantastic to be at the cutting edge of that and being able to come up with a much more nuanced response tailored to individual offices within certain, for instance, global organisations, because that meets loneliness where and how it is. But the challenge always is how does the measurement, how does the data, how does the science behind this translate into something that is meaningful and useful to the individuals within those workplaces, within the organisations, within communities, within families—wherever the human is. So, yes, in a similar way to Paul, we're working with academics as well.

The Hon. NATASHA MACLAREN-JONES: Is there any role that you have with the UK or the French governments or is this all private sector?

PHIL McAULIFFE: I don't want to speak on behalf of ABSL—Annecy Behavioral Science Lab—but they do work with the French Government. They're integral within means to address loneliness within the European Union, including this week. There's a Lonely-EU launch that finished yesterday. They also work within

the United States with NASA and various universities. It's within Europe and within the United States, with plans to do more here on this side of the world as well.

The Hon. SCOTT BARRETT: I will just ask a quick question, possibly to Mr Dolby. Upon your reflection on your journey into loneliness, is there a path you wish you'd taken, or a path that was there, or even one that was better lit, on your journey there? This could be a high-level thing, right down to "I wish I'd joined the pub choir" and the like.

PAUL DOLBY: I can tell you exactly what it is. I wish I'd understood my family pathology, and by that I mean my mother's story. I wish I'd understood. She went through some extreme trauma at the age of 13, which I was loosely aware of but she'd never shared for over 70 years. After my first critical event, as I'll call it, in 2018, I wrote her a letter. I call it my "unsaids", and I shared this letter with her. It provoked her, on my subsequent trip back, to actually share two letters that she'd had for 70 years from her father, who she witnessed die in a traumatic situation with cancer. And it just suddenly explained so much of my life.

It basically—I have two beautiful children over here. I'm happily divorced. Those things would never have happened had I not left the UK. But my misunderstanding of my relationship with my mother and her not having—she lived in loneliness for 70 years and continues to, and I can't change that. But what I am able to now change is my understanding of that relationship and how that—I talk about wearing my Heather glasses. I've seen so many things in my life through that lens of the way my mother was fiercely protective of me, and now I understand it was to protect her from her own trauma.

The impact that had on my life has been so significant, but I didn't know the story. Now I know the full story, I'm able to really understand how I interact with my own children, how I interact in relationships. Some may say it has come too late for me at 53, but, yes, I wish I had a way of communicating intergenerationally better than we did and that my parents had been able to articulate their own stories, because that had a huge impact on my story. Sorry if that's going a bit too deep, but that's absolutely it: I wish I'd been able to talk to my mum.

The Hon. SCOTT BARRETT: Thank you.

The CHAIR: Mr McAuliffe, would you be prepared to answer the same question? I know you come as someone with lived experience. Are there junctures or choices?

PHIL McAULIFFE: Yes, absolutely. The advantage of going after Paul is that I had some opportunity to pause and reflect. For me, simply, I wish that I'd had the courage to live more as me. And I got very good. As we know from our work at Humans:Connecting, I got very good, at school, at saying the right thing to the right people at the right time to get the right outcome, and I suspect this is a—no matter the room that I'm in, that message resonates because it's a common technique that we all develop or many of us develop to get through tough days as an adolescent, and it works. It works and it works and it works—until it doesn't, sometime around midlife.

The midlife crisis, opportunity, reawakening is that opportunity to come back to ourselves, and loneliness is often a symptom of that, where we've made—one of the sources of my loneliness was I was being all things to everybody. I was being nothing to myself. I was very good at my job, working in diplomacy. I was very good. I was climbing the ladder in the Australian Public Service. I was getting into rooms, making decisions and having my voice heard, but it wasn't my voice. I wasn't in there. At each and every opportunity now, I walk into rooms and places and spaces in conversations as me, and I wish that I could say that back to 16-year-old me, when Jonathan and I met at school, all the way through to 39-year-old me as well. That was the genesis of mine.

The CHAIR: Regrettably, that's the end of our time. I particularly express my thanks to you for the work that you do but also for your willingness to come along to give evidence and express the vulnerability that you have in this forum. That is seen and greatly appreciated. Thank you so much.

(The witnesses withdrew.)

Associate Professor J. R. BAKER, Chair, Australian Social Prescribing Institute of Research and Education, sworn and examined

The CHAIR: Thank you so much for making the time to give evidence today, Associate Professor Baker, and for the submission. Would you like to start by making a short statement?

J. R. BAKER: Yes, please. We all know the story of the boiling frog: Drop it in hot water and it jumps, but raise the heat slowly and it won't notice the rising danger until it's too late. We are that frog, not noticing as our social connections dissolve degree by degree. But our problem is bigger than just losing social connection and social health as a society. It's the gradual death of our social contract: the fundamental understanding that community isn't just about living alongside other people, it's about creating with them and contributing to them. Being part of the community means owing something to it, building something for it, and this was the original philosophy of the spirit of mateship.

Instead we've reduced citizenship, in many ways, to a transaction. We pay taxes and vote and expect services in return, and no longer see ourselves as co-creators of the places we live. We've become customers of our own society. When society stops expecting contribution, it stops thriving. When your car breaks down, what do you do? Usually you call the NRMA. They tell you what's wrong and try to get you back on the road. But when someone's social life breaks down, when they lose connection, purpose and community, who do they call? Right now it's hard to call anyone. We tell them to reach out, but that's like asking them to somehow jump-start a car with a dead battery. Now imagine the gridlock if one in three cars were broken down on our roads every day. We'd call it a crisis and we'd demand urgent action. But one in three Australians are lonely, one in two lack companionship at least some of the time, and social isolation is as bad for your health as smoking 15 cigarettes a day.

But this crisis is invisible. It hides behind closed doors in silent suffering, in quiet houses and apartments. That's why we need roadside assistance for social and civic health. Just like the NRMA, social prescribing is a trusted service when we're stuck. A social prescribing link worker is like that reliable mechanic who shows up and not only fixes your car but makes sure you get where you need to go. Sometimes you just need a jump start from a neighbour, and that's great. Sometimes you're not sure what's wrong and you know you're just not moving forwards. That's where social prescribing comes in. A link worker doesn't just address the immediate problems of loneliness. They ask, "Where do you want to go?" They help figure out what matters to you, and they remind you that you yourself matter. Being part of a community isn't just about getting help when you're broken down; it's about being part of the network that keeps everyone moving.

The New South Wales Government has already shown that social prescribing works. Our own workers compensation scheme and icare invested in a world-leading trial of social prescribing seven years ago. The result was that for every dollar invested, $3.84 in benefit was created. New South Wales did this before the rest of the country was even thinking about social prescribing. The community resources and link workers referred to already exist. The healthcare providers and trusted people—pharmacists and GPs—who can identify people with unmet needs already exist. Social prescribing is really just about adding the missing pieces to connect the dots—an easy, cost-effective, sustainable solution we know will work. It's worth remembering that we need to preserve the rich assets our communities have for social prescribing to work. It relies on those assets to bring people together. I'd like to take a moment to talk about bowling clubs, but it could be netball, art galleries or anything else.

Over the past 40 years Greater Sydney has lost half of its bowling clubs—120. On the way here this morning, I drove by Gosford City Bowling Club, which is probably closing in the next few weeks. Why? There are a lot of reasons but, in part, it's on council-owned land being reclassified from "community" to "recreational", a technical shift that opens the door for commercial redevelopment. A bowling club is not a recreational facility, and this one is special. It's a third space, a third place—one of those rare places between home and work where community happens. It's where Bill Murphy, who is 91, finds his only social connection every day, after losing his wife 18 years ago. It's where a group of stroke survivors who regained confidence and movement supported by familiar faces can grab a beer afterwards. It's where deaf bowlers can turn up and know there'll be people who understand them. It's where 17 members who play are blind, the largest number of any club in Australia. It's where people come from all over—from Quakers Hill and from Morisset—because this club welcomes people with a disability. It offers some of the only accessible greens in the region, and people with a disability are actively invited to play.

A bowling club is actually where bridging social capital is built. It's where people from different walks of life meet, talk and form connections. It's where they talk about what they have in common and avoid talking about their differences often. It's where intergenerational capital grows, older people can mentor younger people and wisdom can be shared across ages. It's where civic infrastructure is maintained, not in bricks and mortar but

in relationships, trust and belonging. Yet these places keep disappearing, not because they're not needed but because our system often values commercial returns more than civic wealth. But every lost club, every closed hall, every bulldozed gathering space is another crack in our social infrastructure. This cost isn't just measured in dollars; it's measured in the pain of loneliness, disconnection and exclusion in the people left behind when community vanishes. Once these places are gone, where do people go? One of the members is 101, and she gets up every day just to go bowling. What happens if that club goes in three weeks?

Our system we live in today is designed for disconnection—often not intentionally, although a lot of people actually do it intentionally for different reasons. For example, it's easier to doomscroll or gamble from a toilet seat than play with your kids. It's simpler to share conspiracy theories online or stalk a stranger's pictures than share a meal with neighbours, and it costs a lot less. It's more profitable to build algorithm-driven echo chambers than create real community spaces. When community tries to rebuild, often they hit a wall of regulation. You can't lend a neighbour a power tool without worrying about liability. You can't run a street party without expensive insurance and securing a range of permissions, and you can't start a community group without drowning in paperwork as if you're a corporation. If you let your kids play alone in the park, you might even be arrested for child abuse. We've regulated community into submission, made sharing a legal risk and turned informal helping into a liability nightmare, and we see the impacts everywhere.

We should design for contribution, not just for consumption. We need to design our communities, our services, our policies and our legislation for connection. When you walk up to a door and see a push pad or pull handle, you don't need instructions. Good design makes the right action obvious. Imagine if we designed our communities and our legislation the same way. Designing for contribution matters greatly. Social prescribing asks what matters to a person, but it also gives them the opportunity to realise that they matter, that they have something to offer and that they have something to contribute. A community isn't about living alongside others; it's about creating with them. Right now, we're losing that expectation that people contribute.

The opposite of loneliness, in many ways, is having purpose and being valued, and these are inherently tied to contribution. The cost of loneliness and isolation isn't just lost productivity or worsening health care. When people feel disconnected from their communities, they become susceptible to extreme views and even radicalisation. We see bad things in the paper at the minute. When local papers close and community groups dissolve, misinformation often fills the void. When we lose our third places, we lose the informal connections that build democratic resilience. This isn't just a wellbeing issue. It's an economic issue, a security issue and a democracy issue. When people stop believing they matter, they stop showing up—first for their neighbours, then for their communities and then for democracy itself.

There are five simple things we must do now. First, jump-start people in communities. Social prescribing isn't just about services; it's about helping people reconnect with meaning, purpose and each other. Every community should have link workers who can connect people to activities, groups and opportunities to contribute. Right now, people want to connect, but the system doesn't make it easy. Two, make community assets easy to use. Schools, libraries and public buildings should be open for local use after hours without layers of red tape. It shouldn't take months of approvals to host community meetings or weekend sports events in a space that already exists. Three, reward businesses that build community and not those that extract from it—maybe my most contentious one. Local cafes that host book clubs, shops that sponsor sports teams and businesses that hire locally should get payroll tax breaks—maybe. Meanwhile, gig economy giants, automation-driven businesses and companies that replace human connection with algorithms should invest in communities through a social infrastructure levy. If a business extracts value without reinvesting, it's weakening civic health.

The CHAIR: Professor, could I just make a request? We're already 15 minutes in. If you're happy to tender the document, we might take the rest and it will come into evidence. We can ask supplementary questions as well. I'm just conscious that we've got you here as our resource and expert, and we'd like to be able to use that to the best of our advantage. Social prescribing has come up a lot in the submissions that we've received, across a whole range of submissions. I'm still puzzled a little bit about what that looks like. Before you even prescribe, how is someone diagnosed? What does that look like? What is the follow-up? This idea of a link worker, is that formal? How is that? If you could describe quite systematically the process, that would be really helpful.

J. R. BAKER: Sure. Obviously, people have a range of things that affect their wellbeing. They're sort of the building blocks of health. Some of those can be as simple as noticing that they feel the actual tangible pain of disconnection, isolation or rejection. Other things can be more practical and visible but feed into that still. We've heard from a lot of the evidence presented and the submissions that social and economic factors, distance, the tyranny of regionality and all of those things impact. Social prescribing is really about when people have those bits missing from the building blocks of health, whether it's food security, housing or connections to others, a trusted person—you'll hear later from a colleague who is a pharmacist, who talks about how pharmacists are some of the most trusted people in the world, but it could be a teacher, a GP or anybody—realises and recognises that

there's a need. That can be facilitated through training, but it can also be intentionally making a call to action to our communities to look out and to invite people to connect.

The previous speakers aptly described how feeling included, feeling like you belong and feeling like you can be yourself are key, essential factors in wellbeing. When people have those things missing, you can gently offer them opportunities so that they can connect to their tribe, to their group, to their interests or to their passion. In practice, they get linked in to a link worker. They are supposed to ask you what matters to you, effectively, and what can make life more wonderful. What that does is it really shifts the conversation to what's important to a person. It kind of captures some of the stuff that other people have talked about that has been lost. Religion has been lost and social infrastructure has been lost. It gives them a different way to talk about purpose, meaning, values and vision. From that, you can connect people to those social assets, community groups and other things that then improve quality of life, effectively, because you move out of an identity, so to speak, of being lonely, isolated or not valued by society and it brings you into a place where you have identity and purpose that's different.

The CHAIR: Can I ask a follow-up question? Using the term "social prescribing", for me, is quite a formal term. It's quite a formal way of describing it. In my head, there's quite a process, but you're describing a fluid process or thing. We have had some discussion of this in the Committee. Do you think the term "social prescribing" is helpful or does it risk making something sound like there is a formal, medicalised process that you go through?

J. R. BAKER: Both. My answer would be both. It is helpful. If you think of the current system, if someone is feeling profound loneliness, they might talk to their GP. They might get something that might not be a sustainable solution. They might get antidepressants; they might get a referral to a psychologist. That doesn't change their circumstances and it doesn't change their life direction some of the time, but it's what we have.

Inviting people in a position to make those referrals in the language they're used to made sense, particularly when the UK rolled things out. It really is a response to struggling healthcare systems not able to keep up with the deluge of mental health related issues and chronic health conditions and all the rest of the stuff—the things that go out of control when you don't address those building blocks of health. That part is helpful, but to prescribe—I guess you'd know what prescribing means more than I would, which is I guess to dictate by putting things in writing, effectively. There are some issues with that because a person really has to prescribe for themselves. You can't tell a person what matters to them. You can't tell a person how their life could be more wonderful. So there is the limitation to the language, but in terms of that vernacular, making it something acceptable and accessible to the most likely sources of noticing that there's something wrong I think was probably the underlying logic for it. But, yes, there are limitations.

The Hon. NATASHA MACLAREN-JONES: I have one question before I hand on. In your submission you referred to the UK's all-party parliamentary working group recommendation around creative health. What is creative health?

J. R. BAKER: That submission was with a bunch of colleagues, so I might have to take it on notice. Was that in the arts on prescription section possibly?

The Hon. NATASHA MACLAREN-JONES: Page 12.

The CHAIR: It's absolutely fine to take it on notice.

The Hon. NATASHA MACLAREN-JONES: I'm not sure if it means looking at it more holistically or creatively or if it's an arts thing. I am happy for you to take it on notice. That's fine.

J. R. BAKER: Yes, it's quite possible. I only jumped to arts because I think today in Texas there's an arts on prescription event happening. I noticed this morning that the headline was "doing art reduces your dementia risk by 63 per cent". So not only do you get a connection but, of course, there are benefits in terms of health and wellbeing outcomes.

The Hon. NATASHA MACLAREN-JONES: The only other question is in relation to the social prescribing framework, because delivery of health care, particularly in Australia, is obviously State and Federal. Have you had any engagement or done work at a national level on how this would be looked at across all jurisdictions?

J. R. BAKER: Yes. The Commonwealth Government department of health has been running a national study into the feasibility of social prescribing. Whilst I don't think it's publicly released yet, I think you can ascertain just from the submissions people made to that that a lot of the suggestions were that it does belong partly in primary care and that it's a shared responsibility between local government, State government and Commonwealth because everyone has different pieces of the puzzle of wellbeing. Obviously, the Commonwealth, with primary care as a lever, would probably use a mechanism like PHNs to support that sort of thing. If you

extrapolate from the Dutch models of social prescribing, you could theoretically use a level B consult within Medicare right now to do preventative health things to address chronic health risks. We know that if we can address social isolation and loneliness, we can justify that as preventative health measures. So there are places where immediately you could insert it into that.

There is a consensus statement which was developed last year around Social Prescribing Day—which I hope we referenced, but if not we can provide that afterwards—signed off by 100 different organisations, including big orgs like the RCGP and the Pharmaceutical Society and the like. It does provide a road map for how all governments could work together to implement social prescribing across Australia.

Dr AMANDA COHN: I've got a couple of questions, and I appreciate they may need to be taken on notice as well if I'm referring to sections written by a colleague. I'm quite predictably interested in nature-based programs. You cited a really interesting study showing that having at least 30 per cent of local land use as parkland supported a quarter reduction in the odds of becoming lonely. There's a comment in the submission that implementation of nature-based programs requires addressing practical barriers. I was hoping you could speak to what those are and how we can address them.

J. R. BAKER: I could, but I looked at your list of people providing expert testimony today, or expert submissions—I don't know what the correct language is—and I noticed that the PowerLab group was presenting later. They are probably best placed to address those specific things, because that's their expertise: designing environments to reduce loneliness effectively and to increase green capital. Is it all right if I both take it on notice and suggest they might be best placed to answer that one?

Dr AMANDA COHN: Yes, please. I have a second question, if I may. In your opening statement you referred to some of the barriers in community for community use of existing facilities and assets. Are there specific examples of barriers you can provide us—again, on notice, if you like—that we should be looking at addressing?

J. R. BAKER: On notice, if I can. If it's possible to table a document, I did have a list of possible areas where the Government could do things easily and immediately, I suppose, to address things across a range of departments.

Dr AMANDA COHN: Please.

The CHAIR: It would be great to table that, if you could. Mr Barrett, anything from you for now?

The Hon. SCOTT BARRETT: I didn't have anything specific, but regarding the range of activities that we want to send people to to get them involved, is it important to have quite a big range? We heard earlier about people finding their tribe and that sort of stuff. I'm guessing it's important to have that diversity in the different groups and organisations and activities available. I'd like you to touch on that a little bit more.

J. R. BAKER: It is sort of like going to a restaurant. If it has one dish, you know what you're going to order. That can be okay if it's a great dish. In the old days a lot of restaurants just did what they were good at, but most of us now expect a range of things to address our appetite. It isn't always easy to connect with something you don't really relate to. There are some amazing things, like in the UK. There are lots of fishing groups that have easy, low-cost entry points that people can join. But you wouldn't ask someone who is a vegan to do a fishing group sort of thing. So there are things that are grossly inappropriate for the people who might be referred to them. The range of options is important, and it's not always going to be locally accessible.

