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c/-Committee Secretary
NSW Legislative Council
Standing Committee on Social Issues
6 Macquarie Street
Parliament of NSW
Sydney NSW 2000

Submitted via email to: Committee.SocialIssues@parliament.nsw.gov.au

Dear Committee Members,

Inquiry into the Prevalence, Causes and Impacts of Loneliness in New South Wales

The Australian Psychological Society (APS) appreciates the opportunity to contribute to the Standing Committee on Social Issues *Inquiry into the prevalence, causes and impacts of loneliness in New South Wales.*

About the APS

The APS is the leading professional association for psychologists in Australia. Psychologists work in diverse ways and contexts to unlock the full potential of individuals, organisations and communities through the application of psychological science and knowledge. At the APS, we are dedicated to advancing the scientific discipline, ethical practice and application of psychology. Our work is informed by United Nations human rights treaties and conventions[1] and the United Nations Sustainable Development Goals (SDGs)[2] and Conventions. We advocate for a fair, inclusive and environmentally sustainable world, recognising the evidence that national and global prosperity, now and in the future, hinges on prioritising the wellbeing of people and the planet[3].

As experts in human behaviour and the application of prevention, early intervention and treatment science, psychologists are well-positioned to contribute to this important conversation about loneliness in NSW and offer evidence-based solutions to address loneliness, strengthen social ties and promote health and wellbeing across all NSW communities.

On the following pages, please find our submission to the inquiry terms of reference that the APS is best placed to respond to. If any further information is required from the APS, or if you would like to request an APS representative attend a hearing, I would be happy to be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

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APS Response to the Inquiry into the Prevalence, Causes and Impacts of Loneliness in New South Wales

Loneliness can affect anyone, at any time. The impacts of loneliness became especially evident in Australia during COVID-19 social distancing measures and lockdowns, reaching a peak of 1 in 2 Australians reporting loneliness and 1 in 6 experiencing problematic levels[4–6]. However, high levels of loneliness existed prior to the COVID-19 pandemic and have intensified in the years following COVID, especially for specific groups, such as young people[7].

Our responses to the inquiry terms of reference are guided by several key points:

- Understanding the nature and extent of loneliness can be complicated by the associated but distinct concept of social isolation (and others such as belonging, social support, social identities), alternative terminology (e.g., social isolation versus emotional isolation) and different measures[8]. In our submission we have adopted the following definitions:

  Loneliness describes a negative or distressing feeling that people experience when their social connection is less than they desire[6]. It is typically measured with validated psychometric scales[7,8] or directly asking how lonely someone feels (e.g.[9]).

  Social isolation is a state of minimal social contact. It can be measured with validated psychometric scales[9], or asking about the number of social connections one has with family, friends and others.

- Although higher levels of social support correlate with lower levels of loneliness,[9] ***loneliness cannot be assumed based on limited social contacts***. Some people have few social contacts but are not lonely and desire or delight in solitude, while others experience loneliness even though they are surrounded by others[10].

- ***Loneliness is associated with poor mental health but is ot a mental health condition***. Instead, it is a social phenomenon and indicator of inadequate meaningful social relationships and support that are fundamental to the human sense of self and purpose in life[6].

- We draw on the expertise of our members and the evidence-based research to illustrate the influences and impacts of loneliness and recommend strategies for reducing its prevalence and impacts for individuals and communities. However, some caution is advised when applying these findings to the NSW context, as not all the relevant research has been conducted within Australia and state or territory jurisdictions such as NSW.

Responses to Terms of Reference

a) The extent of loneliness and social isolation in NSW and how this is measured and recorded, including opportunities for additional and/or improved data capture.

Before COVID-19, an APS survey found that 1 in 4 Australians aged 12 to 89 experienced loneliness at least some of the time, and more than 1 in 2 adults reported sometimes lacking companionship[10].

The latest available population data from the AIHW shows that in 2022 almost 1 in 7 Australians experienced social isolation and over 1 in 6 experienced loneliness[7].

