# Submission to Inquiry into Social Isolation and Loneliness in Queensland


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## Position Statement:

In this submission our aim is to provide evidence that speaks to three key points identified in the inquiry: (a) the nature and extent of loneliness together with its consequences, (b) key causes, drivers and vulnerable populations, in addition to (c) community-based solutions to manage loneliness.

## Nature, extent and impact of social isolation and loneliness in Queensland

### 1. Rates of loneliness in Queensland are comparable to those of people in other Australian States and Territories.

This conclusion is supported by data from the ABC's Australian Talks survey (for which Prof A. Haslam was a scientific advisor). These are representative data from over 36,000 Australians in 2019 and 9,000 in 2021, approximately 20% of whom were Queenslanders (reflecting the proportion of Australians living in the state).

These data show that 12-15% of Australians (Figure 1a), including those living in Queensland (Figure 1b), report frequently or always experiencing loneliness. Notably, these figures have not changed over time, indicating that there has been no improvement (or decline) in the last 2 years.

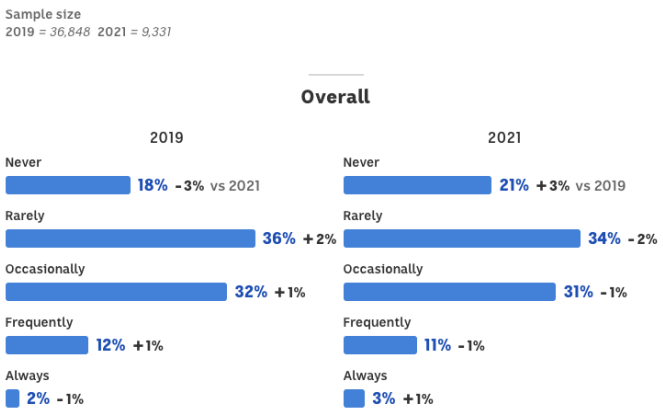


Figure 1a

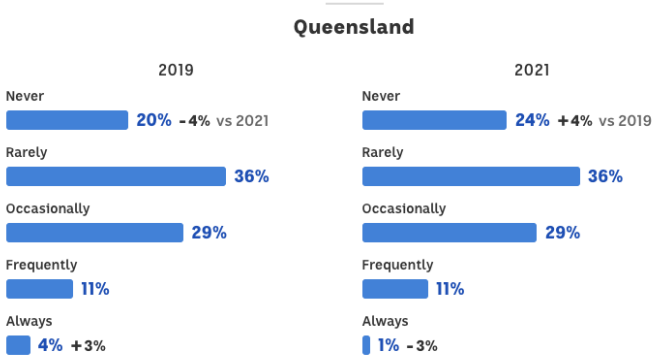


Figure 1b

## 2. There was a small but notable increase in reports of isolation and loneliness over time in the first wave of COVID-19.

Data from a 2-wave University of Queensland research survey conducted by our team during the first wave of the pandemic indicated that loneliness generally increased across Australian States and Territories in the context of COVID-19 restrictions.

- Time 1 (blue bars) conducted 17-20th March 2020 (Total sample=728; Queensland sample=131)
- Time 2 (red bars) conducted 24th June-2nd July 2020 (Total sample=480; Queensland sample=91)

*To what extent do you feel isolated from others?* (1=hardly ever, 3=often).

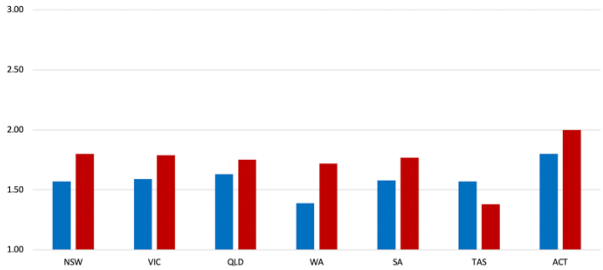

Figure 2a

*To what extent do you feel lonely?* (1=hardly ever, 3=often).