I think COVID did a small favour in terms of creative ways to connect if you can't do that locally. One colleague I believe did research on dance, which included people in regional New South Wales possibly, or somewhere regionally in Australia, but also in the UK and other places, and looked at if you could still connect to dance classes even if they weren't locally available to you through shared video connection. There's obviously something nice about having someone face to face that you see because you might be able to have that side conversation afterwards and be able to rely on them for things beyond social health measures but also social capital measures like, "Can you help me move the fridge this weekend when I'm moving?"—those practical, tangible things that make you feel supported and part of something are sometimes more absent when you don't have that physical contact. But you can still connect in with things that matter to you. So I suppose a range is great and you can be creative with that.

The CHAIR: One of the things we've heard and read in some of the submissions is that measures to ameliorate loneliness are often through group activities. It seems to me that social prescribing is a lot about trying to connect people with groups, but what we've heard is that the step from feeling isolated or lonely into a group activity often seems too big a step to take. How does social prescribing deal with that aspect? It seems to me—and I've only done the reading through this inquiry—that it is very group focused.

J. R. BAKER: Yes, it can be. I can probably answer that. And I didn't fully answer your earlier question, so I might do two at once. The lowest level of intervention in that sort of social prescribing landscape that isn't social prescribing itself is a community connector model, which is often referred to as compassionate communities or that sort of thing, because a newspaper article titled that some time ago. The essence of that model is that a community link pretty much puts all its assets into an information access point—a phone number, a directory—and all the citizens just refer people to it. That's a passive, very affordable, very good return-on-investment sort of mechanism. If you had local councils or libraries—a whole list of stuff you could do that matters to you—it's that sort of low-cost version.

But, as you say, for the people who can't just jump-start their car by turning the key and hoping it's going to work, a link worker is that touchpoint where they can employ skills like coaching or just doing warm connection activities to help you feel confident to go a place you might have never gone, to explore something that's of interest to you and to have deeper discussions. I know in the executive world and in big business we value coaches, but a lot of the time people don't get a coach if they don't have the economic capability of having that to just focus on the things that matter. I've seen plenty of CEOs who can tell you exactly the five things that matter, their 10-year plan and everything else, but a lot of the rest of us are left kind of listless, wondering what we're supposed to do and not having someone ask us what actually matters to you and where do you want to be in five years.

The CHAIR: There's a difference between a social prescriber and a link worker.

J. R. BAKER: Yes.

The CHAIR: If that's the case, where is this link worker? Where are they situated and how are they funded?

J. R. BAKER: At the moment I can give you a couple of different answers to that. Most of the models in New South Wales I could talk to have been funded either by PHNs or there's the icare pilot that was funded. Usually the link worker can be situated in a community-managed organisation. In other places they could be in community centres or neighbourhood centres or neighbourhood houses depending on the vernacular. They can be co-located in GP practices or pharmacies, or other places. In northern Sydney, for example, there are some link workers in GP practices, some in community health centres and some just in the community so that anybody can access them.

In south-east New South Wales, there's a program that's aimed at providing social prescribing for people at risk of, or living with, chronic and complex health conditions, but 90 per cent of the people accessing that are on some sort of healthcare card or pension, and those link workers float because of the large regional size between a range of practices. We kind of would call that a patient-centred medical neighbourhood model, where a bunch of practices and pharmacies can access a shared resource, which is the link worker, and connect their patients to that. Where they physically sit can vary, and there are strengths and weaknesses to every approach. But it is possible to deploy them in a range of ways for a range of regional contexts.

The Hon. SCOTT BARRETT: Professor, some of the options you were providing before were financial incentives to aid this community connectedness. I presume that the other side of that is you believe that there are financial rewards for having this social cohesion.

J. R. BAKER: Yes. I suppose in the grander scale, we usually use money as the sort of measure of value, which I get. But then if you look at things like informal caregiving, looking after sick family members or children or all sorts of different ranges of people, if you try to value that, the value is quite high. When you try to value sort of different ways where people actually live contributory lives, oftentimes we don't capture the full sort of value of that. We look at productivity and economic figures and GDP as the only metrics. I suppose by activating more people, whether it's bushwalking clubs, which still have indirect effects, you have savings in terms of actual expenditure.

If you think of older people who keep out and about walking or who play games—playing games on its own is going to knock down your risk of a cardiovascular event by 20 per cent if you're over 70. It saves money in terms of health care; we don't pay for the cardiologists and for the rehab and for the emergency department room. But we also get people out and about doing stuff, which actually builds up dexterity and balance and those sorts of things, so we keep them from becoming frail and falling, and it builds cognitive capacity. We know that there's going to be a huge number of people with cognitive issues like dementia in the coming years, but it actually keeps some of those things at bay longer. What you get in that sense is a statistical value of life years, so actual good years or health years—if you want to call it like healthy years—but years where you get that sort of value to your life, where you're not sick, you're not separated, you're not lonely and you're not disconnected. It's about giving value in different ways. Then economically, if you reduce costs and don't spend as much money, then of course you get the gains that way too.

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The CHAIR: Thank you so much, associate professor. We have reached the end of our time. Thank you for your submission and for your time today. I think you've both agreed to table something and to take some questions on notice, so the secretariat will be in touch with you about those and if there are supplementary questions.

(The witness withdrew.)

Ms JENNY KIRSCHNER, Pharmacist and Founder, Pharmacy Addressing Loneliness and Social-isolation, affirmed and examined

Ms LILY PHAM, New South Wales Vice-President, Pharmaceutical Society of Australia, affirmed and examined

Ms AMANDA FAIRJONES, New South Wales State Manager, Pharmaceutical Society of Australia, affirmed and examined

Adjunct Associate Professor LEANNE BOASE, CEO, Australian College of Nurse Practitioners, before the Committee via videoconference, sworn and examined

Mrs REBECCA SEDGMAN, Policy Adviser, Australian College of Nurse Practitioners, before the Committee via videoconference, sworn and examined

The CHAIR: Welcome. Thank you very much for making the time to come and speak with us today and for your submissions. Could I ask if each organisation wants to make a short statement, perhaps starting with the nurse practitioners?

REBECCA SEDGMAN: I'm happy to start with our introductory statement on behalf of the college. On behalf of Leanne Boase, the CEO of the Australian College of Nurse Practitioners, myself—as the policy adviser—and our members, would like to express our thanks to the Committee and the Chair for the opportunity to participate in this important hearing. The Australian College of Nurse Practitioners represents nurse practitioners across Australia, also representing practice nurses, midwives and future nurse practitioners across Australia. We strive for improved and equitable access to health care and the prevention of disease and the promotion of health.

Loneliness is a widespread emotion that affects people of all ages and can have serious consequences on both physical and mental health. Loneliness, secondary to long-term social isolation, has been associated with an increased risk of early death and poor self-reported health, largely due to its connection with elevated stress, poor sleep and unhealthy habits like overeating or physical inactivity, which have been shown to increase the acquisition of non-communicable diseases such as cardiovascular and cognitive diseases. Loneliness and social isolation can also lead to weight gain, which in turn increases the risk of developing type 2 diabetes, particularly when coupled with a sedentary lifestyle. From a mental health perspective, loneliness can trigger or exacerbate feelings of depression, anxiety and elevated stress, all of which have a detrimental impact on the overall wellbeing.

Adolescents are especially vulnerable to the health impacts of isolation, as social connections play a crucial role in their emotional and cognitive development. Isolation during these formative years can have long-term adverse effects. Furthermore, individuals who are neurodivergent, such as those with autism, ADHD, dyslexia or other neurological conditions, often face unique challenges forming these social connections, which can intensify their experience of loneliness and increased health risks. Given these considerations, addressing loneliness and promoting social connectedness is vital to improving both physical and mental health across all demographic groups, and we are happy to be invited to share in this conversation today.

The CHAIR: Ms Fairjones or Ms Pham, do you have a statement?

LILY PHAM: We do, thank you, Chair, and thank you for the opportunity to speak today. I'd also like to acknowledge the traditional custodians of the land on which we meet today and pay respects to Elders past, present and emerging. The PSA, or the Pharmaceutical Society of Australia, is a peak national professional pharmacy organisation representing Australia's 39,000 pharmacists working in all sectors across all locations. Specifically in New South Wales there are currently around 11,000 registered pharmacists. PSA is the profession's standard-setting body and the custodian of standards, guidelines and code of ethics.

Generally, in New South Wales we've got 2000-plus community pharmacies, and we are considered among the most accessible frontline health professionals in the community. It's estimated that, on average, an Australian will visit a community pharmacy up to 18 times each year. We as pharmacists can do better to harness these well-established and well-distributed networks of pharmacies to promote social connections and minimise the likelihood of people experiencing loneliness and the associated negative health outcomes. Pharmacists in the community already work in collaboration with other health practitioners such as GPs and allied health practitioners, so we strongly support that all pharmacists are able to access comprehensive training programs and practice support tools to ensure the delivery of consistent, effective and actionable strategies to address loneliness at the patient, pharmacy and community levels. It is through this commitment that the PSA has been closely working with Jenny Kirschner, the founder of Pharmacy Addressing Loneliness and Social-isolation.

In general, the PSA makes a couple of different recommendations, the first being to fund pharmacy training on loneliness for all pharmacists in New South Wales; invest in the rollout of the UCLA loneliness scale

screening for use by pharmacists in community pharmacies and credentialed pharmacists when conducting home medicine reviews; fund mental health first-aid training for all pharmacists and pharmacy staff in New South Wales community pharmacies; fund pharmacists to deliver remunerated telehealth consultations to allow connections with people in geographically isolated areas and those with mobility limitations due to illness and disability; and, finally, to partner with the New South Wales Government to develop a comprehensive suite of continuing professional development modules, guidelines, articles and webinars addressing loneliness.

The CHAIR: Ms Kirschner?

JENNY KIRSCHNER: My journey in this space is actually both professional and also deeply personal. I have had a lived experience of persistent loneliness firsthand, and it really is soul destroying and intensely painful. Recognising the struggles of loneliness in so many of my patients, and really the lack of awareness and understanding and action towards loneliness, inspired me to create PALS, Pharmacy Addressing Loneliness and Social-isolation. PALS' mission is to inspire, educate and mobilise the pharmacy industry to play a role in addressing loneliness. Today I invite the Committee to imagine the transformative potential of leveraging an existing and highly accessible workforce across New South Wales and pharmacies.

As mentioned, there are 11,000 pharmacists and 2,000 community pharmacies. Pharmacists are one of, amongst others, the most trusted professionals. They are really a community-embedded healthcare professional. They serve as critical regular access points and touchpoints for individuals who are at high risk of loneliness and also those who are experiencing loneliness and social isolation, often providing the only regular face-to-face contact. Community pharmacists know of the many patients who deliberately spread out their script fulfilment just so they can come in for a chat. I've seen it. These patients—fellow humans—are starving for human connection and they're desperate to have their existence witnessed. The personal relationship formed between pharmacists and patients is a really powerful form of social capital.

Given the scale of the problem and the strong evidence linking loneliness to serious health risks—as you have heard over the course of the hearing—with significant economic implications, I believe that pharmacists can no longer ignore seeing this issue or remain silent. I believe it is a professional responsibility to equip pharmacists and other health professionals with the knowledge, skills and competency framework to know how to act. Yet until recently this high-quality evidence-based training has been absent. In August 2024 I launched the world's first accredited pharmacist training program on loneliness. That was created with expert interviews, including the World Health Organization.

The program that I created engaged the scientific expertise of Professor Johanna Badcock, who was the former director of evidence and training and vice-chair of Ending Loneliness Together. In partnership with the Pharmaceutical Society, the introduction of this training has seen unprecedented enrolment numbers, with pharmacists reporting high levels of satisfaction with their experience and improvements in knowledge and confidence to understand the health impacts of loneliness, engage in conversations with patients about loneliness, and provide better support to those experiencing loneliness. Some of the comments include things like, "I will discuss with team members the possibility of holding morning tea gatherings," or, "I might have a health promotion event once I find some services in our rural area to refer patients into."

Just to note, in addition to my work in Australia, I serve on the leadership team of the International Social Prescribing Pharmacy Association. We will soon release a paper on the potential role that pharmacists can play in social prescribing. This has been developed with input from peak pharmacy and peak social prescribing organisations across Australia, US, Canada and the UK. The good news is loneliness is a modifiable health risk factor and the pharmacy profession in New South Wales is willing and ready to be activated. This is not about pathologising loneliness at all. This is a preventative, proactive approach, intervening at the community level before individuals require costly medical interventions or emergency departments visits.

I am calling on three things for the inquiry to consider today as integral components of the State's response to loneliness. Number one is to fund the training on loneliness for every pharmacist in New South Wales and to support the evaluation of this training. As we have mentioned, the online accredited training program is ready to go for rollout, with opportunities to expand content for priority and vulnerable groups. I would like to table, if anyone is interested, a summary of what is covered in the program. Number two is to leverage the extensive pharmacy network for public health messaging through partnership with NSW Health promotion units and other health promotion experts to develop targeted campaigns that raise awareness, reduce stigma and promote the protective health benefits of social connection.

Number three is to empower pharmacists as navigators to local services and referral pathways by investing in pharmacist-involved social prescribing initiatives in collaboration with key stakeholders. I really believe it is going to take courage to address loneliness. It is about the courage to believe that it's possible. It's also the courage to create a cultural shift that prioritises and values meaningful connection. This is a valuable and

unique opportunity to activate an entire workforce across New South Wales to really help drive this shift towards addressing loneliness. Thank you for listening.

The CHAIR: Thank you very much for all of those opening statements. In reading the submissions, one of the things that struck me was that there was a lot of talk about screening opportunities, screening for loneliness. There are two aspects of it that I have been thinking about. One is: What does that look like in practice? How do you engage with people? There is the at-home review of medications, I think, was one option, but that in-pharmacy situation. The other part is—and I'm still grappling with social prescribing generally. You've heard the previous witness and we've had it mentioned in a range of submissions that it seems to be quite ad hoc.

This view to moving towards social prescribing relies on some kind of goodwill, or understanding of, or knowledge of, or mapping of local organisations or services and the prescriber. It feels to me that there's a programmatic bit missing. I don't mean to try and make everything seem formal, but if you're thinking of policies which help, it's hard to put your finger on the thing that's going to assist when it does seem to be quite an ad hoc process. My questions in there are two. One is: How does that screening begin? A medications review would seem like a more logical place for that. The second question is: With this advocacy for social prescribing, what are the points of leverage? What are the observable things that can be done, rather than what seems like quite an ad hoc system? I'll go to Ms Kirschner first.

JENNY KIRSCHNER: To cover the two parts—and perhaps I'll lean on the Pharmaceutical Society of Australia also—there are home medication reviews, which has been spoken about by Ms Pham. There are also medication reviews that are conducted within the pharmacy in the consultation in the clinic rooms. As part of those medication reviews, which happen frequently in the pharmacy, you ask questions also around exercise and diet. My approach would be that it's incorporated into the holistic approach that we take anyway so it does become business as usual or less ad hoc and more streamlined. Any further comments?

LILY PHAM: I might touch briefly on screening. I guess, at the moment, pharmacists do a lot of screening, predominantly within the physical condition side of things, less formally mental health related or loneliness related. A lot of these services that occur at the moment will rely on some kind of health promotion to engage a consumer or engage a patient to opt in and say, "I'd like to participate in this screening." One of the things around pharmacists being such a touchpoint and so accessible is that rapport that we tend to build with our community as well. Different pharmacies will have different models, of course. But, generally speaking, as a pharmacist who is working in community pharmacy, I'll see certain regular patients and really get to know them personally. That can open up conversations around loneliness or around screening.

Screening doesn't always entail sitting down with a framework already there and ticking a box. It can also be embedded in conversation as well. That's almost the formal and slightly informal approach to screening. Then, from a referral pathway, which is where social prescribing comes into play, it's having those more robust frameworks for pharmacists to be able to say, "In this specific community that I'm working in, these are the resources that are available", and also the knowledge of, perhaps, wait times and what these systems also look like so that the pharmacist can advocate for that patient in accessing those.

JENNY KIRSCHNER: In terms of the social prescribing component—I'll just move there for a moment—I've been working on, in consultation with the ASPIRE organisation also, different frameworks and models that could be used in the pharmacy space and, as I mentioned, overseas consultation with peak bodies also. There are different models that can be used for social prescribing—full stop—and in pharmacies, some of which might be just a soft-touch, signposting-type version, a billboard or something which is showcasing what is on in the local area. Another place for pharmacy to be involved is referral to either social prescribing services—there are many social prescribing services, a handful of those around New South Wales, that could be referred into. And then there's also the option further down the track of the pharmacist being involved in that co-design of the prescription, with that patient, knowing them well, knowing what they like, knowing what's available and really help to facilitate their role.

In the pharmacy, I've had a day where I've had a social prescribing organisation come in, set up a table and talk to patients as they're walking by. Link workers came along. So it's, one, raising awareness that these things are available and it's a partnership also between what's going on locally, and in the pharmacy, and offering that and making it visible to customers, to patients. Also, even talking about it increases the value—that this is something that we see as important—by having those things showcased. I hope that answers part of the question.

The CHAIR: Thank you. If I could go to the nurse practitioners, because you mentioned screening in your submission as well, what happens then?

REBECCA SEDGMAN: I can talk to the screening. We do have screening available for nurse practitioners to utilise to screen for loneliness. But we're talking about, once they're screened, the resources to

then utilise those link workers or navigators to then be able to prescribe and where to prescribe to in all those local health districts. I think it's not the ability to screen that's the problem. It's the ability of the time and resource it is to then refer and look at what's available in each. So this needs to be streamlined. I can refer back to a program in Victoria, called Local Connections. That's a social prescribing initiative that's rolled out in a few local health areas—we call them local government areas; they're not local health districts like in New South Wales—in Benalla, Brimbank, Frankston. I can also share the links to that. But they're easy-click links to find what resources are available.

So the screening's not the issue, I wouldn't see. One of the key areas is to bring this to the forefront of nurse practitioner minds, to screen, because you're looking at a range of health issues and not necessarily thinking about that all the time, about how that loneliness may be affecting the most at-risk cohorts. And then, once you've screened, then where to go. If it's streamlined and the frameworks are there, it makes it easier. But, if you're working in a busy emergency department or a busy GP practice, you don't have the time allocated to then search. So these link navigators, which have been spoken about, are really useful, and they need to be easily accessible.

The CHAIR: I guess my question is the screening part—all qualified professionals, trusted professionals. How does your community pharmacist know the range of things that's out there? How does your nurse practitioner know? And then there's this idea of this link worker, and I still haven't got in my head who this link worker is and where they come from and how they're funded. The process in itself all makes good sense, but I don't yet understand that.