Other 2022 studies suggest even higher rates of loneliness. Ending Loneliness Together found 1 in 3 Australians feel lonely and 1 in 6 experience severe loneliness[7,11]. In NSW, 1 in 3 participants in this study reported loneliness, and in a 2022 Mental Health Commission survey nearly half of NSW residents reported feeling lonely "some of the time" or "often"[12].

Comparing findings across studies with different measures is challenging. Additionally, loneliness and social isolation may be underreported due to stigma, particularly among those who find their loneliness distressing[24]. Nevertheless, ***it is clear that loneliness is widespread across Australia, including NSW, and has been for some time.***

To better understand and address social isolation and loneliness, collecting consistent and comprehensive data across Australia is essential. Currently, comparing data on loneliness and social isolation within and across Australian states and internationally is challenging due to inconsistent measurement approaches[7]. A reliable, uniform measurement framework is critical for informing government policy, community services and tracking efforts to reduce loneliness.

Ending Loneliness Together has developed a series of guides for community organisations on measuring loneliness, evaluating outcomes, and reporting service evaluations (see [13–15]). These guides can also support government agencies, health services, educational institutions, workplaces and other institutions, big and small, to recognise opportunities for improved loneliness data for policy and clinical purposes. For instance, health centres and medical practices could incorporate loneliness-related questions in their intake forms. This data could directly inform the work of clinicians. Data could be centrally collected and reported, potentially through primary health networks and used to guide the development and evaluation of local initiative tracking and changes in prevalence.

There are also many opportunities for gathering important data about loneliness and social isolation to guide policy at the government level, for example:

- Governments can include loneliness and social isolation questions within state-wide social and health surveys. For example, the Queensland Government's *Queensland Social Survey (QSS)* now includes questions to capture information about loneliness, social groups and connections with neighbours, friends and family[16]. Quality state-wide data can contribute to a richer understanding of loneliness trends and support the development of targeted interventions across NSW.
- NSW along with other state and territory jurisdictions could also advocate for the Federal Government to collect loneliness data every five years as part of the Australian Bureau of Statistics (ABS) survey.

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

In the past decade, substantial research has investigated the underlying causes and maintaining factors that contribute to loneliness, as well as some of the protective factors which can mitigate loneliness. While researchers have taken varied approaches, common factors have emerged.

As shown in Table 1, the risk and protective factors for loneliness cut across demographic, health and cognitive, and socio-environmental factors.

Protective factors emphasise the value of social connections, good mental and physical health and meaningful in-person interactions, highlighting the importance of both individual and community-level influences on loneliness.

Key risk factors include poor health, living alone and excessive digital communication and social media. Research has also identified several cohorts who are at increased risk of loneliness:

- people living with mental health conditions, disabilities or chronic disease[17],
- victims and survivors of domestic and family violence[17],
- culturally and linguistically diverse communities (CALD) including migrants, refugees, asylum seekers and international students[8],
- people identifying as lesbian, gay, bisexual, transsexual, intersex and queer (LGBTIQ+)[8],
- parents (especially single parents) and carers[18],
- the unemployed or financially stressed[19],
- former Defence personnel[17],
- people who have been impacted by natural disasters[20], and
- parolees[17].

The data highlights some groups in which individuals may be especially vulnerable to loneliness:

- **Young people.** In Australia, prior to and during the COVID pandemic, young people and older adults reported experiencing loneliness more than other age groups[6,8]. Recent data shows that higher rates of loneliness have continued for youth, but not for older adults. As of 2022, the AIHW found that about 1 in 5 males and 1 in 6 females aged 15–24 were experiencing loneliness, continuing an increasing trend since 2012[7]. The rise in loneliness among young people is not fully understood, but it may relate to the spread of social media and declining quality of social connections[21].
- **First Nations people.** Approximately 34% of Australia's Aboriginal and Torres Strait Islander population live in NSW[22]. This population is relatively young, with a median age of 23 years compared with 39 for non-Indigenous Australians[22,23]. First Nations people report higher average loneliness scores compared to non-First Nations Australians and immigrants[7]. For older Aboriginal and Torres Strait Islander people, lower levels of social engagement (e.g., living alone, feeling lonely, and fewer social activities) is associated with a dementia diagnosis[24].