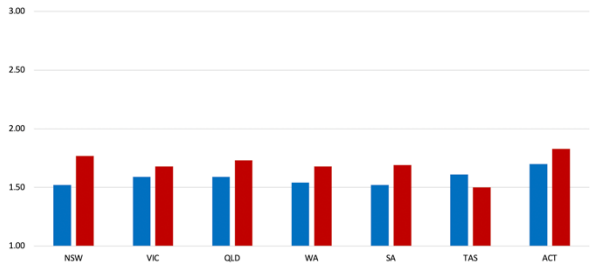


Figure 2b

*Are you worried that COVID-19 will increase the extent to which you feel lonely?* (1=not at all worried, 7=extremely worried)

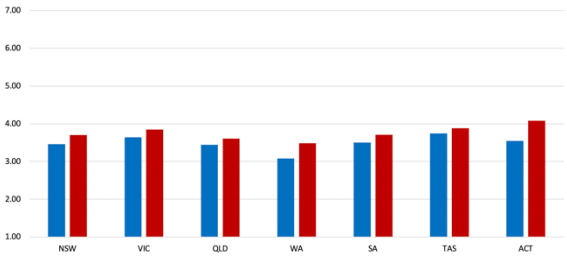


Figure 2c

As these data show, average levels of isolation and loneliness were not extremely high, but there was evidence of a small increase in average rates reported across the states and territories during the pandemic, including Queensland.

The greatest increase in isolation and loneliness between T1 and T2 was observed in two age groups:

(1) Those aged between 17-25 years, 13% of whom reported *often feeling isolated* and *lonely* at T1 increasing to 21% at T2.
(2) Those aged 35-50 years, 5% of whom reported *often feeling isolated* and *lonely* at T1 increasing to 18% at T2.

These patterns align with the larger sample represented in the Australia Talks data. This indicated that young people (see Figure 2d), are reporting feeling lonely more frequently than the general population (see Figure 1a, shown earlier and repeated below) [1].

**Loneliness in young people aged 18-24 years**

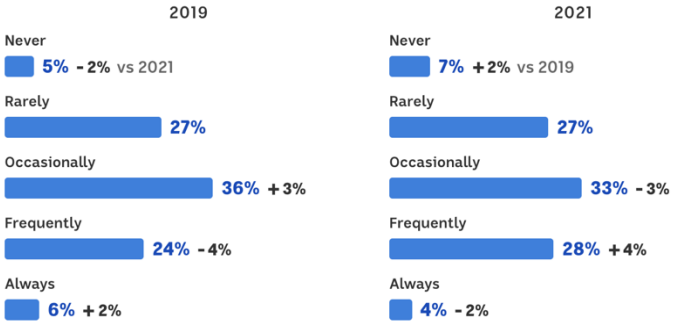


Figure 2d

**Loneliness overall in Australians**

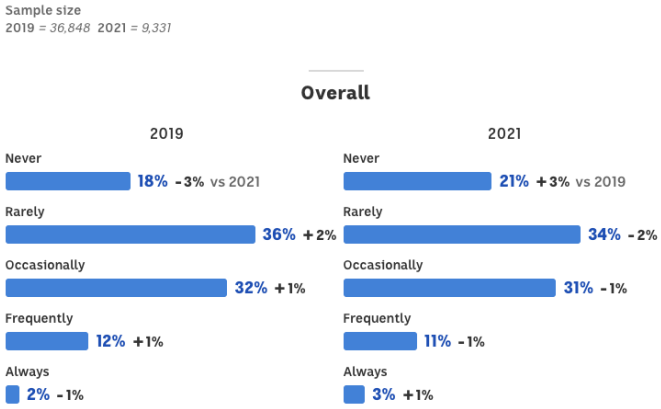


Figure 1a

## 3. Loneliness undermines engagement with COVID-safe behaviours.

Our University of Queensland survey also identified an association between loneliness, community engagement and engagement in COVID-safe behaviour. At the point when COVID restrictions were introduced (i.e., our Time 1 data), loneliness *undermined engagement in safe behaviour.* Compared to respondents who felt more socially connected, those who reported a general sense of loneliness:

- experienced more unsupportive interactions with others,
- received less support, and provided less support to others,
- felt less trust, less control, and felt more threatened, and
- engaged in fewer citizenship behaviours and behaviours to prevent the spread of COVID-19 (e.g., avoid shaking hands, physical distancing)

These findings are not surprising, given that loneliness is experienced as a lack of belonging and connectedness to community. If you do not feel connected to community, you will not feel the sense of solidarity ("that we are in it together") that is needed to engage meaningfully in behaviours that support the collective good. In contrast, if you feel connected to your community, then you are more enabled and willing to engage in COVID-safe behaviour.

## Causes and drivers of social isolation and loneliness.

### 1. A key driver of loneliness is the inability to access meaningful group memberships

A key factor identified as contributing to loneliness in the Australia Talks data is the decline in civic engagement and membership of organisations, clubs and societies. The proportion of Australians who are not a member of any organisations rose from 28% in 2019 to 36% in 2021.

However, this decline is particularly stark among young people (see Figure 3). Among those aged 18-24 years, 29% now report belonging to no groups, organizations and societies compared to 19% in 2019.

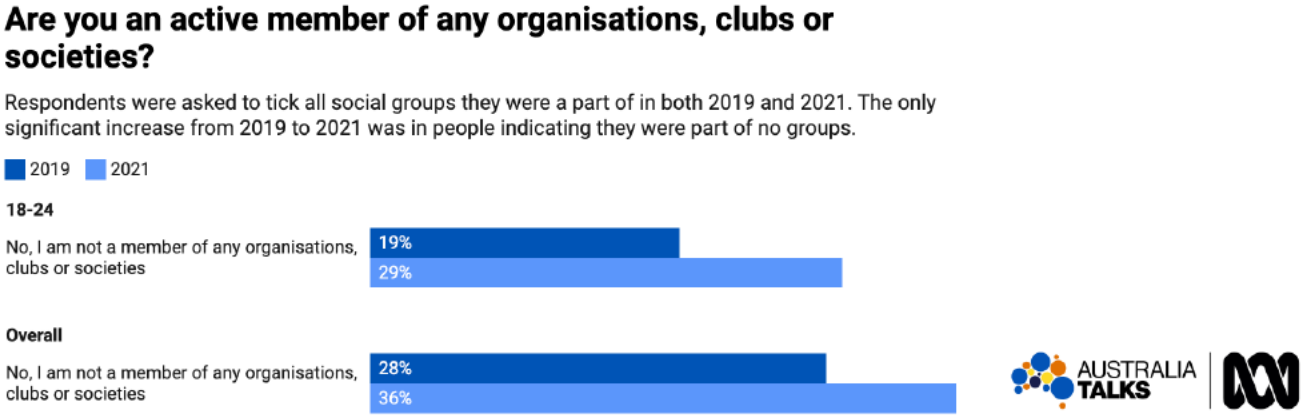


Figure 3

Young people also felt less connected to the Australian community more broadly than those in older age groups. While 48% of Australians strongly agree with the statement that being Australian is an important part of their identity, only 33% of those aged 18-24 agreed with this statement.

### 2. Two groups are particularly vulnerable to loneliness: Young people and those from disadvantaged backgrounds.

Economic insecurity not only reduces access to resources (secure housing, safe living environments, healthy food, etc.), but also opportunities to maintain active, socially connected, lives [2].