JENNY KIRSCHNER: I'm not sure about the funding side of it. From my experience to date, I have engaged with multiple PHNs who have social prescribing initiatives. Some of them have funding, and some of them don't, for online navigation portals, directories. But it does take work to keep them up to date, to make sure that the places that are recommended are suitable, safe, inclusive et cetera. So from my engagements with the PHNs to date—a number of them across different States—they're all at different levels of sophistication with that directory, but they're all aiming towards that. And then if the organisations aren't funded for sustainable service offerings, there's a challenge there. But that's kind of a streamlined way, I imagine, this happening—that there's a directory or there's an online portal and the pharmacist is engaged to know about that portal, confident in navigating it and then able to communicate with patients and look together and search through that, if that helps.

The CHAIR: Thank you. That's good. I've got lots of questions, lots of interest. But I will pass to my colleagues for theirs.

The Hon. NATASHA MACLAREN-JONES: Just following on on the funding, I noticed that in some of the recommendations you are looking for funding for screening tools and telehealth as well. I'm interested to know what engagement you've had at a Commonwealth level, bearing in mind the pharmacy agreements that went through last year, and also why the New South Wales Government would be looking at funding, as opposed to it coming from the Commonwealth, particularly for telehealth.

AMANDA FAIRJONES: That's a very good question. The Commonwealth Government did fund telehealth appointments and virtual care for pharmacists through the pandemic. That was for home medicine reviews, and that funding has been taken away after the pandemic, and we on the ground have seen gaps in practice, particularly in rural, regional and remote areas. We are absolutely advocating for the Commonwealth Government to put that funding back in place. However, until such point in time it does come back in place, there's gaps for the community, which is why we've put it in our submission. I think the evidence is there of the health disparities for people in rural and regional areas and those with conditions as well, where they can't get that face-to-face care. From our perspective, when putting the submission, we just want to see our patients be able to access care. If the funding comes from the State Government or the Commonwealth Government, we'd be happy to—we just would like to see funding there for pharmacists to provide that care.

The Hon. NATASHA MACLAREN-JONES: Also, in relation to the pharmacy trials which are operating in lots of the States and New South Wales—I know that most are to deal with skin conditions and other things—were any of your initiatives fed into the suggested ideas for the trials?

AMANDA FAIRJONES: Funding from a virtual perspective?

The Hon. NATASHA MACLAREN-JONES: No, in relation to the screening tools and also the training programs that you wanted to roll out.

AMANDA FAIRJONES: As in, if someone came in for a urinary tract infection, would you partner the screening?

The Hon. NATASHA MACLAREN-JONES: No. In the pilot that they've rolled out, were your loneliness suggestions ever considered or did you put anything forward at a national level to say this would be good to be also piloted?

AMANDA FAIRJONES: No, not as far as I'm—not for the New South Wales pharmacy trial.

JENNY KIRSCHNER: I was just going to make a comment. This program just launched in August 2024. So it's probably missed the timing, I'd have to assume.

AMANDA FAIRJONES: I think Jenny's 100 per cent right. It wasn't on the radar. And the New South Wales pharmacy trials have largely been based on the Queensland pharmacy scope-of-practice trial.

Dr AMANDA COHN: I had a couple of questions. I'm following up from the Chair's line of questioning. I'm also interested that if we're rolling out a large-scale screening program, that needs to be followed up with intervention. The PSA, in your written submission, you've recommended mental health first aid training as well, which intuitively makes sense. I'm interested to know if that has been trialled, if you've got any evaluation measures for the success of mental health first aid training for pharmacists.

LILY PHAM: In recent years a lot of university providers now also have the funding to provide mental health first aid training to their students. Mental health first aid is only—you get the accreditation for three years and then you need to then refresh it. For the newer graduates and the early career pharmacists, many of them do have that mental health first aid training. But it's the backlog of the pharmacists who have graduated earlier than that that will require mental health first aid training. From an evaluation standpoint, I know that there has been some funding in different States for mental health first aid for pharmacists through the PSA as well. Ms Fairjones, would you mind speaking on that?

AMANDA FAIRJONES: Not off the top of my head, but I could absolutely take that question on notice and go to our teams and see if there has been any formal evaluations done on mental health first aid training for pharmacists.

The Hon. SCOTT BARRETT: There was a hand up for a long time from one of the online witnesses—Ms Boase, I think, was it?

LEANNE BOASE: Yes, that was me.

The CHAIR: Thank you, Mr. Barrett. My apologies, Associate Professor Boase.

LEANNE BOASE: That's alright. A few times through that, I did have a few comments, which might now seem a little disconnected from where we're up to, but I did want to talk a little bit about the nurse practitioner role being very person centred. I think that's a good starting point for how we approach this. Those first points of contact, health professionals such as pharmacists and nurse practitioners and GPs even, embedding into training—we have very much embedded into our training a person-centred approach to assessment and to health care, not a problem centred.

Similar in a way that you might come into a pharmacy with the intent to have your prescription filled and the pharmacist might carry out that task of filling your prescription, the patient might learn to understand that the pharmacist is going to be looking at them as a person and might want to engage with them around their health more broadly, also that pharmacists are ready to engage with that whole person and look at them as a whole person and not just an occasion of service. That's something that we would be aiming for and probably exists already in pharmacy, but it's certainly embedded in nurse practitioner practice, where I have a person or a family come into my room and we're not there to deal with the problem; we're actually there to look at people and talk to people. That's just a different approach, because in a lot of places, like with GP clinics and with emergency departments, people are coming in with a problem to be solved. I think philosophically it'd be great to get to the point where—yes, we do have to solve problems as part of this, absolutely. But first we look at people and we talk to people and we think about what else might be going on for that person.

But it's definitely a multifaceted approach. For some people, loneliness can exist also in very heavily populated city areas. But we're also very mindful of the added risks with remoteness. One of the things that concerns nurse practitioners is funding. Currently nurse practitioners, as autonomous health professionals that can reach out to people in all parts of Australia, are not funded for home visits, for any after-hours-type services. We're not funded for medication reviews or anything like that and we're about to have our telehealth funding removed by the Federal Government, which will significantly impact on our delivery of mental health services. It will also significantly impact on people living in remote areas as they will now be required to attend face to face. Otherwise, they do not get a Medicare rebate on their service.

There are a few things—definitely at a Federal level—that the States really don't have the power to change. But pushing towards Federal Government around the needs, I know in this instance we're going to be talking about people living in New South Wales, that people in New South Wales need reasonable access to telehealth, people in New South Wales need access to funded home visits from the most appropriate types of health professionals that can meet those needs. I think we need to keep pushing in that direction and also looking for State-funded opportunities to improve as well. But I just thought it was worth flagging that that telehealth option is about to be removed by Federal Government for nurse practitioners to be able to reach out to remote and rural areas, people who can't attend in person.

Also, we have done a lot of data around the number of consultations that nurse practitioners are currently providing in rural and remote areas, and that's often the only connection that people have. From there, we can obviously build on and make more connections, but it's often the only connection that people have and they genuinely cannot afford to travel for health care nor engage with health care with private fees, nor should they have to. Frankly, everybody should have access to high quality care. That was probably a little bit not well aligned with where we're at now. But I just thought I'd like to catch up with those points based on the conversation so far.

The CHAIR: Thank you for that. We've got another hand up there.

REBECCA SEDGMAN: I just want to add to this in capturing the larger volumes of patients in our community who are experiencing loneliness and maybe they don't want to let on that they're not doing so well. Pharmacies do have a huge amount of access to patients within the community. Why couldn't we change the scripts so scripts have a loneliness factor at the bottom? If the resources do become available, and the funding, whether it comes from a local district area or an emergency department, that there's a tick box at the bottom that you need to do social prescribing and that would then be a simple way where the patient wouldn't have to verbally disclose to the pharmacist that they're not having a good time, that they're lonely and they're suffering from feeling isolated. Then that conversation can be had with the pharmacist without the person actually really needing to do much more other than maybe a referral then to a link service to be set up—just as an example of a strategy that's maybe easy to accommodate, perhaps.

JENNY KIRSCHNER: I just wanted to say that what I've seen and what I truly believe is that all health professionals, amongst others, actually need to know about the issue. Whilst we've heard from lots of people all in the last three sessions I've listened to who are very well versed and have a good understanding viscerally about it and are well read up, most of the health professionals don't actually—they might know the word "loneliness" now, but they don't know the nuances. They might not know that it's different to social isolation. They might not know that there's direct and indirect measures of measurement. Just to comment—it's in my submission—I'm currently sitting on the advisory committee for TAFE Queensland, which is Queensland Health's development of a micro-credential on loneliness and social isolation more broadly. It ties into what the nurse practitioners have mentioned now.

We can all get more involved, but I think we need to make sure that everybody understands the issue and also how to have supportive conversations around it, as was mentioned, as well as knowing what referral pathways are possible and where escalation or what services are available. There's some kind of core foundation here that I wholeheartedly believe is critical. I'm speaking to organisations in Canada, UK and America also about the pharmacist training program that I've created because there's nothing that exists, but there's an awareness. The US Surgeon General has an advisory out and he calls on health professionals to be trained—again, amongst others. We all know everyone needs to play a role here, but I just think I should call that out because, whilst it's easy to talk about it, the health professionals need to understand it because then I think there's a way forward. As we've heard before, it helps to destigmatise it, humanise it and normalise it such that we can talk about it. Then we can have social prescribing on the bottom or we can just have these conversations more comfortably.

The CHAIR: Ms Kirschner, I think it was your submission that talks about loneliness and social isolation for pharmacists. I think you mentioned that—I wondered if you could speak a little bit about that. Of course, healthcare professionals are on the front line of those very delicate issues, and that can often take a toll.

JENNY KIRSCHNER: Sure. It's not specific to pharmacists. It's a lot of the healthcare professionals. A lot of healthcare professionals would avoid help-seeking behaviour, just because of the stigma and shame. It's a high burnout, lots of pressure. There is evidence, not specifically in Australia that I know of, that health professionals are at risk of loneliness and social isolation. I was intentional about adding a module in the training program that specifically addressed that. Interestingly, the comments in some of the evaluation say that they are happy to do X, Y and Z, but that they also realise that they need to do self-care better.

I, again, believe that the intention of this training program—there are a lot of pharmacists who would be feeling lonely, a lot of pharmacy international students also, and I've heard that they're experiencing a lot of loneliness coming from a different place, not having the same language in a high-stress profession and not having

time or funds to socialise. My intention was two-pronged: to get everybody upskilled, but also getting them to think about it in an indirect way that they can preserve their own wellbeing and prioritise connections, because they know that they have to. I don't have numbers, but Ending Loneliness Together has a toolkit for healthcare professionals specifically around addressing loneliness within that cohort.

The CHAIR: Could I just ask one more question about the social prescribing process? You have someone come in, they're screened, and the conversation is had either with the local pharmacist or with a link worker. That could potentially be one conversation. What's the follow-up, and what's the evaluation? How much ongoing connection is needed? As you said, the pharmacy is where often people come in just to have that conversation.

JENNY KIRSCHNER: To answer the question, this is a new space, and these models are being determined. But the way I see it—because globally, this is new in pharmacy space and more broadly. I think the first opportunity is that you can have a lot of informal follow-ups. Because these patients are generally patients who come in with chronic diseases and having medications dispensed, it doesn't have to be a formal, documented follow-up consultation. It could just be a note that you write in the dispensing history that this patient you've had the consultation with for social prescribing and that you've recommended whatever, and so when they come in, you see that. So there are ways for informal follow-up.

Some of the pilot concepts that I'm working on at the moment include a 30-minute follow-up, and I can hand over to the PSA, if we like. As pharmacists move more to consultation models, we are considering within that scope also that they are paid for service-type models, not necessarily from the customer, but it depends—some kind of funding remuneration for the time. There's an initial consult, which would be screening—and I actually think a bit more of a conversation, leaning into the uncomfortable and having that more open conversation around this—and then the opportunities for formal follow-up or referral into more formal processes. In terms of evaluation, that is also being put forward as needing to collaborate with other people who are more experienced in this space, the researchers, and whether it is just wellbeing measures or whether in time, over longitudinal periods of time, you can measure health outcome measures also. This is all being constructed currently, at the moment.

AMANDA FAIRJONES: I can probably speak from the Pharmaceutical Society's position, too, on social prescribing. When I say position, we don't have a formal position at the moment. But to reiterate what Jenny said, our policy, as an organisation, that we're looking at and what our policies might be, there are many things that need to still go into place, from high-level principles—that will be collaboration between all members of the healthcare team, including pharmacists—training for pharmacists, as well as development of a clinical governance framework, and also the involvement of government will need to provide support. At the moment, from high-level principles, the PSA has expressed a preference to place an emphasis on piloting and evaluating pharmacists in social prescribing. This is to make sure that it's effective, scalable and sustainable. With our partnership with Jenny, we are working with PHNs and hoping to develop pilots on the ground at a PHN level to do that.

LILY PHAM: I guess I might just add quickly as well. A lot of the pharmacists prescribing pilots at the moment have an embedded follow-up service integrated into that framework and that prescribing protocol. That's something that is a possibility with loneliness. On a more slightly off-topic but very adjacent tangent, in Canada—specifically, in Nova Scotia—there is a first-of-its-kind program called the Bloom Program. That is a program that's pharmacist led and looks at the management of people with severe and persistent mental illness, not only around medication management but some of the elements of social prescribing embedded in there. That was piloted with good success and is now embedded as part of that district's day-to-day services, as business as usual. I can definitely look into some of the research findings behind that and put that on notice too.

The CHAIR: That'd be great. Thank you.

JENNY KIRSCHNER: Sorry, I could provide—there has been a project done overseas where they use pharmacists for screening of loneliness and social isolation. There's one paper, and I could submit that paper as evidence, if you'd like.

The CHAIR: Yes, please. That's probably a good point at which to say thank you. We have come to the end of our time. You've all been very generous with your time, your evidence, your submissions but also in agreeing to take things on notice and to provide those to us. The secretariat will be in touch with you about that. Again, thank you so much for your time and expertise today.

(The witnesses withdrew.)

(Luncheon adjournment)

CORRECTED

Mr CAN YASMUT, Executive Officer, Local Community Services Association, affirmed and examined

Ms MADDY WILLIAMS, Policy and Research Manager, Local Community Services Association, affirmed and examined

Ms NATALIE MEYER, Manager, Nimbin Neighbourhood and Information Centre, affirmed and examined

Mr JOEL ORCHARD, Chief Research Officer, Wardell Core Inc., affirmed and examined

The CHAIR: Welcome to the hearing. Thank you so much for your time this afternoon and for your submissions. Would you like to begin by making a short statement? Perhaps we will start with Mr Yasmut.

CAN YASMUT: Thank you for inviting us and for considering our submission. Let me start by introducing ourselves and our membership, before outlining what we see as the critical role of neighbourhood and community centres in addressing loneliness and social isolation. LCSA is the peak body and membership organisation for neighbourhood and community centres in New South Wales, and we are advocates for the practice of community development. Neighbourhood centres are place-based, locally governed community organisations, and our 170 members constitute the largest community-led social infrastructure network in New South Wales. Among many things, neighbourhood centres facilitate community development projects, deliver social services and are an integral part of disaster and crisis management, responses and recovery.

In recognition of our and our members' submissions to this inquiry, we would like to take this opportunity to highlight five key concepts. One, loneliness and social isolation are separate, yet closely related, concepts. Two, social infrastructure reaching lonely people on a neighbourhood level is essential—by "neighbourhood level", we mean lower than local. Three, loneliness is as much a social issue as it is a health issue. Four, addressing loneliness requires a community development approach rather than a service delivery response. Five, measuring loneliness and the impact of strategies is a complex issue and requires a whole-of-community and whole-of-government approach. We have expanded further on these concepts in our submissions and in some supplementary information that we had promised and that we would like to table here today. We welcome any questions from the Committee to further explore them today and beyond.

The CHAIR: Thank you very much, Mr Yasmut. Ms Meyer, did you have an opening statement?

NATALIE MEYER: I'm assuming you've all read my submission, so I don't want to go back over that. I'll just concur that it's a growing issue. Loneliness and social isolation are not the same, but there's quite a strong link between them, which we found in Nimbin when we did our survey. Our health and wellbeing survey indicated that certain demographics—in particular, men—were less likely to be connected, less likely to feel belonging, less likely to be involved in community and less likely to volunteer. Then, when we did our subsequent loneliness survey, one of the key demographics that was saying they were lonely and experiencing loneliness was men. There is a strong correlation, but they're not the same. You can be quite isolated and not lonely, for example. In Nimbin—and this seems to be the case across other rural areas—the number of people living alone has risen alarmingly and currently is at 46 per cent, compared to the national average of 26 per cent. There's something in that that we need to delve into more if we have the time and the resources.

Even though neighbourhood centres and community centres are funded to provide a range of services and programs, the best work that we really do in this space is largely unfunded, unacknowledged and not understood very well. We understand it really well because we've been doing it and it's our best work. I've given you some examples from Nimbin of that kind of work. I've been in the job for 25 years, so I've got the benefit of some longitudinal understanding of the problem. I've seen lots of services and programs come and go, be in favour and fall out of favour. But the key to it is having that social infrastructure on the ground for the long term that's in it with the community through thick and thin.

In our community, at the neighbourhood centre, we also experienced the bushfires in 2019. We also experienced COVID. We also went through the floods with our community all together through thick and thin. It's that constant presence on the ground over a long period of time as a key resource for your community. That is what social infrastructure is. It's really important to have that, not just services and programs. A lot of what we do is just about being there for people when they need someone to talk to or somewhere to hang out that's not problematic. We take them away from what they're dealing with and they can sit around and talk to other people. A lot of that stuff isn't really counted and isn't really valued, but that's the key to dealing with this issue of loneliness.

The CHAIR: Thank you very much. Mr Orchard, did you have anything to add for an opening statement?

JOEL ORCHARD: Yes, thank you. Much like the other neighbourhood centres, our community facility offers the same sorts of supports and services. What I was really hoping to press home is the context that our neighbourhood centre was established in, in the response to the 2022 floods in northern New South Wales. We're uniquely positioned with a context that is almost exclusively disaster recovery focused. We witnessed firsthand the devastating impacts that social isolation had on people's health and wellbeing, but also the dramatically increased risk, especially to loss of life, during the initial emergency response efforts. I'm sure you would have seen and heard stories on the news about senior citizens living at home who were rescued off roofs or stuck in roof cavities. The extreme nature of risk during a disaster like that when people don't have other people who are looking out for them, they don't know their neighbours or they don't have people to call in those kinds of crises is really quite profound.

Through the past two years, we've really seen how people who don't have strong social networks are so much more disadvantaged when it comes to their mid-term and longer term recovery. We see that from a social and mental health perspective but also in terms of connections and resource allocations. It's very apparent in our community now, three years after that disaster, that people who are living alone or have struggled with social connection are languishing in their disaster recovery. Some of those people are still living in incredibly subpar living conditions. By comparison, those who have strong family networks and strong social networks are making much greater progress with their recovery. I think that those two points in terms of the increasing risk of catastrophes and the frequency and intensity is really important not just in New South Wales but Australia wide.