  Currently, however, it appears that research about social isolation and loneliness for Aboriginal and Torres Strait Islander people is severely lacking. Warr et al[8] suggest that nuanced attention to connection to country, culture, spirituality and acknowledgement of historical trauma are more appropriate than generic health and wellbeing service provision for Aboriginal and Torres Strait Islander people. More research is needed to develop a more culturally nuanced understanding of risk and protective factors and impacts of loneliness for First Nations people.
- **People living in rural and remote locations.** Over 3 million people, or 38% of the NSW population, live in regional, rural or remote areas[25]. Not only are they geographically separated from others (a direct cause of loneliness for some), people who live in these areas have proportionately higher disease burden, mortality rate and health risk factors (e.g., smoking, low exercise and increased alcohol intake)[26]. As per Table 1, these factors are all associated with increased loneliness. However, caution is to be exercised as “remoteness” is not always perceived by people living in these areas as being socially isolating or lonely[8].

Young people, First Nations people, people living outside of metropolitan areas, and others living with vulnerability and disadvantage are obvious priorities for health promotion and prevention approaches and targeted intervention strategies. These initiatives can be embedded in schools and local communities, supported by peers and community mentors and elders. It is also essential to consider intersectionality and the compounded impact of multiple risk factors and marginalized identities, such as First Nations youth living in remote communities, who may face heightened isolation and limited access to culturally appropriate supports. Recognising these intersecting factors allows for more tailored and effective approaches to reduce loneliness and improve wellbeing in these populations.

Table 1: Risk and protective factors for social isolation and loneliness

Demographic Risk Factors	Demographic Protective Factors
• **Age** – young (< 25 years), and older adults (> 65 years) experience greater loneliness[10,27,54] • **Gender**- older women report higher loneliness levels directly, but older men report greater levels when asked indirectly (not evident in younger adults)[27,29,54,55] • **Migration** – being a migrant is associated with higher levels of loneliness[27,56,57] with language cited as a significant barrier[8] • **Martial status** – unmarried people are more likely to report being lonelier than married people[27,29,55] • **Living status** – living alone is associated with higher reports of loneliness (except in assisted living)[27,29,58] • **Socio-economic status** – lower income, education, unemployment, and living in a poor region is associated with greater loneliness[27,29,59]	• **For migrants –** identifying with the majority was found to be a protective factor against loneliness[57] • **Age –** some evidence to suggest that overall, greater age is associated with lower loneliness[59] (however, stressful life events that are more likely to happen to older people e.g. death of a partner, deteriorating health, or financial worries are associated with increased loneliness)[8,58] • **Living with others**- is associated with lower loneliness[58]
Health and Cognitive Risk Factors	**Health and Cognitive Protective Factors**
• **Physical health** – indicators of poor physical health are associated with loneliness (e.g., poor sleep, cardiovascular reactivity, mortality)[27,29,60] • **Mental health** – indicators of poor mental health predict loneliness e.g., depression, anxiety)[27,29] • **Cognitive health** – cognitive decline and increased risk of dementia are associated with higher levels of loneliness [27,29,58] • **Biological and genetic factors** – some evidence of genetic and biological factors which are associated with loneliness (e.g., brain-structural differences, cortisol processing)[27] • **Physical disability or sensory impairment** - people with a disability or sensory impairment report greater loneliness than people without a disability[61] or sensory impairment[62] • **Poor emotion regulation –** loneliness associated with indicators of poor emotional regulation e.g., more rumination, catastrophising, blaming, suppression and withdrawal; less cognitive reappraisal and active problem solving[63,64]	• **Good overall health** - self-assessed is associated with lower loneliness[59] • **Good mental health** - self-assessed is associated with lower loneliness[59] • **Low social anxiety** - is associated with lower loneliness[59] • **Getting the right amount of sleep** - is associated with lower loneliness[59]
Socio-environmental Risk Factors	**Socio-environmental Protective Factors**
• **Digital communication** – depending on its purpose and use, digital communication (e.g. social media) can lead to increased loneliness[27,59]. For example, self-reported social media overuse is associated with increased loneliness[59] • **Community fragmentation and disorganisation** – is associated with increased loneliness[65]	• **Social networks** - Having a 'confidant' or friends, relatives, neighbours, children[5,27,58,66] is a strong protective factor against loneliness. Having the right amount of in-person social interactions also associated with lower loneliness[67] • **Meaningful daily interactions** – Second strongest protective factor in large US study > 20,000 participants[67] **Digital communication** – depending on its use and purpose, some digital communication use can be a protective factor[27,67] • **Good romantic relationships** - associated with lower loneliness[67]