(i) Young People

We have already discussed data relating to young people's loneliness, civic engagement and general connection to the Australian community. In addition, another factor that may underlie the sense of disconnection felt among young people is the economic insecurity they face. Again, the Australia Talks data speak to this point. While 31% of all Australians considered job security to be "somewhat" or "very much" a problem, this is true for 47% of those aged 18-24 years.

(ii) Vulnerability and Disadvantage

The effects of disadvantage on illness and health are well known, but the Australia Talks data also highlight the impact of disadvantage on loneliness. In particular, the rates of loneliness in people with disability (Figure 4a) are higher than those of people living without disability (Figure 4b). Among those

living with disability 24-26% report frequently or always feel lonely, compared to 12-13% of those without disability. Again, rates of loneliness have not changed over the last two years.

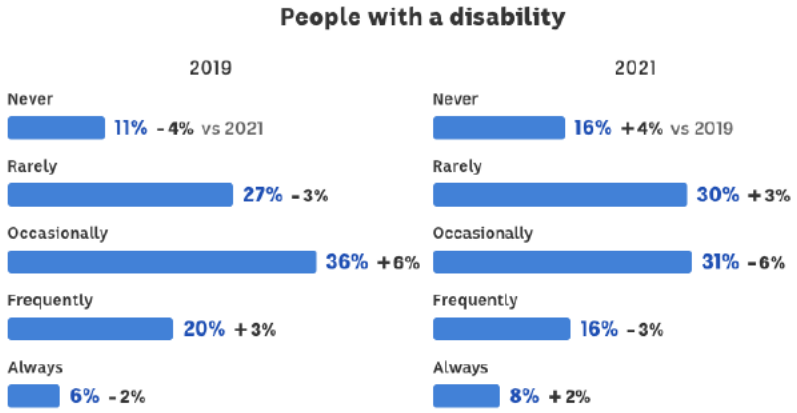


Figure 4a

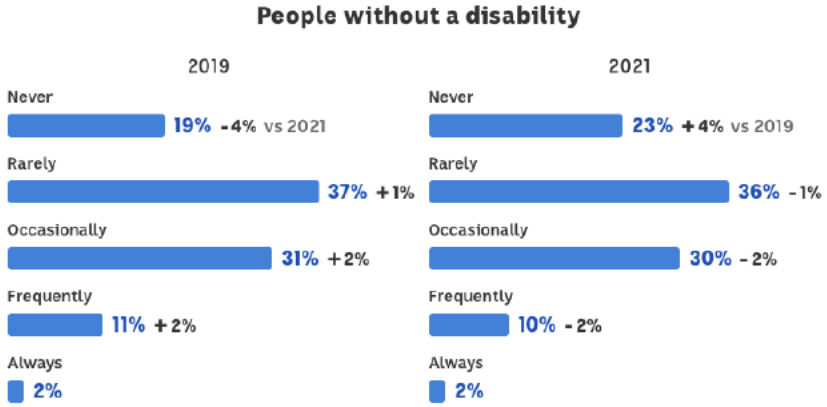


Figure 4b

A similar pattern is observed in people living on low income. However, in this case, rates of loneliness in those on low income have increased. In 2019, 21% of people earning less than $600 a week reported frequently or always feeling lonely and this rose to 26% in 2021. In contrast among those on much higher incomes, a very low percentage — just 1% — reported always feeling lonely.