The third part of our work in the disaster space is preparedness. Building social networks for people has really improved people's prospects for future incidents, but it also makes people feel calmer and safer and helps them deal with long-term traumas that they've experienced from previous disasters. We're embedding things like phone trees and local neighbourhood networks for people and making sure we're very aware of, throughout our entire rural community, where people are excessively vulnerable—where there are senior citizens living at home, people with mobility challenges or people with psychological challenges that aren't always across what's happening in the wider area when there are extreme weather events. It helps us, as a community, respond to their specific needs.

What I've seen is that community and neighbourhood centres are frontline workers, but because we don't have flashing lights and uniforms, we're often overlooked as a part of that really important disaster recovery ecosystem. All of those skills, knowledge and expertise that we've developed as a professional volunteer force translate to other forms of disasters, which we've seen through COVID. Our community has gone through the whole cascade, from droughts to floods to fires to COVID. They've all happened in one place in the last 10 years. It's increasingly important that small communities are better prepared and have the investments to build that social infrastructure. We noticed in our community how extreme that is, because there was no neighbourhood centre before the floods and we've had to build this from scratch thereafter. We've had the benefit of a very strong comparison over a very short amount of time. I'm very happy to answer any more questions that you have.

CAN YASMUT: Chair, may I ask a question?

The CHAIR: Certainly.

CAN YASMUT: We had actually prepared an opening statement to be shared between Maddy and myself. So if you wanted to hear the complete opening statement, then I would like to ask for permission for Maddy to speak and complete it.

The CHAIR: Certainly. My apologies. Often it's one person from each. My apologies, Ms Williams. Please, carry on.

MADDY WILLIAMS: That's okay. As you've just heard, neighbourhood centres as place-based social infrastructure have this essential role to play in alleviating loneliness and social isolation locally. We know this because they're already doing it, in the ways that you've just heard about. They have to navigate that work around inflexible, underfunded, time-limited programs; insecure staffing; and a lack of resourcing to keep the doors open. Yet they still do it, because facilitating social connectedness is in the DNA of neighbourhood centres. They are a universal access point with a no-wrong-door policy. As builders of trusted relationships and holders of local knowledge, centres help lonely people regardless of if they qualify for funded programs, and they can quickly detect shifts in community loneliness, as many have since the onset of COVID. Neighbourhood centres know how loneliness and social isolation pose dangerous risks before, during and after natural disasters, and they know how to support their communities through these challenging times.

We believe that one of the most important steps the Government could take to reduce loneliness is to provide universal core funding to neighbourhood centres. This would enable them the staffing and the remit to respond to social isolation and loneliness, however it manifests in their communities. We accept that it is

politically unpopular, verging on impolite, to ask for money, but this epidemic can't be managed effectively while ignoring poor resourcing presently and in the future. We'll leave economic costs of loneliness to the economists, but what I will say is this: There is an economic cost to the status quo. These costs are felt deeply in the healthcare system, in social services and in lost productivity. And the human cost is unquantifiable: suicides, preventable deaths, and families and communities hollowed out by disconnection.

We invite the Government to test the responsiveness of our social infrastructure network and the capability of neighbourhood centres to address loneliness locally by adopting our recommendation for a loneliness investment fund. It would involve a one-off $20,000 investment into every New South Wales neighbourhood centre to address loneliness as they see fit and funding to LCSA for research and evaluation. We are confident this investment could be rolled out efficiently and that it would provide invaluable local insights and solutions. Let us show you what we can do.

The CHAIR: Thank you very much. And my apologies again, Ms Williams.

The Hon. ANTHONY D'ADAM: Thank you for your appearance today, Mr Yasmut. You mentioned in your opening statement that there's a difference between a community development approach and a service delivery response, and that only a community development approach would be able to adequately respond to loneliness. Could you elaborate on that further for us?

CAN YASMUT: Certainly. First and foremost, they are not two concepts that are happening in isolation. We have an experience of most of our members being good service delivery agents, receiving funding from government to deliver services as we know them in different spaces of the human services sector. Service delivery, by its very nature, is a very deficit-based model because it looks at what is wrong with people. It looks at what are the issues that need fixing. People are treated as clients or consumers and funding measurables are often then based on what difference did we make to a person's individual experience.

Community development sits very much in contrast to this. The contrast is such that it is a practice. It's a very accepted social work and also community organising practice that looks at a strength-based approach, taking the person as a whole, not just what's wrong with them. There is a very famous fable that I think illustrates this very quickly, as a bit of a shorthand here. If someone goes hungry, you can give them a fish and the person won't be hungry in that moment. But if you teach them how to fish, they will be able to not go hungry ever again. I think that is the relationship between community development and service delivery.

We, as proponents of community development practice in New South Wales, know that in our neighbourhood centres workers apply a community development mindset when delivering services. They are not mutually exclusive and they are not necessarily one better than the other, but community development is very much dependent on local presence, local relationships, and on the fact that we need to probably honour the fact that processes often are not funded. To get to trusting relationships with the most vulnerable people in our communities takes time and it takes effort. It's called community development work for a reason: It is actually work. But that is often not recognised in funding models and in the way that human services roll this out.

When we think about loneliness as an issue that is of epidemic proportions, what we do know is that—as we've heard from our members and from Maddy's opening statement—it often comes down to those relationships for the local presence. It is often on a neighbourhood level and bringing people together and giving them a place and spaces where they can gather and be themselves and also connect. I don't know if that answers your question, Mr D'Adam, but that's where we feel that community development, as a strength-based approach, will empower the communities that are affected by any solution to have some agency and ownership over the solutions that might work for them. Often with service delivery models there is a top-down component to that that looks at fixing people rather than empowering them to take care of their own issues.

The Hon. ANTHONY D'ADAM: Perhaps you might be able to elaborate on the idea of community development with some practical examples of how it's applied. Maybe this is something that the panel members might be able to do.

NATALIE MEYER: I've got millions. A really good one is the Death and Beyond group. Death and Beyond is a grassroots group in our community, and the neighbourhood centre auspices that group. We basically provide the scaffolding to enable that group to happen. We deal with the money; the money goes through our accounts. We deal with invoices and we deal with the cost of that group operating, but they basically do their own thing. Their main goal was to get a cool plate—a cold plate, a cold bed—which you use when somebody has died. It's to enable a home death without the stress of dealing with the deceased loved one, because you have this cold bed that you put the person on after they've passed away and you can hold them at a constant temperature, which is minus 34 degrees approximately, for up to five days in New South Wales under the law, which allows the family

time to gather, say their goodbyes and make the arrangements for the funeral without that pressure of someone having just died.

This is way outside the scope of any kind of service delivery model. The person has already died. It just doesn't fit into anything at all, but it was something our community identified as needed. Off the back of that, because we have that cold plate, there was a series of 12 information sessions every weekend just recently around death and dying, ways of dealing with death and dying, processes and all sorts of stuff, dealing with wills and estates, dealing with the people you have to deal with when someone has died, dealing with coroners—all sorts of information. For an ageing community, there was an incredible amount of interest in this and loads of people have been going to these workshops.

We also used the cold bed, apart from what it's actually used for—by the way, it has been used four times so far since we bought it—as a tool to promote the conversation around the issue. That is pure community development. There are no dollars in it. There's been no funding. It's got nothing to do with funding. We're not measuring outcomes. But it has definitely brought the community together around the issue of talking around death and dying, which is a bit of a taboo topic but it's something that we all have to go through. When you're dealing with an ageing community, it's definitely a topic of a large amount of interest. That's a classic example of a community development activity—it's been going for some 12 years now—that would totally fly under the radar. Nobody would really realise that we're doing this. The neighbourhood centre has the cold bed, so we're the ones that make the arrangements if someone needs to use it, which means being available 24 hours a day because people don't necessarily conveniently die during business hours.

The Hon. ANTHONY D'ADAM: Mr Orchard, did you have something else you wanted to add?

JOEL ORCHARD: Yes. At the other end of the spectrum, we found there was a massive gap for young mothers, especially new members to the community, and that there wasn't the social infrastructure for people to have that kind of peer support network. We found quickly after the disaster that there was a group of mums presenting with very common traumas. There were a couple of mums that were pregnant at the time of the floods or had just had infants. It was an extremely stressful situation for them to be homeless and without all their possessions and raising brand-new little babies. A couple of them were new members of Australia as well. So they informally started a mums and bubs support group, which then organically evolved into a formal playgroup.

As a neighbourhood centre, we were simply able to just provide that facility and support them. We had a counsellor available at that time, so we allowed them access to someone who was qualified to offer mental health support. And now, three years later, they're quite an independent group of mums. They gather quite of their own volition. They've organised more formal playgroup services and support with other family services. They meet regularly, independently of our organisation. They've built a very strong peer support network, which has not only provided the classic playgroup support services but it has identified a number of women in the community experiencing domestic violence. It has provided them with additional layers of support. We've been able to resource mothers that didn't have access to nappies and clothing for their new infants, and the mums are now sharing resources together. I think that's a really beautiful example of just that little bit of impetus that has allowed something to happen now quite naturally all on its own, and they've really shown for themselves a strength-based model.

The Hon. SCOTT BARRETT: Mr Orchard, I have a couple of questions for you about the disaster recovery stuff, unless you have some strong objections to this view. Social connectedness obviously helps prevent and battle loneliness, and organisations such as yours help build on that connectedness. Given what you saw during the floods and after the floods, I guess I want to go on that journey of the strain this places on the need for these organisations and the sort of surge and fatigue. When you look up where there were floods, the first thing you see is "North Coast town comes together to heal". In the initial instance, there's this big surge of connectedness that I feel going through—this example and my other experiences in drought and flood, and fires and stuff. Can we first touch on that? I'm then guessing that after a time that fatigue starts to break down some of those organisations that people have become so dependent on, which then leads to higher risk of loneliness. I'm putting what I'm after out there up-front to see whether you concur with that and can add to that.

JOEL ORCHARD: Thank you for the question. I guess maybe there's two points for me. Maybe we're unique in our example. In Wardell we lost our local pub, which was flooded and destroyed and hasn't reopened. That was essentially the only primary gathering point for the entire village. We lost three local primary schools in the area, and we lost those school communities. What they call the sports and rec club has now been turned into an emergency accommodation site, and that was the other sort of formal gathering place. Wardell Core evolved in a vacuum of spaces for people just to come together, and we were able to layer that with all of the disaster recovery ecosystem that was necessary, not just social connection. There was all the government services and mental health and food relief and all of the rest.

But what I think we've witnessed is the community have really identified just how valuable what they have created and enabled to happen in their community is, to the point that they're desperately clawing on and fighting to maintain that service. They see that as such an essential part of the community infrastructure now that they're quite desperate to maintain this neighbourhood centre, even though we now no longer have any funding related to the disaster at all. We're in a point of transition ourselves, looking for how we can sustain what's now believed to be fundamentally important. Many would argue that it's a fundamental right for a community of our scale to have a social gathering place, and especially in the absence of anywhere else to gather.

I don't believe that we can just sort of wind up or is there even actually fatigue. In fact, there is probably now more enthusiasm to maintain things that people have found such great pleasure and such great relief in having access to. To my original point, it's just that it's in such stark contrast—from having nothing before the disaster and then going through that catastrophe to now having something that everyone has been able to co-create. People feel a really great sense of ownership over that and are very committed to keeping it.

The Hon. SCOTT BARRETT: You're sort of the phoenix that came out of the ashes. But if an organisation such as yours wasn't there, what fears would you have for the community?

JOEL ORCHARD: I think we can most certainly say we have reduced dramatically the risk of loss of life to suicide. There have been a number of suicides in the community which have rocked everyone. That's sort of Northern Rivers wide, but we've seen it in our local area. I think the risk of social damage that's related to the exacerbation of substance abuse and domestic violence that follows natural disasters, we've been able to alleviate quite dramatically. Being able to create access to services that simply wouldn't have been available in our rural community at all I think has made enormous impacts on people's lives, their health and their ability to recover.

I think it's really quite frightening to think had there not been a community-led organisation that could have provided that support service in our absence—because, unfortunately, all other government services and existing services are still in many regards completely at their existing sort of breaking points. We can't make referrals because all of the surrounding mental health services are full. The combat agencies and all of the relief agencies were overwhelmed with need, and spontaneous volunteers and community were able to step into all the gaps that existed. Because we're small and agile, we're able to fill them very nimbly.

Dr AMANDA COHN: I'm just picking up on this line of questioning around disasters first. You've made a very strong case for the role of your neighbourhood centre in disaster recovery and disaster resilience. Where do you fit at the moment in terms of the Government's disaster recovery framework and the way that those things are funded?

JOEL ORCHARD: In the Northern Rivers, I would say all the neighbourhood centres have been like the frontline service and have been the remaining frontline service following the disasters. They didn't sort of come through and do the clean-up and then leave. They're still fighting for people's recovery. I would say that in the vast majority of cases the clients and community members that are using our facilities are still accessing that because of the impact of the disaster. We're here for the long game, whereas, traditionally, the recovery services sort of come and go. We've finalised all of the grant funding that was available for us from both Federal and State government specifically for disaster recovery. That came to an end at the end of last calendar year.

So now we're sort of evolving to how do we meet the ongoing need without any dedicated relief or disaster recovery funding. We'll look for grants and philanthropy and social enterprise opportunities in order to sustain the most critical services that we offer. But I think it's very, very clear that the scale of disaster was not met equally by the amount of resourcing, especially for services like ours. Disaster recovery is a very long-term thing. It doesn't happen very quickly. The 2022 floods were unparalleled in their scale. To say that a disaster of that nature can be wrapped up in two years when we still haven't seen houses which are condemned demolished in our street—people are still living in houses without kitchens and bathrooms. We've been going through the process of doing that in the past 12 months, and yet there are still so many more. So I think there's a long way to go yet.

Dr AMANDA COHN: I've got a follow-up question, if I may, and anyone's welcome to answer this. This kind of scrambling for funding and trying to find philanthropy or short-term grants—what impact does that have on the neighbourhood centre itself and the ability to do that core work?

JOEL ORCHARD: I assume most people would say the same. The amount of wasted energy just going through the process of applying and then you're in such a competitive field of need, it's exhausting. It means that we're totally taken away from the focus we're established for, which is to help people. I spend so much of my time doing the applications to be rejected. Even by that, we'd say we've had a really high success rate of getting funding, and yet you're just chasing your tail all of the time. Some stability and some base load funding would just mean

there's someone always dedicated to be out looking for funds and navigating those stakeholder relationships, which are essential to our financial resilience.

NATALIE MEYER: I would say in our neighbourhood centre that we've been on the ground for 50 years providing a very wide range of services and also community development activities. Community development is where we started. To really bring it down to dollars and cents, my role as a manager is funded for 21 hours a week; I work up to 50 hours a week. I don't think there are many generations coming behind me that are going to step into that role and be willing to do all that unpaid work. A lot of that work that I do that's unpaid is, by definition, unproductive. It's a lot of time spent frigging around trying to find enough resources to pay my own wage, to pay the bookkeeper, to pay the rent, to pay the basic costs of keeping the doors open, because we're not allowed to charge that to funding. We're only allowed to charge 10 per cent admin. But there's an expectation that we will deliver services to a very high professional standard, which requires proper financial management. But nobody wants to pay for that.

It's becoming a situation where it's, firstly, a lot of time spent—for someone highly skilled like me, I should be out in the community working with my community, but I spend a large amount of unproductive time trying to find the resources just to keep our doors open. I can't remember what I was going to add to that. I just think that there's a real problem with productivity loss in our sector that we've got very highly skilled people wasting a lot of time chasing their tail around in circles.

There's also a lack of recognition of what is expected of us in contemporary times in terms of professional management, of services and of when we deal with very highly vulnerable clients, some of whom are going through multiple complicated things involving sexual assaults, domestic violence, all sorts of crimes, substance misuse and all sorts of complicated problems. We have to have a very high professional standard, but nobody is willing to pay for that. We're expected to deliver that off the back of volunteers or people like me who have three degrees. We're expected to work millions of unpaid hours just so we can keep the doors open.

I think it's really important to eventually confront the importance of having this social infrastructure on the ground. Again, that social infrastructure versus services—they're two different things. Having that continuity of social infrastructure on the ground is what enables those services to come in and be able to deliver from. It's the basis of all of that work. If we get forced out and there are no more small, locally-based organisations on the ground, there's no-one with those really deep connections with their community. There's no-one that can actually find out what is actually going on because nobody trusts anyone enough to actually talk to you. We are well trusted. We can find out in three days what 96 people reckon about loneliness in our community. That's because we have the reach in our community, we have the trust and we have the ability to talk to the people in our community. I don't think these things can be undervalued, but they are undervalued. That's the reality of it.

Dr AMANDA COHN: Mr Orchard, you mentioned that the two-year funding that you had from flood recovery ended at the end of the last calendar year. How are the lights on at the moment?

JOEL ORCHARD: We work very closely with a local philanthropic foundation, which has offered us enough funding to just pay our overheads. That has maintained the door open status. We are actively promoting fundraising efforts for this year. We've rallied a great group of our volunteers together to look at various ways we can raise funding—everything from Bunnings barbeques to looking at social enterprises and little old ladies who like to make jam and chutneys. Every little dollar is counting at the moment. We're doing all of that without any staff. This year we're a completely volunteer-run and -led organisation, which will be very difficult. But I think there's great momentum for it.

The Hon. NATASHA MACLAREN-JONES: Firstly, I just want to thank you all for everything that you do for local communities. I wanted to follow on with questions around disaster recovery, maybe starting with Mr Yasmut and then also more localised around the Northern Rivers. I'm interested to know, post a natural disaster—looking at the two years or three years from the floods now—what is the demand for services and for people coming forward now that may not have reached out for support in the initial crisis period?

CAN YASMUT: Thank you for your question, Ms Deputy Chair. We have done some research that is practice-informed through the work that our members have been doing over the years. We had the privilege to actually visit some centres together not long ago, where we know that it is actually the local community organisations, like neighbourhood centres and community centres, that are there before a crisis, they are there during a crisis and they are there in the long term for the recovery as well. The interesting thing that our research and policy position is actually assessing is that we know that community development is the type of leadership and the way of doing things before a crisis happens and in the long-term recovery. When the crisis itself is actually imminent, we need strong, autocratic, government-led leadership to deal with the issue at hand. Dealing with a catastrophe is essential. I think we are very fortunate in Australia and in New South Wales as to the services that we have, and I honour them.