c) Evidence of the psychological and physiological impacts of loneliness on people, including young people, the elderly, those living with a disability, those living in regional areas and the bereaved.

(d) Evidence linking social connection to physical health.

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

Loneliness is a public health issue that negatively impacts health, wellbeing, productivity and daily functioning of the population and significantly drives up health system costs.

Loneliness is a risk factor for poor mental and physical health, including:

- depression, anxiety, paranoia and suicidality[27,28]
- dementia for older people[29],
- poorer cardiovascular health, coronary heart disease and stroke[30], and
- mortality risk[31,32].

There is also evidence that the absence of supportive relationships and social integration increases the risk of dying from various diseases, including cancer (e.g.,[33,34]).

Loneliness has been associated with increased general practitioner visits, extended hospital stays and higher risk of adverse health outcomes, particularly among older adults and individuals with mental ill-health[35–37]. However, increased use of health care services extends beyond at-risk groups. Studies show that loneliness independently contributes to higher primary healthcare and hospital services utilisation in the general population, regardless of social isolation, demographics, chronic conditions or prior healthcare usage[38,39].

Loneliness predicts decline in mental, physical, and cognitive health—making it a prime target for public health intervention. In 2019, economic modelling conducted by the National Mental Health Commission shows that for every $1 invested in programs that address loneliness, the return on investment is between $2.14 to $2.87 respectively[40,41].

Thus, the evidence indicates that addressing loneliness can:

- improve mental wellbeing, physical health and productivity, and
- reduce the demand and costs associated with primary care and hospital services.

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

(h) Developments in other jurisdictions regarding the implementation of policies and initiatives relevant to the treatment of loneliness as a public health issue

- *Ending Loneliness Together* is a national network of organisations chaired by psychologist Michelle Lim, who have come together to address loneliness in people living in Australia[42].
- The Australian Government funds a national *Community Visitors Scheme* which supports local organisations to recruit volunteers who provide regular visits to Australians in receipt of Commonwealth-subsidised aged care services.
- The Queensland Government completed a *Parliamentary Inquiry into social isolation and loneliness in Queensland* in 2021 leading to the following initiatives:
    - The Queensland Government *Communities 20232 strategy,* a 10-year state-wide strategy that includes planning towards taking action on social isolation and loneliness in Queensland[43]

- The *Queensland Social Survey (QSS)* replaced social cohesion questions with social isolation questions for the first time in 2021 and in 2023 questions measuring loneliness were added to capture information about loneliness, social groups and connections with neighbours, friends and family[16].
- From 2022 until 2026, the Queensland Government *Communities Innovation Fund* will provide up to $200,000 per year to community organisations for innovative projects that create meaningful connections for Queenslanders experiencing social isolation and loneliness[44].

- *QCOSS Social Isolation: Best practice guide for service delivery 2023* assists Queensland Government funded organisations who provide Seniors Isolation Services[45]
- The VicHealth *Mental Wellbeing Strategy 2019–2023* includes a focus on promoting positive social connections among young people[46], and later this year they will release a report entitled *Women, Their Social Connections and Social Cohesion*.
- The UK has a *Centre for Loneliness Studies* at the University of Sheffield, the *UK Loneliness Strategy* and appointed a Minister for Loneliness[47].
- *Gather My Crew* is a free, online rostering tool that helps family, friends and community members to organise themselves in support of someone who needs help.
- *Moderated Online Social Therapy* is an online program from Orygen designed for vulnerable young people experiencing mood disorders, anxiety and psychosis[48,49].