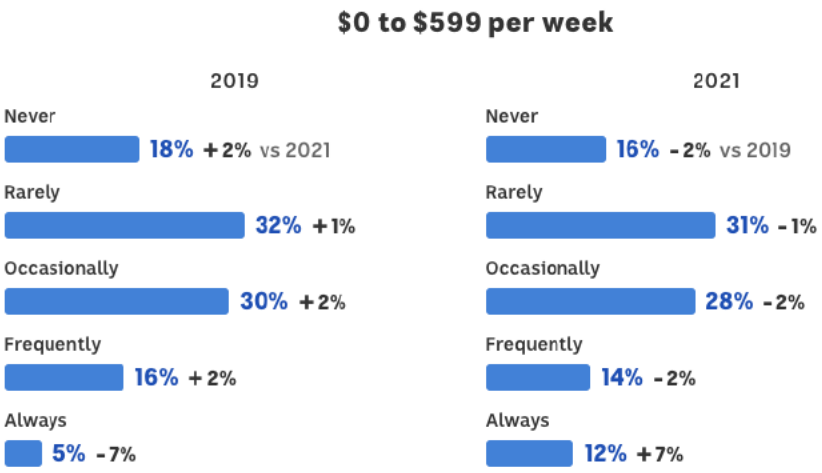


Figure 5a

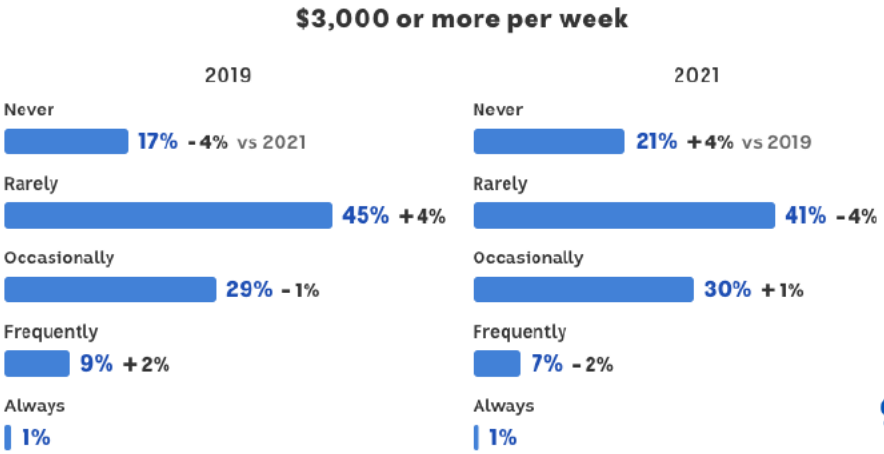


Figure 5b

## Successful initiatives

Outside of formal healthcare treatment, there is growing evidence in support of two general approaches to manage loneliness in the community.

### 1. Social Prescribing

This approach integrates "link" workers into General Practice clinics to deliver hands-on, practical, support to connect people to activities and groups in their communities (e.g., arts, education, interest, and exercise-based groups). These activities are typically supported by the NGO, charity and volunteer sectors.

- A systematic review of 86 social prescribing schemes found they resulted in short term reductions in loneliness and mental health symptoms [3].

- There is an opportunity to determine the efficacy of this approach for local communities in Queensland, co-funded by an Australian Research Council grant. This research is being undertaken in partnership with the Mt Gravatt Community Centre to examine the efficacy of social prescribing, as part of the Ways to Wellness program (https://waystowellness.org.au). Data collection is underway and will be reported as part of another submission to this call led by our colleague Associate Professor Genevieve Dingle.
- Nevertheless, questions are already being raised about the sustainability and costs of the social prescribing treatment model and the extent to which it alone can enhance client independence sufficiently to achieve longer term positive outcomes [4].

## 2. GROUPS 4 HEALTH

This University of Queensland program addresses two key gaps raised above; the need to:

(i) enable people to engage meaningfully with social groups in their community,
(ii) allow people to manage their membership of those groups themselves

GROUPS 4 HEALTH (G4H) is a manualised program that provides people with the knowledge and skills they need to build and sustain their social group and community belonging independently in ways that support their health and well-being. The program targets 5 key issues about connectedness, summarised in Figure 6.

| | |
|---|---|
| **Appreciating Groups** | **Feeling connected:** Why is a sense of connectedness so important? |
| **Mapping Groups** | **Seeing connections:** What are my group connections? |
| **Strengthening Groups** | **Being connected:** How are my connections impacting on my life? |
| **Extending Groups** | **Making connections:** What do I want my connections to look like? |
| **Maintaining Groups** | **Keeping connected:** How do I stay connected when things get tough? |

Figure 6

Three clinical trials support the efficacy of G4H.