But just like Joel was saying a little bit earlier, there is a very sudden point where emergency services and that emergency crisis management mindset actually disappears. It is not long after the media disappears. It is not long after overwhelming donations into a community disappear. People feel they have done what is needed to get past the crisis point, but then there's the long-term recovery. I would like to just entertain one thought, and that is probably, from an analytical point of view, something that the academics certainly have approached LCSA for and said, "This is innovative. This is interesting thinking." The point that I'm trying to make here is that we're dealing actually with a web of trauma in communities, especially in long term. That has to do with the fact that it is more often than not that a community experiences more than one crisis at any given point in time.

Loneliness is an epidemic. COVID is a pandemic. There is maybe a drought happening that has a very slow way of creeping into people's lives. You have a bushfire which can come very suddenly and actually crash people's lives very quickly. We have community organisations on the ground trying to navigate this idea of "We are community development organisations one moment, then a crisis hits and we have to do emergency relief, then we want to pivot back into community development community rebuilding mode and, just as that is happening, another crisis hits and we are in crisis mode in relation to another one." You have this compounding effect, Ms Maclaren-Jones, that is affecting communities as a traumatic experience rather than just individuals.

Speaking from personal experience, it took us and my family years to actually be able to deal with a traumatic event due to a natural disaster that happened to our own property. It took us five or six years to actually get to the point of saying, "Hang on a minute. What about us? How are we dealing? How are we feeling?" Neighbours were running towards our home when another tree was falling down, thinking it was our home. The community, the neighbourhood, was traumatised, although people themselves were not being affected. That brings me back to the community development aspect of addressing these epidemic issues like loneliness as well. It has an effect not only on the individuals that are affected—and certainly not in crisis—but there is a long-term issue. I'm a firm believer that it is that community development, community building and the trust for relationships on the ground that can help navigate this web of trauma that happens in small communities in particular.

NATALIE MEYER: Even though it's contrary to our argument about we all need more resources, some things are not about money. Obviously, when people get affected by disasters, a lot of people need money to help them rebuild and get their lives back together. But some of it's deeper than that. After a disaster, you get a lot of social fracturing, for example. Some people don't get affected and some people do get affected. There's a fracturing between the people that got impacted and the people that didn't. There's a fracturing between the people that were more resourced or had insurance and those that didn't and between those that get grants and those that don't and those that get the house raising and those that don't. There is a lot of fracturing that goes on.

Again, this is where social infrastructure comes into it. This is much bigger and much deeper than just, "Did my house go underwater? Did I lose everything I own?" This is about the actual fabric of your community breaking apart. That's very long-term work to bring the community back together again after an event like that. We in Nimbin specialise in this, and we just did a project specifically around that to address disaster fatigue and to try to address that kind of fracturing that had happened because of the disaster and try and bring the community back together around stuff we were doing before the series of disasters affected us, starting back in 2019. So we went back to our community planning processes that we'd neglected since 2019 because of the bushfires and COVID and the floods. And so we, the neighbourhood centre, were the leaders and provided a leadership role in bringing that community planning back to the table, bringing the community back to the table to look at bigger-picture stuff and to try to address some of that fracturing that happens post-crises, post-disasters and things like that. Again, this is a social infrastructure thing; it's not a service delivery thing.

Dr AMANDA COHN: The LCSA indicated that they wanted to table some documents.

The CHAIR: Yes. They mentioned that in the introduction, so we'll get those tabled. We are at the end of our time, regrettably. Thank you very much for being here today. It's quite a distance to travel to be here. We appreciate it. We appreciate your submissions and also, as Mrs Maclaren-Jones said earlier, all of the work that you do every day. Certainly, we will take the documents to be tabled. If there was anything taken on notice—I can't recall there being—the secretariat will follow up with that. We might also send you some follow-up supplementary questions. Thank you so much for your time today.

(The witnesses withdrew.)

Ms SARAH MATHEWS, Chief Executive Officer, Little Big Foundation, affirmed and examined

Ms HOLLY REYNOLDS, Board Member, Little Big Foundation, sworn and examined

Professor XIAOQI FENG, Professor of Urban Health and Environment, University of New South Wales School of Population Health, and Founding Co-Director, Population Wellbeing and Environment Research Lab (PowerLab), affirmed and examined

Professor THOMAS ASTELL-BURT, Professor of Cities and Planetary Health, University of Sydney School of Architecture, Design and Planning, and Founding Co-Director, Population Wellbeing and Environment Research Lab (PowerLab), affirmed and examined

The CHAIR: Welcome, and thank you for making the time to give evidence this afternoon. We appreciate you being here. Would you like to start by making a short statement? Perhaps we start with the Little Big Foundation.

HOLLY REYNOLDS: Good afternoon again, and thank you for the opportunity to speak with you today. At the heart of our mission is this belief: that social connection is the fabric of our society. Connection, the opposite of loneliness, and community are skills to be honed and muscles to be flexed for most people. But too many of us lack the opportunity to flex this muscle. We've seen the power of connection firsthand at our work at the Little Big House in Summer Hill. It's a community hub that we opened in 2021, which hosts more than 90 community-led initiatives every month. The interesting thing about this community space is that it is funded by the property developer EG and that it was launched post-completion, not a sales strategy, but a true commitment to the social cause of loneliness reduction. This begs the question, "Why aren't we incentivising the creation and ongoing support of community spaces to reduce loneliness?"

We know that housing density is growing to deal with a housing shortage, and with it comes the risk of isolation. But density doesn't have to be soulless. It does need, however, intentional design to create opportunities for connection—and this is where planning and collaboration become so important. Building homes without community spaces is like building a house without a foundation: It's unstable. Developers, councils and State departments need to embed community infrastructure and not just the hardware but the soft infrastructure, the social infrastructure, into every new development. But it's not just about creating these spaces. It's about funding their activation, ensuring they remain vibrant and supporting the people that bring them to life. I'd like to hand over to Sarah.

SARAH MATHEWS: Connection doesn't happen by accident. It needs intentionality, and it needs support. I'd like to highlight two key takeaways that we've learnt at our experience at the Little Big House: firstly, that spaces matter, but they need to be alive with activity. A leafy park is valuable, but not nearly as valuable as one alive with Saturday sport, birthday parties and walking groups. Likewise, a community centre or neighbourhood hub that is a hard-to-access empty room does nothing to reduce loneliness. And, secondly, local people need support to support their community. Individuals who want to host book clubs, craft groups or even beer-tasting nights are ready to step up. What's missing is the support to make it easy for them to do so. Traditional community spaces do a great job of servicing structured community groups, but they do little to flush out the good neighbours waiting right next door who want to lead connection opportunities.

At Little Big, we rely on our community coordinator role or our link worker, and this is something that needs ongoing funding. In addition to the many strategies suggested today, we urge the inquiry to consider strategies that support developers and corporate players to fund community activation post-completion, to consider density bonuses for developers implementing community-building initiatives and to create guidelines for incorporating loneliness prevention in large-scale residential projects. It cannot be ignored that development disrupts community cohesion, leaving people asking, "Is this still my community?" and "Is this somewhere that I will feel at home?" By making it enticing for corporate players alongside government to support volunteer-driven programs and ensuring spaces for connection, we can give people somewhere to belong, no matter how their neighbourhood evolves.

XIAOQI FENG: Thanks for inviting us. I am Professor of Urban Health and Environment at the Faculty of Medicine and Health from UNSW, along with Professor Thomas Astell-Burt from University of Sydney. We are the co-authors and also the creators for the concept called the lonelygenic environment, which is a key important paper published at *The Lancet Planetary Health*. From here, just a brief about what is a lonelygenic environment. This is environments that we describe that—the neighbourhood we live in but with very limited access or no access to any public facilities or even walking paths such as playgrounds, green space. This really isolates people and, between their neighbours, they have nowhere for greeting each other and making connections unless they drive to somewhere.

In our proposal, we have three recommendations. Number one is reframe the problem from blaming loneliness on the individuals to place or environment or context factors. This means moving massively away from currently just treating loneliness mainly by health sector to prevention. And also that means we need to work with multi sectors such as planning, transport and also with community—remove stigma from loneliness on the individual. Our number two recommendation is improving places around us, around the people. This requires us to fund the research which actually demonstrates the project, what works. Changing environment can reduce the risk of developing loneliness and increasing the social connections between each other—for example, like New South Wales Government currently launching the TOD plan, the transport oriented development. This is a great opportunity for us to learn when there's new community building and what we need to do in our place, in our neighbourhood, and also if we could work with the planners, council—if there's a new park open or even some new benches added, how does this have impact on people's health and on reducing loneliness?

Number three—what we recommend is that we need to reconnect people with their places. What does that mean? Even if you build all those public facilities, it does not mean people just go. Some will, but some people will stay disconnected, and those are the populations and communities we should really target. We should run randomised trials to see what kind of way will work—for example, the research we are currently conducting on nature prescribing and to bring people to connect with nature who currently do not spend even two hours a week in nature. Those are the three recommendations we would like to give: reframe the problem from individual to place- and environment-based factors; number two, improving our places around people; and, number three, reconnect the people with their places. Thank you.

The CHAIR: Professor Astell-Burt?

THOMAS ASTELL-BURT: That summarises pretty much what I would say too, so I endorse that. I also wish to thank everyone in the room for tackling this very important subject. Thank you.

The CHAIR: I might start with your research and the example you've given. I've got a few questions that I think are related, so I'll try to conflate them a little. You talk about connections between parks, green spaces, trees and loneliness. I think in your submission you actually say Australians with more parks and trees nearby have lower risk of becoming lonely. You have already mentioned your nature prescriptions. But what's the extant research on this? How do we know that when people spend time in nature they feel less lonely?

THOMAS ASTELL-BURT: There is a variety of studies which have been occurring for the best part of 30 years now which elaborate and expand our intuitive understandings, I think, that getting out into nature is tending to be beneficial for our mental and social wellbeing. Even as early as the 1990s there were already experiments well underway and being reported which showed that people who were randomly assigned for walks through nature versus walks through greyer surroundings had meaningfully improved levels of concentration, meaningfully reduced levels of anxiety and meaningfully reduced levels of high blood pressure. That all feeds into the work that we've been doing recently, between Professor Xiaoqi Feng and I, extending this into the work around social connection and loneliness.

For example, in a study we published in the *International Journal of Epidemiology* in 2022, we looked at data from all over the country, all over Australia. We tracked over 10,000 people over the best part of four years. We identified those who were not identified as lonely at that baseline and saw how many people became lonely at the follow-up period of time four years later. We then segmented the population to those who had high versus low levels of nearby parkland, and what we found was that those who had, within a walkable distance of home, about 30 per cent land cover as some form of parkland had 26 per cent reduced odds of becoming lonely four years later. That was in general and taking into account other what you could maybe think of as competing explanations—differences in age, income, ethnicity, marital status. But on marital status, there was an important qualifier. For the people who were living alone—now, alone does not mean lonely, but it is a risk factor—what we found was the similar amount of parkland nearby halved the odds of becoming lonely four years later.

It's very difficult for me to see any other interventions which seem to be quite so potent and quite so scalable across millions of people across our country. We can qualify this also with regard to some of the research which is found in other jurisdictions. For example, there was a wonderful study over in Sheffield in the UK which found that many people will seek time out in nature as a form of reconnection with something that they feel to be not judgemental, something that they feel to be more dependable than other humans. This is often a concomitant of loneliness where people feel wronged, they feel mistrust, they feel a lack of safety in among other people—loneliness in a crowd because people do not feel safe in a crowd. There are lots of opportunities here to say that investing in a quality, greener environment not only does the intuitive, which is provide settings for people to come together and say hello, but also provides opportunities for people to feel restoration and to take the edge off loneliness, which makes it a very sufferable condition for many in our country.

The CHAIR: That's a really fascinating answer, and your research is extremely compelling. We've heard lots of people talk about space as the chance to connect with others, but it's very interesting to hear you talk about green space as a remedy or prevention in itself. It's quite a different take on that as well. You spoke about lonelygenic environments. But in your submission you talk about equigenic environments as well. Could you speak a bit more about that and perhaps give the equivalent explanation as you did with lonelygenic?

XIAOQI FENG: We're actually conducting research. Thomas might want to say something and I can add because he is leading about the equigenic project, which was just funded.

THOMAS ASTELL-BURT: Equigenesis is another term which was actually coined a little while ago but is slowly seeping into the ether. It refers to conditions and interventions which are not only beneficial in a broad scheme but have disproportionate benefits for populations with high potential to accrue those benefits. For example, one of our colleagues over at the University of Glasgow published in *The Lancet* in 2008 a study which showed that greener neighbourhoods across the United Kingdom have lower mortality rates. This has been replicated in many countries, but what they also found was that the slope of benefit was greater in communities living with socio-economic disadvantage. Put another way, greening places has benefits for everyone, keeps people healthy and out of hospital—and we've shown this too in many studies in Australia. But there seems to be a case for the returns on investment being disproportionately greater in those communities which are more vulnerable to all of the things which we know cause suffering, including loneliness. So the point here I'm trying to make very shoddily is that greening may help everyone to stay connected and less lonely, but it may help disproportionately those who are most vulnerable in society.

The CHAIR: Thank you for that explanation.

XIAOQI FENG: I just want to add on that, even from our earlier research, we find particularly children can benefit from green space a lot more. What we were also shocked to find was that not only you need to have the quantity of green space but also quality. It does not mean you get these public facilities, but we also need to make sure it's high quality. We find that children's mental health gap actually increases. Children who always live with high-quality green space, they not only have better mental health at the beginning, but then over time the longitudinal study shows that the gap is wider between those ones with high quality and also the ones with lower quality. That's another thing; we make sure to not only just provide it but also with quality, please.

The CHAIR: It also has implications for the results that Professor Astell-Burt was talking about with regard to where you provide that green space and the longitudinal importance of that over the course of someone's life.

The Hon. ANTHONY D'ADAM: I have a question for Little BIG Foundation. It's a fascinating example that you provide. I'm curious about the capacity of or whether there are any limitations on other strata schemes adopting this model. I'm also curious about the ongoing funding arrangement, whether the Flour Mill scheme is funded through the strata levy or whether there's some independent funding source that enables it to continue providing this social infrastructure within a strata complex.

SARAH MATHEWS: I can speak to that. The way that it's structured currently is we're almost entirely funded by EG Funds still, post-completion. We don't receive any strata contribution at this stage. It is something that we'd like to do in a future development. With this particular location and the timing of the way the foundation launched, it was post-completion, so it was too late to build anything of that into the strata contracts. Speaking of green space, the site does have a large park and communal plaza, which is maintained by strata. So we have a working relationship with the strata committee and are quite heavily involved in that way, but the funding at this stage is entirely from a corporate donor.

The Hon. ANTHONY D'ADAM: Is there any legal impediment to strata schemes providing or setting up these types of arrangements?

SARAH MATHEWS: I would have to take that on notice but, to my knowledge, I don't believe so. But I would want to check that to confirm that for you.

HOLLY REYNOLDS: If I could just add to that, knowing the pressures on strata schemes at the moment, it could be an impediment. Funding through strata, maybe, but it would be something that we need to investigate.

SARAH MATHEWS: One of the challenges we have experienced, observing and working with stratas, is that with those challenges the very first things to go, as we know in a lot of organisations, are the social impact strategies. If there is a park within the strata scheme and it needs to be upgraded, it won't be upgraded at the expense of other things that need to be done for the strata scheme. Those kinds of community facilities and infrastructure will always be the first thing to go.

The Hon. ANTHONY D'ADAM: What kind of mechanism could we put in place to ensure that that kind of social infrastructure is maintained as an obligation of the scheme going forward? Obviously people paying strata fees are under that pressure. There's always going to be that impediment to erode these kinds of arrangements, even though there's clearly a collective value at an individual level. It's the tragedy of the commons, isn't it? Is there a mechanism that can be put in place to see these kinds of arrangements preserved in the future?

HOLLY REYNOLDS: Do you want to take that?

SARAH MATHEWS: My understanding is that there are certain clauses that you could potentially put in place for periods of time, but once that land or that asset is owned by that strata, it's theirs to do what they like with. Should they have a community facility and it's costing them money to operate it and they don't have that money, they would be able to close that facility. In the event they have a park that a market is operating in and that market is causing damage to the land and they don't have the funds to maintain that land, they could cease to let that market operate. I would presume there would be some clauses that you could put in place, but with community ideas and things that come forward from individuals within a community, they're the things that we find most successful as opposed to ideas that a developer would impose on day one. Perhaps there is a clause that you could put in place that gives you the ability to enforce certain things on day one, but it doesn't give you any scope for the things that will come up for the next 15 years.

HOLLY REYNOLDS: In work that I do in community engagement and community across a number of different residential developments, I've experienced where developers have established programs—not on the scale of what Little BIG does but established opportunities for book clubs, walking groups and things like that. What we have found over the years is that the community will take it over themselves, but they tend to be low-overhead, low-cost sorts of things. That is a great sign of success because that's something that's sustainable if the community will take it on for themselves. But these things are not established necessarily with the mission of combating loneliness. It's more a social opportunity, which is still wonderful, but it's often at the very front end of projects of new communities as well and used as a marketing tool and a reason for people to want to live there.

The big difference with Little BIG is that we really are coming at it from a really distinct and clear social good mission. Our challenge now is exactly that—to find out how we can ensure that the great work that has been done can be replicated and sustained for the longer term, because we have seen so many amazing examples of where it has had such deep impacts in the wellbeing of the people that live not just in the community of the Flour Mill, which is about 700 residents, but within the Summer Hill community as well, the broader Summer Hill community. Another beauty of Little BIG House is that it is about creating cohesion between established and new communities. As we see more and more new communities coming, we believe that's going to be a far more critical consideration that we need to make.

The Hon. ANTHONY D'ADAM: It strikes me that the schemes were set up with a view to adding value for the developer. It's like an intangible asset, in a way. Has there been any work done to assess the actual value of the intangible asset that's created by the scheme?

SARAH MATHEWS: It costs money to quantify things like that.

The Hon. ANTHONY D'ADAM: Presumably the developer has some sense that this is going to add a certain premium to the overall value of the property?

HOLLY REYNOLDS: It is one of those very difficult areas, and one of the speakers earlier we heard talk about this thing that isn't necessarily valued. It's really hard to put a value on these things. We know intrinsically that they add value. We hear anecdotally that if people were given an opportunity to live in this community without any social infrastructure like Little BIG, or Little BIG, they would choose to live in Little BIG. Definitely in terms of when you talk about a value add, it is that perception that it is a good place to live. Therefore, if I've invested in this place in the longer term—it's like making sure your streetscape looks amazing. People will be more attracted to somewhere that has a reputation for being a great place to live, where neighbours know each other and, in your hour of need, there could be someone there to help you or even just to say hello to on the way to the car park or whatever.