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

The range of vulnerable groups, drivers and protective factors identified in this submission makes it clear that a one-size-fits-all approach is insufficient for preventing, mitigating and responding effectively to loneliness in our community.

Instead, ***a multi-component and stepped state-wide response is required*** that includes whole population health promotion, inclusion and education strategies along with targeted responses to vulnerable members of the community. This includes prevention and redirection for socially vulnerable people at risk of loneliness to appropriate, effective low-intensity early intervention community-based supports, or specialist mental health treatment services based, on assessed needs.

The APS, in partnership with Ending Loneliness Together and RU OK?, have previously called on the Federal Government to invest in a national loneliness strategy based on health promotion, prevention, early intervention and treatment science[50]. We identified two key gaps to be addressed urgently to reduce the prevalence and impacts of loneliness:

- Limited community awareness and skills about how to manage loneliness, and
- The absence of guidelines to identify, monitor or target loneliness within community, mental health systems and other agencies.

A first step the NSW Government can take towards effectively addressing these gaps is to co-design a NSW Loneliness Strategy.

This should involve collaboration across the NSW community, engaging all sectors, industries and people with expertise and lived experience or who are at increased risk of loneliness (e.g., youth, older people) to ensure the strategy development and implementation are inclusive and informed. Actively engaging the NSW community in the design and implementation of a loneliness strategy can also raise awareness about loneliness and its impacts and begin to tackle associated stigma.

In the absence of national strategy, a comprehensive, co-designed NSW strategy would not only enhance community mental and physical wellbeing, boost productivity and reduce healthcare costs, but also strengthen advocacy for Federal government investment in a unified national loneliness framework and resourcing.

Practically, a state-wide strategy could be guided by the following key questions/priorities with responses tailored to the NSW context:

- *What is loneliness?* (Example strategic action: Rollout of a community awareness campaign and toolkit to build community capital)
- *Where do I go to get help?* (Example strategic action: Implementation of a state-wide e-health loneliness portal that identifies resources from self-help to low acuity care, such as social prescribing, and specialised care providers).
- *How do I provide the best care?* (Example strategic action: Training and resources for health professionals and community organisations to improve identification, referral and treatment for effective and appropriate care, including evidenced-based CBT and emotion-regulation therapies, group therapy and community-led interventions that build social capability and identity (e.g., [51–53])
- *How do I measure and evaluate loneliness*? (Example strategic action: Implementation of a loneliness measurement framework to improve identification and change in loneliness in individuals and the community).

We also call for the integration of psychologists into a statewide NSW loneliness strategy.
Psychologists, as Australia's largest mental health workforce, are uniquely equipped to contribute to the mitigation of the impacts of loneliness and the reduction of prevalence, being embedded across many sectors such as health, education, clinical care, community services and forensic settings. Psychologists' comprehensive training enables them to deliver evidence-based assessments and interventions tailored to individuals and groups experiencing mental ill-health and other loneliness-related vulnerabilities when needed.

Beyond direct treatment, psychologists are ideally suited to design, lead and evaluation evidence-based prevention and early intervention programs that strengthen social connectedness and resilience within community settings such as schools, workplaces and health care settings. Psychologists have the training necessary to ensure that interventions and evaluations are rooted in evidence-based practices.

Fully utilising the expertise of Australia's largest mental health workforce—psychologists—will reduce health, wellbeing, productivity and care costs associated with loneliness and deliver substantial benefits to the NSW community.

In summary, loneliness is a critical public health issue affecting mental, physical and economic wellbeing, especially among vulnerable groups such as young people, First Nations and CALD communities, and those in rural areas. The APS recommends developing a comprehensive, co-designed NSW Loneliness Strategy that leverages evidenced-based approaches and integrates psychologists as an essential profession in prevention, intervention, and treatment roles.
The strategy should address loneliness measurement and evaluation, and the establishment of multi-component strategies, from self-help to community-based initiatives, targeted approaches for at-risk groups and more intensive supports delivered by psychologists and other health and allied health professionals as needed.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time and evidence-informed knowledge, experience and research to this submission.

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