SARAH MATHEWS: In terms of specific work to track that, we can see that property values within the Flour Mill, which we immediately preside, are increasing at a greater rate than comparable properties close by. We can see that rental demand is higher for the properties that are in the closest proximity to our space. Obviously these things are not directly attributable just to the work we do, especially because we are not a gated community, where we have people coming from the entirety of the inner west and beyond what we offer. We are tracking those metrics. But to get to a point where we're able to say that we have increased the value for this developer by dollar X, it's a significant and complex piece of research that Little BIG and the developer are not in a position to do at this stage. This developer intrinsically believes that it is adding value to their brand and to the

property owners post-completion. Should we get to a point where the planning sector can see the value that a property developer can bring, they may see benefit in that process as well—but quantifying it, not as yet.

The Hon. NATASHA MACLAREN-JONES: I have one question. In your submission, you talk about some of the things that the department of planning could be doing. Have you had an interaction or have you looked at expanding around community or social/public housing?

SARAH MATHEWS: We haven't directly moved into social housing, but there are absolutely significant parallels with the aged-care sector and what they do and build to rent. I'm not sure if there's anything in particular you could talk to on that.

HOLLY REYNOLDS: We see it as an area of opportunity, definitely. There are plenty of examples in communities that have affordable housing or social housing salt-and-peppered into the tenure mix. This kind of program would be really beneficial for the whole community there. They're things that we're very interested in looking at into the future. We'd love to see that Little Big becomes almost a template for how to create community but also tailored to where those communities are and who is living there.

SARAH MATHEWS: But from a social perspective, one of the huge benefits that we have in our space is that it's a very high-end fit-out compared to a typical neighbourhood hub. Because of that, we run a safe space for people feeling at risk of suicidality, depression and loneliness simultaneously with a yoga class, a beer tasting group, a book club and a life drawing class. The venue itself and the space doesn't necessarily hold any stigma or separation because of economics within the community. You can genuinely be anyone coming in for anything, and you don't need to walk in with a label on your head to be accessing a service. Loneliness, whilst it definitely is exacerbated by income level and a whole bunch of other factors, also doesn't discriminate against age and wealth. We are open to anyone. Within this new development, we are able to kind of democratise that space in a really nice way.

Dr AMANDA COHN: This morning I asked Associate Professor Baker from ASPIRE a question relating to a study that he'd cited in the ASPIRE written submission. He advised me to ask that question to you. I now realise it's because it was your study that was being cited in that submission that I tabled this morning, which was the *International Journal of Epidemiology* paper. I was particularly interested in the nature-based solutions. In a more practical sense, what are the barriers to that happening now? This is such compelling evidence, and it's something that we should be doing. Why is this not already happening?

THOMAS ASTELL-BURT: To some extent, it is already happening, but it's not evenly distributed. There are some parts of Sydney which have green spaces where communities are eminently flourishing. One that comes to mind is not too far away from here, in Zetland, near Rosebery and Green Square. Go there on any evening during the week and you'll find people dancing, people walking their dogs, people jogging and people just standing around having chats. It's difficult to see that in a lot of other suburbs. Why? Because this one has a green space at its heart. It's walkable, it's well lit, there are benches everywhere and there are good things to walk to nearby. I don't live there; I'm not being sponsored by it. I just think it's an interesting place.

In Rhodes as well, along the riverbank in the evenings, when a lot of people don't feel safe to go outside, people clearly feel safe to go outside and be part of their local community there—dancing, boxing, kids on scooters and all the rest of it. It's an intergenerational experience. The answer to your question is that it's not evenly distributed around the country, particularly in lower socio-economic communities, where there are perhaps a lack of these sorts of resources or people don't feel safe to go outside to meet with their fellow neighbours.

XIAOQI FENG: I just wanted to add on top of what Thomas said. Some areas don't have those facilities, but this is also not in our health system. You go to see a GP, for example. It is rare that someone will issue a nature prescription. Imagine if we actually have this item, this code, in our MBS and our PBS system. This will potentially enable a lot of people to get bulk-billed and to get a nature prescription. We really need to review our health system as well and make sure this is not just for someone who could afford it, but that it's for everyone.

Dr AMANDA COHN: I've also got a follow-up question from Mr D'Adam's questioning around strata schemes. A different Committee recently had an inquiry into local government finance. There was this question of developer contributions not being able to be required for social infrastructure like public libraries. You're nodding. Is this something that you've looked at? What other options or levers does the State Government have to promote or incentivise the creation of these spaces?

HOLLY REYNOLDS: The detail around contributions is probably beyond my expertise, but it's certainly something that we've been discussing in terms of not necessarily looking for more funding but potentially there are already developer contributions that could be directed in different ways. Where—for example, with the 7.11s—it's a contribution towards physical spaces, potentially there is an element of that that could be directed toward ongoing funding to provide, like Sarah was mentioning, the link worker.

SARAH MATHEWS: Link workers or the community workers, yes.

HOLLY REYNOLDS: One of the wonderful things about Little Big is the volunteer machine that is powering it in order to be able to deliver 90 events a month. It's quite extraordinary. But they still need the support of that link worker. That's where that perpetual funding for a decent length of time would be really helpful.

The CHAIR: I have one question that relates to the answer that Professor Feng just gave and the work that you've been doing. You've been looking at nature prescribing for loneliness and those kinds of things. You suggested that it should be something that is formally able to be prescribed. This is moving into different territory, but I wondered if you, in your research, had collated all the different types of research that pointed to the medical benefits of green spaces. I'm thinking of the work of Elizabeth Blackburn and telomeres and maintaining telomere health. Is that something you've done? That would be absolutely fascinating, if you could take that on notice. If there's anything that collates the entire list of benefits of green spaces—whether it's on loneliness, mental health, telomere health or whatever other niche aspect—it would be fascinating if there's anything that you could provide the Committee either now or on notice.

XIAOQI FENG: We'll be very happy to provide that based on our research and others. We published a paper last year to demonstrate how much money it can save in the health sector just based on cardiovascular diseases. The paper, if you would like to have a look, is called "Show me the money!" We're talking about how we can save millions and millions of dollars. We're very happy to provide that evidence after this inquiry and if you want to talk more. I certainly think there is an opportunity for us to save money from the other part of the equation and also keep people happy and out of hospital.

THOMAS ASTELL-BURT: We can certainly provide this information that we published in *The Lancet* half a year ago. It's a meta-analysis of all nature prescription trials and studies around the world. We found that there was evidence to show that enabling and empowering people to spend more time in their natural environments near home reduces their blood pressure, reduces their levels of depression, reduces levels of anxiety and, of course, as you might expect, increases step counts and physical activity more generally speaking. An important caveat to place on this is we also published another study last year, which showed that one in three Australian adults across the country spend fewer than two hours a week in any form of natural environment. Many are spending all of their time inside, as we know. In the same nationally representative survey, we found that four in five of those same adults would welcome a nature prescription from a health professional, but we're just not offering them. There is a need and there is a demand. We should offer it.

The Hon. SCOTT BARRETT: I think my question will go to Little Big. Ms Reynolds, you just touched on the importance of the volunteering at Little Big. I wonder if there's a dual benefit you could touch on there, in that someone that is lonely or disconnected could find a passion in running a dance class, which in turn impacts their loneliness but then provides an outlet for lots of other people.

HOLLY REYNOLDS: Without a doubt. I think we've all experienced that. If people are having a down time, helping someone in your hour of need can often make you feel better. There is that wonderful parallel of people who might be experiencing loneliness but actually do get involved in the community and there's a greater benefit for all. We've got so many examples, actually. I'll quickly hand to Sarah to say a little bit more specifically.

SARAH MATHEWS: We surveyed both our participants in the programs as well as our volunteers, and our volunteers are overwhelmingly experiencing loneliness. It's why they come to us. It's why they reach out for a way to connect for themselves. Then they do and they find that kind of benefit in being there for other people and being able to hold space for other people. There's endless research on this. I know there's a great article from the '70s around the strength of weak ties—just being able to put a face to a name and bump into someone walking down the street who lives in your community and the value of that to your wellbeing and reducing your loneliness.

The gentleman who runs our board games group, as an example, was experiencing a relationship breakdown. He had a passion for board games. He had an entire room full of board games with no outlet for that and wanted a community. He didn't have his children with him as often as he was used to, so he had a lot more time on his hands. He wanted a space importantly that was free because he was going to host an event that was free for people to attend. Even the cost of a relatively inexpensive community space was too much of a cost. He now hosts that every single week. He's got a group of three other co-hosts who support him, so he doesn't have to be there every week if he can't. I would say he gets between 20 and 40 adults on a regular basis. Whilst he would still say he struggles with his loneliness now, he definitely feels he has a community around him in a way that he didn't a year to two years ago. I would say that story is replicated with 60 per cent to 80 per cent of our volunteers, that that's why they come to us in the very first instance.

The parents group is another really great example of that. All of the volunteers of the parents group kind of recruit a replacement as they go back to work to take over the program, because they know that it was so

valuable to them that they need to see it continue even if they won't continue to use the service themselves anymore. I've had them tell me things like by being bestowed with the title of "parents group volunteer", they feel they have this social permission and social licence to tap another parent on the shoulder in the park who looks like they're having a bad day and say, "Hey, we meet at the Little Big House on Tuesdays. We have pastries and coffee. That's all there is to it, but come. There'll be other parents." It's not a breastfeeding service or anything like that. It is entirely social and to reduce social isolation.

The Hon. SCOTT BARRETT: I have one other question. You as Little Big might help overcome these hurdles, but is it easy to set up a board playing group or one of those organisations? We've heard about some of the hurdles around regulation and red tape in doing that. Without someone like Little Big, how easy is it to start and maintain those groups and organisations?

SARAH MATHEWS: I would say it's possible with existing structures of most community centres if you're already an established group. If you've gone through the process, registered your business as a not for profit, registered with the ACNC and have your public liability insurance, sure, you could probably then tackle affording the $70 a week to book a space. But if you are really just wanting to start a book club and you don't want to have everyone in your lounge room, if that's the level of being a part of your community that you're ready to do—the insurance and the complexity of running a book club is really not that difficult, so what Little Big offers is a structure around that: support for the volunteer, support with making sure that event is embedded with as much social connection and it's as warm and welcoming and beneficial as possible. Access to an almost no-cost space—the way we operate is if the event has a cost, there's a sliding scale fee. But if your event is free, the space is free for you to use. I would say on the whole it's very difficult. I heard a story just the other day of a yoga class trying to get access to a community facility and the red tape was too difficult for them to do, so they didn't in the end. They decided not to teach that class.

The Hon. SCOTT BARRETT: So that process is greased a bit by Little Big.

SARAH MATHEWS: Absolutely. I heard earlier today about the role of link workers and community workers and the value to individuals in the community, but also to those willing to step up and volunteer and lead. A lot of people feel like volunteering is a big commitment. I think what we do quite well is make volunteering an achievable commitment. Even the very practical thing of picking up a key for a community centre adds an hour to your one-hour session that you want to operate. So even some really simple keypad access is just—there are a lot of really quick wins that I think existing facilities could look into to make spaces more accessible. But I would say the really big thing is insurance. Having an insurance policy before you can just be kind to your neighbours seems absurd. Then some support, because it's very difficult to expect someone to turn up time and time again and to not burn out doing that—some support for those volunteers so they feel valued, they're willing to keep doing it, and they can have a co-host or a buddy to make those things more sustainable and last long term.

HOLLY REYNOLDS: Very quickly to add to that in that area, Little Big is hoping to establish another Little Big House in the coming years. I've been chatting with a senior citizens group who was telling me that fewer and fewer people want to put their hand up to lead groups and, "What's going to become of us?" We're hearing that out in the community as well, that there is that fatigue. A previous speaker in a previous panel was talking about the generation coming behind us. We're hopeful that there are people that will still want to do that and be part of it. But, as Sarah says, if we can make the barrier to entry lower, that's only going to help.

The CHAIR: Thank you all very much. That has brought us to the end of the session. We greatly appreciate you coming along today, the work you do and the amazing research you're doing. I think you have agreed to take some things on notice. The secretariat will be in touch about that. Again, thank you so much for your submissions and your time today.

(The witnesses withdrew.)

(Short adjournment)

Ms JESSICA TAYLOR, FoundoBlue Program Supervisor, Construction Industry Drug and Alcohol Foundation, affirmed and examined

Mr ALEX KALLIRIS, Program and Clinical Manager, Construction Industry Drugs and Alcohol Foundation, sworn and examined

Mr ROBERT TAYLOR, Manager, Alcohol and Drug Foundation, before the Committee via videoconference, affirmed and examined

Ms CHLOE BERNARD, Senior Policy Officer, Alcohol and Drug Foundation, before the Committee via videoconference, affirmed and examined

Dr MARLEE BOWER, Senior Research Fellow, The Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, affirmed and examined

The CHAIR: Welcome, and thank you for making time to give evidence. Could I ask if each organisation would like to make a short opening statement. We might start with Ms Taylor?

JESSICA TAYLOR: Good afternoon. The Construction Industry Drug and Alcohol Foundation welcomes the opportunity to contribute to this critical conversation to the parliamentary inquiry into the prevalence, causes and impacts of loneliness in New South Wales. Drawing from our extensive experience in mental health, addiction recovery, crisis response, mental health and suicide prevention training, and community support, CIDAF clinicians witness firsthand the devastating effects of loneliness on individuals and society as a whole. Foundation House residential rehabilitation service and the FoundoBlue mental health and suicide prevention training and outreach counselling service hear story after story from clients of how loneliness underpins their substance use and gambling addiction.

Poor mental health contributes to relationship breakdowns and suicide ideation and deaths. The impact of chronic loneliness extends far beyond personal suffering. It places immense pressure on healthcare systems, contributing to increased hospital admissions, mental health crises and substance misuse. Loneliness is also an economic issue, leading to reduced workplace productivity, higher absenteeism and a decline in overall wellbeing that affects individuals, families and the broader community. Chronic loneliness and isolation is a risk factor in people dying from suicide, devastating families and communities. Loneliness is a silent epidemic. It doesn't discriminate. People of any age, race, culture, gender, religion, sexuality, socio-economic status and geographical location can be at risk at any time from the pain, suffering and ongoing despair of loneliness and its devastating consequences.

Workers in the New South Wales construction industry encompass all of these demographics, and construction workers are the backbone of our nation, building our homes, schools, hospitals and infrastructure. And yet, despite working in team environments, many suffer in silence, battling chronic loneliness, stress and mental health challenges. This is due to long hours, exhausting labour, remote job sites, FIFO and DIDO arrangements, missing family time and a culture that too often discourages vulnerability that leave many workers isolated both physically and emotionally. Construction workers are significantly more likely to experience loneliness, mental health struggles, substance abuse and suicide than workers in other industries. In Australia, two construction workers die by suicide every week, and these are not just numbers; these are our parents, our children, our siblings and our loved ones. They are the people who build our nation, yet feel disconnected from the very communities they helped to create.

We have made a number of recommendations to this inquiry. The first one is creating a ministerial portfolio to address loneliness by elevating loneliness as a national priority and creating clear political accountability for tackling the issue. A focused portfolio can also improve inter-agency coordination that cuts across health, housing, employment and community services. Our second recommendation is social initiatives that target vulnerable populations. We looked at intergenerational programs, initiatives that bring together different age groups, such as community centres that host events, mentoring programs and shared learning projects, and social education campaigns to increase awareness.

Seeing the success of previous social awareness campaigns such as the Life Be In It campaign to increase physical activity and health literacy, as well as the Slip Slop Slap campaign for skin cancer, often naming the issue is enough to enact change. For example, you might have someone who's suffering from mental health issues or substance use, and when you investigate what's going on in their life, what's at the core is loneliness. Our final recommendation is to address social and economic disadvantage. We're currently in a housing crisis right now. Many people are experiencing unstable housing. Renters, for example, will often have to move accommodation once every 12 months and be priced out of an area. It's really difficult for people to maintain social connections when they're faced with moving their housing every 12 months.

MARLEE BOWER: Thanks for the opportunity to speak today on behalf of the Mentally Healthy Futures Project based at the Matilda Centre at the University of Sydney. Our five-year project is dedicated to advancing evidence-based policies to improve mental health, with a focus on social connection as a public health priority. We want to commend the Government for leading this inquiry. Social disconnection, including loneliness and social isolation, is a growing public health issue in New South Wales, with wideranging impacts on mental health, economic productivity and community resilience. The most recent data suggests that one in four New South Wales residents experiences persistent loneliness. Our own research shows that one in every 13 New South Wales residents reports not having done an activity with friends or family in the past month. That's deep isolation and probably, on odds, one of us in this room. The COVID pandemic, economic pressures and climate-related crises have further deepened inequalities and social connection, disproportionately affecting young people, low-income groups and those with disabilities.

Our submission makes six key recommendations for the Government. Firstly, to prioritise social connection as a policy focus, so beyond just loneliness and isolation, recognising that social connection's broad benefits for health, wellbeing and economic resilience are important. While loneliness is often understood as an individual experience with individual solutions, like befriending schemes or therapy, social connection is easily understood as something that whole communities can come together to facilitate and enable. New South Wales should—and there will be some overlap here, which is good—implement a cross-developed departmental whole-of-government approach, like other jurisdictions in the UK and Denmark more recently, that integrates social connection into policies on housing, work, urban planning and health to create environments that foster social interaction.

I want to highlight a few pieces of our own research which show why this is so important and the harm of ignoring loneliness at your own peril. Our research shows that loneliness and isolation can make or break the success of housing programs for people exiting homelessness, increasing cost for the State. Our research shows that unaffordable and inadequate rental housing is directly linked with loneliness. By prioritising affordable, quality housing close to employment and community hubs, New South Wales can help residents maintain social ties, improving mental health and wellbeing. Another study of ours on national data shows that workplace and volunteering reform would likely reduce loneliness. Increasing opportunities for secure employment and creating the infrastructure opportunities and incentives for volunteering will reduce the risk of loneliness amongst New South Wales residents. I can explain any of these works later in more detail, if that's at all of interest.

We need to launch public health campaigns to reduce stigma around admitting to loneliness, something which is particularly important for men, who are less likely to admit to loneliness. Currently, that kind of shame or stigma around admitting loneliness prevents people from seeking help. We need to raise awareness of the importance of social connection as not a "nice to have" but as something we "need to have". We must invest in improving community-level infrastructure equally across New South Wales—such as parks, community hubs or youth centres—to support local social interaction. Our own research demonstrates this, and I can also share that with you.

Finally, New South Wales needs to invest in and expand data collection and research to better understand the causes of social disconnection, and tailor solutions for New South Wales communities. There are currently no high-quality, regular measurements of loneliness in the State, which means that we can't actually monitor if anything that we try and intervene in actually works. We also need to measure not just averaged over all populations but pinpointing those who are most vulnerable at loneliness or else we won't know how much change is happening. New South Wales has a unique opportunity to lead the way in tackling social disconnection by embedding social connection into statewide policies and programs, and investing in preventative strategies, data and research now will help mental health outcomes, economic productivity and community resilience in future crises. Thank you.

ROBERT TAYLOR: We'll just say a few words each. I'd like to begin by acknowledging that I'm joining you from Wurundjeri country today and pay my respects to Elders past and present. The Alcohol and Drug Foundation welcome this opportunity to speak on this important issue. Loneliness is not just a personal struggle. It's a significant public health concern that increases the risk of mental health conditions, physiological disease, and alcohol and other drug harm. We know that strong and connected communities help prevent harm before it starts. We know that social isolation and substance use share common risk factors, including mental health challenges and socio-economic disadvantage. However, stigma and the criminalisation of personal drug use further entrench social disconnection. People who use drugs are among the most stigmatised in society, which worsens health outcomes and isolates them from support networks. Expanding health-based responses rather than punitive approaches will be key to addressing these issues.

CHLOE BERNARD: The ADF's work in prevention has shown that community-based initiatives can reduce both social isolation, and alcohol and other drug harm. Prevention programs like those run by the ADF

focus on increasing community engagement and participation to build resilience and reduce risk factors associated with loneliness and AOD harm. Programs such as the Local Drug Action Teams and Good Sports demonstrate the effectiveness of proactive, community-driven approaches that foster social connections and create supportive environments. Addressing loneliness requires a coordinated approach across social policies, including housing, employment, health and justice. By embedding prevention strategies into broader policy frameworks, we can build stronger, more connected communities and reduce the social and health impacts of isolation. Recognising the intersection between loneliness, mental health and harmful substance use is key to developing effective long-term solutions. Thank you for your time, and we look forward to your questions.

The CHAIR: Thank you very much. If I could begin with quite a general question. Obviously, we've been talking about, in our terms of reference, social isolation and loneliness. What we've seen almost uniformly is this idea that an antidote or a preventative mechanism for that is social connection. All of these terms, including "loneliness", are quite amorphous and subjective, and so is social connection. I want to get from each organisation what your view of social connection is. How do you identify that a person is or isn't socially connected?

ALEX KALLIRIS: I think it's important to note as well that our research is based off us being frontline workers on the ground rather than academic research. But I guess the difference for us that we've seen in the past and at present is that, when we can have the whole—you know, you're in a room full of people and you still feel alone. We see that frequently. But the difference between that is that we'll see men, for example, will open up, and they'll be really vulnerable, and they'll be emotional with people that they're talking to, or they'll make things a constant joke or banter and laugh about a topic. I guess that's the difference between we seeing someone connecting with an individual and someone just being in the same room as them.

Because we have the residential service as well, we see the time line of someone connecting with another individual over a period of 28 days, and that difference is significant. It's outstanding to see someone come in and be really withdrawn, still detoxing from drugs, alcohol or gambling, and then we'll see them 28 days later, hugging another individual, getting upset, getting emotional, crying and being really, genuinely happy to what they've experienced and what they've achieved over that time. I suppose that's the connection that we're seeing. In the public, it's a bit harder to manage or to witness, as we have the Foundo Blue side. That's purely outreach, counselling and suicide prevention training on construction sites. So we'll still have that line between, "I'm not going to get that emotional" or "I'm not going to get that vulnerable in front of everyone else, because these are my co-workers", whereas, in the residential side, "Everyone's doing it already, so why not get involved myself?" That's the difference that we see.

The CHAIR: That's a good example.

MARLEE BOWER: It's a really interesting question. I think definitionally social connection is just the umbrella term that lumps all these kind of, yes, very amorphous terms together. Things like loneliness, social support, they're the kind of subjective aspects of social connection. Then there's things like frequency of contact or how many friends you might have, and that's the objective measure. It's much easier to measure change in social connection because you can observe it. People see more people; they connect. But loneliness is much more amorphous and difficult to connect with through observation alone, because you can't often tell when someone's lonely. That's something that makes our job a lot harder, people working in this space. I think what's really interesting is that social connection you can change more readily by forcing connection. But, if you got me to force a connection in my community by joining a netball team, that will only increase my social isolation and probably create some more enemies in the world.

But I think what you need is those kind of meaningful connections, and with people that you value. That's the kind of thing that's going to reduce loneliness and create impact. What I was trying to say in the intro—and I might have botched it a bit—is that there's a trend in the loneliness space to really focus on individual action and responsibility in the loneliness world, about individual solutions: go to a therapist, seek help from those who need it, deal with it yourself. But actually I want to say a lot of the solutions are community oriented. We can all play a role. As a policy action, that's where we need to be. I suppose that movement towards social connection allows us to see that the changes that we make on a housing level, on a community-centre level, and the way that we define what good work means and what good labour rights means is really important. That's going to be the thing that shifts loneliness, not forcing connection.

The CHAIR: I guess part of it for me is, because these are abstract terms, how then, as policymakers, do you do useful things which foster these things, which we can't very well define. That's my struggle with it a little bit. I'll go to our witnesses online for their response.

ROBERT TAYLOR: The Alcohol and Drug Foundation does a lot of work in the primary prevention space. So we work in the alcohol and drug space quite upstream. We look at risk and protective factors around alcohol and other drug harm. It's interesting, as we're talking, to think about loneliness. It's both a risk factor for

alcohol and other drug harm, but it's also an outcome of alcohol and other drug harm. There is that two-way relationship. So, with that in mind, I think what the previous witness was just saying is exactly how ADF would be thinking about this. We work with communities. We try and engage and mobilise communities because we know that imposing from without onto a community is ineffective. It doesn't support it. While it strengthens the community, intervention effects only last as long as funding is there, as long as services are there. Services to the group can be varied. When you build community capacity, when you help facilitate community growth and help communities find interventions that are meaningful for them, it's much more likely that's going to lead to meaningful change in this constellation of risk and protective factors that we're interested in, being loneliness, as well as it being an outcome.

The Hon. NATASHA MACLAREN-JONES: I wanted to ask a little bit more in relation to the construction industry submission in regard to the partnership with private business operators to combat loneliness in Japan and the neighbourhood surveillance program and how that works.

JESSICA TAYLOR: Yes, sure. Let me just find the page.

The Hon. NATASHA MACLAREN-JONES: Page 24.

JESSICA TAYLOR: You're talking about the Nagayama model in Japan?

The Hon. NATASHA MACLAREN-JONES: Yes.

JESSICA TAYLOR: One of the challenges was—Japan has an ageing population, many people who are quite lonely and isolated perhaps because of the death of their partner. The partnership with the private business is a partnership created by the community that gets social service volunteers, like a range of private entities, whether it's people that deliver the mail, delivery services, utility companies, medical practitioners, people who come round to check the gas—are all trained to recognise and identify the signs of loneliness and help facilitate that person accessing social services. It's a really positive initiative that I think really suits the Japanese society—but also bearing in mind that Japan has a very community-focused model. I find here in Australia we tend to have a lot more individualistic society, where it really is about the individual or the family. Looking at how other countries who might have their different models of how they engage with their community might be helpful if we can perhaps reorient our individualistic society to be a bit more community focused by adopting some of these initiatives.

The Hon. NATASHA MACLAREN-JONES: I think that's one of the challenges. We have seen volunteering in Australia and others certainly go backwards to where it was at. With the model in Japan, is it supported by government in any way to recruit volunteers or is it purely driven more by that community spirit or the desire to be involved?

JESSICA TAYLOR: I know with the Nagayama model, where they created the community centres and seniors cafes, it's my understanding that it was a government initiative. However, I'll have to take that on notice and give you more information.

The Hon. NATASHA MACLAREN-JONES: Dr Bower, you touched on volunteer initiatives or incentives and things that you've identified. Could you elaborate a little bit further on that?

MARLEE BOWER: Yes. We did a study last year looking at the HILDA data, so many, many thousands of Australians over 20 years. There was men that we focused on and found that workforce involvement was the primary predictor of loneliness amongst men. But, once people retired, it was volunteering, for obvious reasons. In talking and collaborating with volunteer sector people after that to see what we can do to actually facilitate volunteering, people were saying the main issues were affordability and access to meaningful organisations that you can volunteer with. People didn't feel like they were comfortable or safe enough in the local environments they lived in to volunteer—so talking about very simple strategies you can put in place and incentives to get people feeling comfortable enough to volunteer in their local community. Because we know that when you do, it's protective against loneliness, particularly for that 55 and up group.

Dr AMANDA COHN: My first question was for the ADF. I was just interested in the Act-Belong-Commit program that you've mentioned. Could you explain that in a bit more detail?

CHLOE BERNARD: Yes. The Act-Belong-Commit program is an approach to more of a universal prevention of mental ill health that originated in WA. The program encourages people to improve and maintain their mental wellbeing by adapting habits and behaviours that are going to be effective for mental health. To break down the different components a little bit, "Act" refers to keeping active, staying alert and engaged both mentally, physically and socially; "Belong" refers to keeping connected to family and friends, to community and to culture; and "Commit" refers to acting on things that are purposeful and meaningful, that provide challenge and an opportunity to grow. Evaluations of the program have found that it can improve mental wellbeing and cognition,

and it also has shown to have some positive impacts on public drinking as well. It shows how taking a holistic and universal approach to improving physical health and mental health can also have impacts on reducing social isolation and [inaudible].

Dr AMANDA COHN: To clarify, you've outlined what the content of it is, but how is that delivered to people?

ROBERT TAYLOR: We can take that on notice in terms of the service delivery. This is something we looked at through the research also.

Dr AMANDA COHN: Please take it on notice, thank you.

ROBERT TAYLOR: Happy to provide it to you.

The Hon. SCOTT BARRETT: My initial question—I think it was Ms Taylor that gave the first introductory statement. There was a suggestion there that we've heard a couple of times about this Minister for loneliness. Given the relationship between loneliness and social connectedness and also the relationship between social connectedness and lots of other issues, health issues, crime et cetera, have we put any thought to making that suggestion for a Minister for social connectedness and framing it in the positive, rather than the Minister for loneliness, which seems to ring-fence one of those consequences?

JESSICA TAYLOR: Yes, agree.

The CHAIR: Agree? Good. Other questions, Mr Barrett?

The Hon. SCOTT BARRETT: I will just ask one other. And it's a tricky one probably for the—based on alcohol in this country. How do we balance that issue that in moderation—you know, a few beers after an event or we catch up for a couple of beers is also—I'm not trying to advocate one way or another here, but it is often seen as a social outlet. It does provide social connectedness. How do we balance that and navigate that?

ALEX KALLIRIS: I believe that the balance of moderation needs to come from a preventative mind frame. In our schools someone is growing up—it's about teaching them adaptive mechanisms rather than maladaptive coping mechanisms. They'll see parents, they'll see siblings, family members, whoever it is—they'll have a bad day at work or they'll have an argument with a partner and they'll pick up a drink. Then it's just reinforced that whole way throughout the generation. Then we've got the intergenerational trauma that comes alongside that.

Teaching someone something different, instead of that learned behaviour of picking up a drink when something's going wrong—instead of it turns into picking up a drink to celebrate or only to celebrate or when we're doing something really positive. That would be the difference, I guess. That's where the culture that I believe in Australia currently sits is: You have a good day, you have a drink; you have a bad day, you have a drink. That needs to be more informed and educated around in the general public through the schooling system or through families or through DCJ—wherever that might be.

JESSICA TAYLOR: I'd like to add to this. This also highlights the importance of having that third space in our community that isn't focused around alcohol—that isn't a pub or a club or a casino—whether it's a room somewhere in a community centre, or parklands where people can go after work and exercise or kick a ball around, or just sit on a chair and enjoy the scenery, rather than the default, which a lot of people do, which is have a beer after work to unwind.

MARLEE BOWER: Can I add something too? It's a really interesting balance because alcohol is the social lubricant of our country in a lot of ways. We need to balance that idea. We need to be able to find ways to socialise outside of pubs. We don't really have norms and values around how to do that, so it's around that cultural change of what it means to socialise in a way that is valued by all group members outside an alcohol-centred environment.

I also wanted to show the flipside of that: When you're trying to reduce or cut out substances or alcohol in your life, it's the networks that you drink with or take drugs with that are going to prevent you from being able to cut it out. People often have to recreate their networks out of the drug-using space in order to do true rehabilitation. There's been years and years of research led from UQ, and some more recently in Wollongong, showing that for people who are trying to cut down on alcohol and other drugs, and just generally, the more social groups that they have involved in their lives—the greater the number—the less likely they are to relapse and the less likely they are to use in the first place. That's stronger than a lot of therapies, so it's good evidence.

The Hon. SCOTT BARRETT: It would be remiss not to lean on Mr Taylor in this one.

ROBERT TAYLOR: I think it's been covered off pretty well. We agree with everything that's been said. Absolutely, having a stronger sense of connection to community, meaningful participation, is going to make someone less likely to experience alcohol and other drug harms. Whether they're using or not, it can change the trajectory of someone's use of a substance. We know that substance use can happen for a variety of reasons, as raised, and multiple reasons at the same time. You can go out to unwind at the end of the week and also celebrate and also drink because you feel poorly as well. So, yes, agree with everything that's been said.

The Hon. SCOTT BARRETT: Happy to hand on, Chair, or come back to me if there's time.

The Hon. ANTHONY D'ADAM: I wanted to ask about micro-social interactions. Can you talk us through what they are and how they contribute to addressing loneliness?

MARLEE BOWER: By that, do you mean the passing interactions people have in their day?

The Hon. ANTHONY D'ADAM: I think it was something that's actually come out of the construction industry submission.

JESSICA TAYLOR: Yes. Micro-social interactions are the interactions that you might have when you go to the shops and you speak to a salesperson about something, or the cashier. It's often just a very small moment of connection that we have with another person. In my submission, I did write about the reliance on being online for a lot of people is really erasing those opportunities for micro-social connections. What we're hearing is for people who are isolated already, doing things like going to the shops and talking to someone might be the only opportunity that they have to talk with someone in the whole day. If we're moving to a world that is increasingly reliant on making purchases over the internet, doing our banking over the internet, organising everything without human interaction, we really are losing out on those opportunities for micro-interactions.

The Hon. ANTHONY D'ADAM: The world's heading in that way. What can we do to address that? What are the other alternative opportunities for those kind of micro-interactions? Where do they arise?

JESSICA TAYLOR: I think that perhaps creating alternate opportunities for those micro-interactions by creating spaces where people can interact, whether it's putting a focus on our green spaces and those third spaces where people can go and sit in a park and talk to the person next to them; and our community centres that run activities where people can go and be able to talk to someone or have a cup of tea or do something in their lunchbreak just to be able to connect with others. It's really important that we take this on board—that this is the way our society is moving—and then do something to counteract that.

The CHAIR: There's a couple of specifics from your submissions that I wanted to ask questions about. Dr Bower, if I could start with you, you talk about—and it is related to the construction sector, because I want to talk about work—a couple of things in your submission. One is about the role that employers have in reducing loneliness. We had witnesses here earlier today talking about that, but you also make a connection between gig work and social isolation, and I just wondered if you could speak a little bit to that.

MARLEE BOWER: Sure. The research we've done, which has linked gig work to social isolation, has discussed the way that it creates very few boundaries between work like and home life. Gig work is praised because it allows you more choice in your day. You can drive Uber in the morning and then be with the family in the afternoon but, of course, that doesn't often give you the income that enables you to live well and support your family or yourself. People have described living a life where they're always on, never off.

Also, they're always waiting for work to come, which means they don't feel they have the opportunity to spend time socialising, plan for socialising. They aren't able to plan for the future—like, in a few weekends, have a picnic. Also, the irregular money that's going in means that it's hard to plan for the financial outlay that social connection often requires—money to pay for food, to pay for a movie, for travel, that kind of thing—so it becomes a lot more difficult to live in a way that allows you to have a socially meaningful life.

The CHAIR: I wondered if I could go to Ms Taylor and Mr Kalliris. I know you wrote in your submission about the culture of working in construction, but also you wrote about the effect of poverty and loneliness. I wondered if you could speak to those two aspects.

ALEX KALLIRIS: Our FoundoBlue program is based primarily with the companies sponsoring a package so that we can train their workers onsite. It's a three-year capacity building exercise where we will train them in suicide prevention and then advanced suicide prevention—and also ways to communicate because we understand that the way that, primarily, construction workers in New South Wales communicate at work is not the way that you can communicate at home. We're running that program now. We're seeing a lot of changes with either workers accessing the help, or wanting to access help, or approaching the people onsite. They don't necessarily have to go to a therapist or a counsellor or whatever. They can go to someone who is trained to actually help out and intervene in these situations.

A lot of organisations that we've had contact with in the past have had workers that live in their cars. We've got construction workers in Australia who make upwards of $3,000 after tax a week, but they have to live in their cars because they can't afford to live in Sydney. They're divorced, they've got financial stresses, they've got cars that they can't afford, they've got families that they need to support, and then they take the loss and they live in their car.

I believe the responsibility of that needs to go onto the employer, because they don't see that their employees are struggling, that more work needs to be done, more training needs to be done and more interventions need to happen. Because they walk past each other at work and say, "How are you?", "Good, good", "How are you?" It's nothing else. But if we promote that conversation, get people talking about this sort of stuff, people will be able to intervene and say, "You don't look right", or, "You're wearing the same thing for a week", or, "You've been asking me for money for lunch." Then they can get in and get the help that they need, whether it's through therapy, through counselling, through financial help, whatever it is.

It's just about being able to access it, and understand and have the knowledge of how to access it and where to access it in the first place. What a lot of people in Australia don't understand is actually how to do it. Trying to get someone onto Centrelink for the first time is a headache. You need to engage a social worker or someone that has actually done it before to actually go through the process, otherwise they're not going to do it. They'll shut it down and move forward, and try and figure out an alternative. Often that turns into crime.

The CHAIR: Can I ask a follow-up question? You said that the way that, particularly in your area, constructions workers speak at home and at work is quite different. Could you explain that a little bit?

ALEX KALLIRIS: I guess the language that's used onsite is very—I probably don't want to repeat it in this room.

The CHAIR: I've been on construction sites.

ALEX KALLIRIS: But the way that they speak to each other and demand, I guess there's really no care or compassion because that's just the way that they are. That's the way that they speak to each other. But if you come home and you speak to your partner and your kids in the same way, you're not going to be met with the same response. I guess that's the difference. You get so used to doing that. You spend so long with these people. You spend so long with your workmates, more time than what you do with your family. That becomes the go-to. I guess the intervention has come in about you probably shouldn't do this at home as well. It just promotes some sort of thought because a lot of them that we've encountered ourselves, it's like a light bulb moment, and they're like, "Oh, yes that's true. No wonder my partner doesn't want to talk to me, or my kids don't want to speak to me anymore because I speak to them like nothing good."

The CHAIR: That's really interesting. That's not what I thought you meant when you said that. I'm really glad that I asked. I appreciate that.

JESSICA TAYLOR: Also highlighting that in construction there is so much pressure on workers in terms of their work hours and working overtime. It's explicit and implicit pressure that if you're working in construction, you will be working overtime and you will not be clocking off at 4.00. If the job needs to be done, you will have to stay and work until you can leave. Often construction workers are working six days a week, 12 hours or 14 hours a day. That leaves absolutely no time for social connection, not even their times to connect with their families. This does lead to burnout, stress, anxiety, depression and family breakdown because partners simply don't want to be a single mum to a partner that's home one day a week. This is just what the industry is.

The CHAIR: Is that across all workers? Is that skilled tradespeople down, or is there a particular cohort that you see who are particularly vulnerable?

JESSICA TAYLOR: From what I see it's all construction workers, all of the trades. When a builder submits a tender, there is a timeframe within which the job has to be completed. There are financial penalties if that job is not completed within the timeframe. Often those timeframes are really unrealistic. The client is wanting the job done as soon as possible, which is understandable. But then that pressure filters down to the frontline worker: "You have to work six days a week. We need to get this job done." Then they're experiencing these negative effects.

The CHAIR: I might go to the ADF. There's something in particular in your submission that I wanted to explore a bit more. Your submission indicates that using a place-based approach might modify risk and provide protective factors for alcohol and other drug harm. We did just hear the previous panel was about place and space. Could you explain a bit what that looks like in practice and what you're referring to in particular?

ROBERT TAYLOR: A good example is our Local Drug Action Team program, which we run around the country where we provide evidence-based tools and toolkits for local communities to create action plans based

on identified community needs. When we're talking about communities we're talking about a partnership with local organisations. Often you might have a youth group, you might have elements of a school and school wellbeing team. You can have sports clubs involved, council, interested community players and sometimes social services, youth service, at the time. They'll get together and they'll say, "Look, we've got this issue. We know young kids are disengaged in our area. We know that there might be social issues resulting from that. What can we do to try to build engagement that's specific to the people in our area that's relevant and that's going to be meaningful for the people around here?"

ADF then provides a range of tools, evidence-based resources, to support communities to run interventions that we know work in place. But ultimately the ownership of the intervention rests with the community. We provide grant funding to the community to help them operationalise and evaluate ultimately that intervention. We know that's really important as well to get the right data and ensure that we're trying to have the impact or we're having the impact that we're trying to. But really it is about empowering communities. It's about letting them identify and providing that process right through. When we say place-based, it is really focused on that geographic area, and it's really focused on ownership and community.

The CHAIR: We might draw this session to a close. Thank you all very much for your submissions, for your willingness to be here today, and for the work that you do in the community. We appreciate it.

(The witnesses withdrew.)

Scientia Professor JILL BENNETT, Director, University of New South Wales, Big Anxiety Research Centre, affirmed and examined

Dr GAIL KENNING, Senior Research Fellow, University of New South Wales, Big Anxiety Research Centre, affirmed and examined

Ms GWENDA DARLING, Member, Aged Care Council of Elders, affirmed and examined

GWENDA DARLING: I am an aged pensioner.

The CHAIR: Thank you for making the time to give evidence. Would you like to begin by making an opening statement?

JILL BENNETT: We can make a quick recap of the submissions. Gail and I are part of a research team—we are leading a research team at UNSW—where we have our government-funded grant to develop AI companions to address loneliness. That means that we make technology, we look at the shortcomings of what's available and create 3D screen-based AI companions. But, most importantly, we do that with people with lived experience. In particular in the area of ageing, which is underserved by AI technology, we work very closely with people in the community, including Gwenda, who's developed an AI companion with us, and quite a number of people with dementia. These characters are really focused on addressing some of the key drivers of loneliness, which include grief, loss, isolation and the transition into aged care. Falls is a big one that impacts people's social capacity, and dementia itself.

At the outset I want to emphasise that in no way are AI companions ever a replacement for human companionship, but they do play an important and distinctive role and can fill a gap. They are proving to be useful in our trials and tests for people who live alone and literally may not have a visitor in weeks, just in terms of being able to bounce ideas and worries off another person. Users are also reporting that they can help with stress, anxiety, confusion and grief. They can help us think through problems and shift negative thinking. This is very important because we know that chronic loneliness can lead to pessimism and negativity and further withdrawal. A well-trained, skilled AI companion can help with reframing that kind of negative thinking and help with developing plans and goals to become more socially connected.

Of course, they can also listen to all sorts of bad-tempered griping. As Gwenda says, you can just vent to an AI companion. You can actually lay a whole lot on them in a way that you wouldn't want to do with a relative or a human friend. The idea for us is that we are developing these companions to be skilled, well-informed "friends", if you like. But, because they're AI, they have access to a wealth of evidence-based information. We're also working on specifically training them to be quite skilled in the way that they listen, don't interrupt or tell people what to think. That's why we call them "skilled companions", because they behave in the way that you'd want a friend to behave, effectively.

The CHAIR: I've got two questions to kick us off. One is to you, Professor, and then one is to Ms Darling. I know there was a link in your submission to the actual video of AI, and I had the pleasure of coming to the event at UNSW to see it, but for the benefit of the transcript and the Committee, could you describe what it is? We're talking about AI, but what is it that you have developed? Then I'm going to ask Ms Darling what your input was, and what you think of the result. I'll go to Professor Bennett first.

JILL BENNETT: At the moment, you can access chatbots on the internet, but they're fairly rudimentary and robotic. They agree with everything you say because they're programmed to do so, and to prolong a conversation. People are using those as companions, but there are a number of problems with them that people will have read about in terms of safety and so on, and just the sophistication of them and the level of conversation. We are developing a new AI module that enables more sophisticated functioning, but we also model companions. We create 3D scans so they can be screen based. In aged care, we've been experimenting with full-size companions on screens because those seem to be quite popular for people who are more sedentary, who quite like the idea of sitting around a coffee table with a friend. Younger people would, obviously, use mobile devices. People of any age can output to any device. It can be on your TV, they can be on the phone but, essentially, they're powered by something like an AI chatbot but with these more sophisticated additions.

The CHAIR: When I went to the event at UNSW, you had almost life-size screens with, essentially, avatars of people. One of them I could recognise as Ms Darling. Ms Darling, would you explain your input into the development of that companion and, also, what your assessment is of its value and how it might be useful.

GWENDA DARLING: I have to admit I'm a technophobe, so I'm not really into the technical side of it. But I do feel passionately about older people, particularly those people living with dementia, having someone available 24/7 to vent with. I was given an opportunity by Dr Kenning to participate and was asked to tell a couple

of my stories which they converted into the voice of—I can't believe she lisps. I also was given an opportunity to, basically, have input into who she became. That was really important for my input. I was annoyed: She didn't want to discuss having a bath, but then, when I coaxed her, she came round telling me about how you got into the embryonic state and how good it was for the endorphins.

Now, as a person living with dementia, in the middle of the night, when I'm up pulling everything out of the wardrobe or getting distressed—as we often do because we don't sleep—it would be really helpful if I had that encouragement. That's why I really supported the project. Because, with the living experience of getting older, living alone, having that connection with someone or something, and having seen the benefit of things like ChatGPT—I have a son who's an alcoholic and drug addict. When he moved into sobriety, he lost his whole community. He had no-one. I think when we get dementia, often we lose our whole community because our friends all drop off because they can't cope. Older people, generally, I think often, particularly in residential care, can be surrounded by people but still be lonely. This is a private way to have a relationship.

The Hon. NATASHA MACLAREN-JONES: One question is in relation to privacy and how you've been looking at that or how you have managed it.

JILL BENNETT: It's possible to keep data completely private, and it's possible for it not to be retained. It's possible for it to be retained locally so that the character has memory. All of those things. I would say that it's an interesting debate for us, because we've had some care providers say, "Can we then see the data of the conversation?" We have actually resisted that because you actually wouldn't share the data of a therapy session with anyone. We're really framing it similarly. I think that's important because, for us anyway, the ethics of this project is very much about asking people what they want and building something for the people with lived experience. Whether it's people in aged care or people living with dementia, it's a contract with the client. This is something that's really important in an area where sometimes you're always looking at systems solutions rather than what really works for individuals. Of course, we can, hopefully, scale it up to something that works across an aged-care provider or across home care, but I think with that ethics at the core.

The Hon. NATASHA MACLAREN-JONES: I suppose looking further—and that's always the discussion when we talk about AI—where does it go? How would you manage, or how would it manage, a situation where you have an individual who might be suicidal or having negative thoughts? Is that technology able to be developed, or is it available?

JILL BENNETT: Absolutely. It's pretty good. Actually, at the moment, what's happening with some chatbots is you have an effort to put in guardrails. Which is good. We need guardrails, but they're often a very blunt instrument and can be quite dangerous. So someone is disclosing and then the character says, "I am an AI and I am unable to pursue this." Of course it's the right answer, often, to say, "Seek professional help", or, "Go to an emergency room." That can be part of the conversation.

We work with what are called trauma-informed protocols where you're, all the time, thinking about the impact on the person disclosing. Sensitive listening, empathic listening and non-judgemental listening are fundamental. That doesn't mean you agree with everything. This has been a problem with some of the off-the-shelf chatbots, that tech companies make them to agree with you because that prolongs the investment in them. Our AI module—not to get too technical—is really looking at the capacity of the AI to understand when you can't take what someone's saying at face value. If they're saying, "I truly believe life's not worth living, and the best thing would be to kill myself", they need to use their knowledge of that person's greater aspirations to help reframe in the moment—effectively to do the things that a trained counsellor would do, but without exacerbating the situation. Always the comparison is with nothing. If you can introduce something that gives the person a way of thinking about their feelings, thinking about what to do next and reframing negative feelings, I think that has to be helpful.

The Hon. NATASHA MACLAREN-JONES: Do you need to think about who would be using it, or even have a criterion of saying, "Okay, there are some people that it should not be recommended for?"

JILL BENNETT: We certainly work with a lot of people with mid-stage dementia, for example. We do work with people with quite serious trauma. I think if there is a cut-off it would be possibly people in crisis, in psychosis, who were at the stage where they needed emergency care. But I think there's no reason—in any context where sensitive talking down and support with emotion regulation is required, I think the character could be trained to work in that. Do you want to say something?

GAIL KENNING: I think what's also important when we're talking in this area, in some ways it can be a modelling for how to have this conversation with others. Somebody is getting to the point where they're not feeling that life's worth living—there's that sense of even hearing themselves. They may not have come to that point before, but hearing themselves and the character being able to engage with them where they are at this point,

and reflect back in a sense, then also allows them to model the conversation of, "Who do I need to speak to? What is the conversation I'm having? Where are my thoughts shifting here?" With the characters we have, there's always that sense of allowing people agency over their own thinking—allow them to think through where they are at this point.

The Hon. NATASHA MACLAREN-JONES: My last question is for Ms Darling. How easy is the technology to use? You mentioned about waking up at night knowing to activate it.

GWENDA DARLING: I really can't answer that question because I only really went to the trial where you held your finger on a computer keyboard, but I can activate things on my mobile phone. I've been diagnosed 13 years ago this year. I have many people at the same stage of where I am right now with frontotemporal dementia who've been diagnosed well over 10 years, and I think most of us can use a mobile phone. Most of us can look up YouTube. But like your concern, Chair, I do have a concern that it's not going to replace a human being in a time of a crisis. If I've fallen and I actually have the AI chatbot or whatever character with me, it is not going to get me the help. I think we've got to look at the dual technology that's there to work with us.

The Hon. ANTHONY D'ADAM: At the moment, presumably. The technology will evolve. It seems very dangerous, I have to say. I'm very uneasy with it. This is a type of therapy. Is it going to be available through some form of prescription? What are the guardrails in relation to the application of this experimental therapy?

JILL BENNETT: It's not an experimental therapy. It could be a therapy. For example, we have all sorts of partnerships where you can use this character as the basis for delivering therapy. The key thing about the character is they provide good peer support. They're trauma informed. You can train them to have the skills of empathic listening and non-judgmental listening, and to operate within a trauma-informed framework, which would be an elaborate guardrail, let's say. But they don't have to deliver therapy. A lot of talk-based support is provided by peers or even supportive friends. At the moment a lot of people are going online and accessing chatbots that don't have these advanced skills, let's say. People fall in love with them. They do act out dysfunctional relationships, but in the same way that people do in reality. But clearly having an intense romantic relationship with a chatbot opens up a whole range of questions.

We're seeing this as something that people can access on an informed basis. Imagine you're at home, you live on your own, you've lost your partner. You don't feel like going down to the pub because you have to make an effort, but sometimes you're struggling with grief and there is no-one there to have a discussion with. This kind of chatbot could do that in a sophisticated way and also access more best-practice information about all the good things you can do than your average mate. The same if we're talking about falls, falls prevention, building confidence after a fall. These are all things that we're working on with clinical professionals. But the attraction is that it's extra clinical in that you don't need to be in a clinical program to access this information. You can build in the security. If you say that it sounds kind of scary and dangerous, compared with what? There's a whole lot more skill and safety built in than in the kinds of encounters that you might have otherwise.

The CHAIR: I think in the video that's in the link there was an example of an aged-care setting where the AI was having basically a cup of tea and a biscuit equivalent level conversation. It was companionship at its most basic level, which to me was one of the appeals. Is that what you see it mostly as being, or more in that intense zone?

JILL BENNETT: It's an interesting question because people do get stuck in. People do understand the scope with this. For example, we've had interesting conversations in aged care. There was a guy who suddenly asked the AI companion what they thought of psilocybin treatments because their son had been encouraging them to enrol in such a treatment. The AI character was really good and said, "There's limited information, some pros and some cons, but really it's how you feel about it." It was a textbook response and the staff loved it and said they couldn't—but the AI was able to get more published information than obviously staff would have at the tip of their tongue. They use it for things like that.

As Gwenda says, people use it to vent. People use it to ask questions that they just can't share with anyone else. There is quite a savvy use of these. People know what they are and sense what they can do, what their limitations are and what their potential is. If you just follow what people are naturally wanting to do with these, make them safe and ensure they're informed. We have a lot of partners working on dementia. The falls project is a good one with a team at NeuRA, who are world experts on falls. They have information that they want to convey about how you rebuild confidence after a fall, because a lot of people end up immobilised and not going out and not socialising. So the information is there. There's great psychotherapy, but no-one enrols in psychotherapy. People don't see themselves as needing therapy. This is another answer to your question. It doesn't have to be a clinical condition.

Then we developed this kind of blokey guy who's a ex-footballer. All of this is always worked up with men who had had experience of falling, which they found humiliating and really difficult to talk about or deal with, to find strategies to overcome. There's all of this information sitting there in the back end that comes straight from the world's best researchers in NeuRA around what you want people to know about the best way to rebuild confidence and to keep reinforcing. That knowledge is not going to get to people otherwise and those people are stuck at home. In this case, if you build a relatable character that can convey this information but also be the kind of person that you wouldn't mind having a drink with or a cup of tea with, I think that's where it sits. Although we do train them with certain skills of, let's say, psychotherapy in terms of good listening and not interrupting—all that kind of stuff. But that's not to say that they have to be a clinical expert.

The CHAIR: I want to go to Mr Barrett, who has been very patient with me, waiting to ask some questions.

The Hon. SCOTT BARRETT: I will ask one question, Chair. You've certainly put forth some cons. I'm not saying that something like this doesn't have its place, but the example you gave sets up my question in that that person that has just lost their wife and didn't feel like going down to the pub, don't you then train that person not to seek intrahuman connection? What we heard from Lifeline was the human connection needs. If they're getting these things from a bot then they're not going to be encouraged to seek to rejoin that human interaction.

JILL BENNETT: We don't train people to do anything. If people are grieving and unmotivated to go out, this is one way of enabling them to have a conversation. The thing about loneliness is it's not about not having access to social connection necessarily; it's about the loss of the quality relationships that make you feel like you. If you've lost a partner, that effort of trying to be social—sometimes it works, clearly, but sometimes it really doesn't. You will feel even more lonely down the pub, right? It sits between having the conversation you need to have and also doing some personal reflection. Say you did have a grief counsellor, this character can make all the similar moves that a grief counsellor would in terms of gently supporting people to think about where they're at and just being with them when they talk about the person they're missing, which is a natural process. It doesn't need to be put right.

But there is the point at which you need to perhaps find a bit more motivation to make connection. Our project around loneliness is specifically about this. You can map stages of loneliness. Different psychologists do it differently and have this idea of a downward spiral or an upward spiral and you can plot where people are. What you want to do is to move people out of loneliness, not by training them but by gently exploring the possibilities for reconnecting. I think that's the kind of conversation that you could have. This is probably going to be how a lot of therapy is delivered in the future, or how a lot of therapeutic conversations are mediated. But it is always about what the ends are and not that people will go, "Okay, so I'll just live at home with a bunch of chatbots."

The Hon. ANTHONY D'ADAM: It's not social connection, is it? Isn't it inherent in social connection that you're dealing with a human being?

JILL BENNETT: Yes.

GAIL KENNING: I think what's important to think about with social connection is it's not necessarily just about the connection to another person; it's a sense of connection to self. That's what we're often missing when we see people being lonely: They've lost that sense of self because it's not reflected in others. Here there's an opportunity to explore that, to explore what your interests are, what your thinking is and where you're at. I think it's particularly important in times of transition. Most of the examples about loneliness are times of transition for people. They might be grief; they might be going into aged care; they might be going into higher levels of supported care. In a sense, that becomes a very lonely time because of not knowing what the experiences are and how you feel about it. This is an opportunity to talk about that, find out more and actually understand yourself more. So that's a sense of important connection that's there.

The CHAIR: Could I ask perhaps Ms Darling to have the final words for us on this? You've just heard a bit of an exchange about potential dangers—maybe an AI situation displaces human connection. Is that something that would worry you, that if you were using AI that you might lose further human connections or that you might not want to make connections?

GWENDA DARLING: I think it's such a personal thing. I love being alone. I was always surrounded by people. I was a social worker and I have so much shame about my diagnosis. Yes, I've talked to Dementia Australia. I'm on their advisory committee. I am involved in things, but I love being alone. Very occasionally I get a little bit lonely, and I would love someone that I could talk to at any time of the day or night and just say what I'm thinking, who could perhaps reflect back to me. I know that I always know what I want and what's best for me ultimately, but sometimes it's good to have someone just to talk it through. It's still there on top.

I do see an issue with people falling in love with the bot. I do see an issue with the alter-reality of it. But there's no way I'm going to ring a peer support line. There's no way I'm ever going to ring a helpline. For me, I think it would be great to have something like a bot that I could talk to when I wanted to talk to someone. I'm totally in control of when I would turn it on. I don't have to make it a cup of tea, I'm just totally in control of it. Particularly in residential care, where we can be surrounded but still be lonely, or if you're like me and you want to be alone but you want to bounce an idea about something, that's where I see the benefit.

The CHAIR: Unfortunately we've come to the end of our time today. I very much appreciate your submission and the time and effort taken to be here today. I'm not sure if we asked you to take anything on notice. There may well be supplementary questions that the secretariat will get in touch with you about.

(The witnesses withdrew.)

The Committee adjourned at 16:50.