1. A Phase I proof-of-concept trial [5] recruited 81 adults with social isolation and psychological distress, and found a significant reduction in:

   (i) loneliness (d=-0.86)[1], depression (d=-0.29) and social anxiety (d=-0.52), and

   (ii) an increased sense of group belonging (d=0.82),

[1] Note that d refers to the magnitude of the effect: 0.2 is a small effect, 0.5 is a medium effect, 0.8 is a large effect

(iii) with improvements maintained or increased at 6-month follow up relative to a matched control group.

2. A Phase II randomised controlled trial (RCT) [6], recruited 120 adults, comparing G4H with Treatment-As-Usual (TAU). Depression was reduced in both G4H and TAU groups, but at 2 month follow up:
   (i) G4H produced a greater reduction in loneliness (d=-1.04) and social anxiety (d=-0.46),
   (ii) and was associated with fewer GP visits (d=-0.33) and greater group belonging (d=0.52).

3. A Phase III noninferiority RCT, funded by Australian Rotary Health [7], recruited 174 young people (15-25 years) who received either G4H or group Cognitive Behaviour Therapy (CBT) and were followed up on program completion, 6 months and12 months later. This found that
   (i) depression decreased in both G4H (d=-.71) and group CBT (d=-.91).
   (ii) G4H was non-inferior to group CBT for depression at all time points,
   (iii) G4H had a slight advantage (d=-1.07) over group CBT (d=-.89) for loneliness after treatment completion, and
   (iv) G4H was significantly better than CBT at 12-month follow up in protecting young people against future threats to social connectedness (in this case COVID-19).

Data relevant to the last point are shown in Figure 7. This shows that while CBT and G4H reduced depression at 12 months when there was no threat to social connection (pre-COVID lockdown), only G4H was successful in protecting people against loneliness relapse during lockdown.

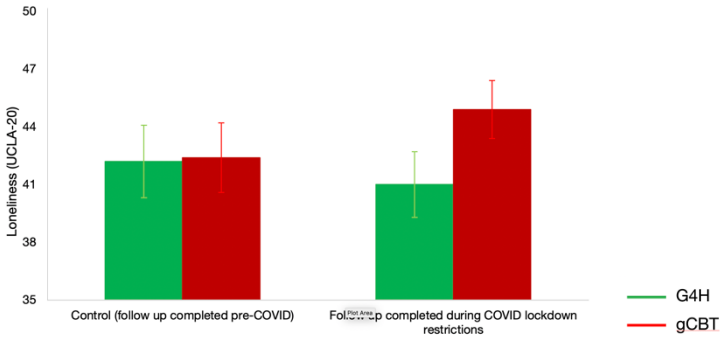


Figure 7

**Recommendations**

There are three key recommendations from the evidence provided in this submission

1. **Invest in *both* social prescribing and G4H.** These approaches are supported by the evidence and are ideally placed for community delivery where loneliness is experienced. Such investment should take two forms:
   a. Employ link workers in GP practices and community centres who know the local community and can provide practical help to connect.

   b. Train case workers and health professionals working in the community sector to deliver G4H, for purposes of loneliness prevention and management. This includes helping individuals to identify meaningful social groups to join, now and into the future, but also to sustain them in the longer term so they continue to function as a resource.

2. **Work on prevention.** Both the above recommended approaches are well placed to address management of loneliness, when it presents, but also its prevention. The evidence shows that two groups are more vulnerable to loneliness — young people and those living with vulnerability and disadvantage. These groups should be prioritised for prevention, that can be targeted in schools and local communities.
3. **Evaluate implementation.** While there is an evidence base that shows the benefit of investing in social prescribing and G4H, we lack data on the added value of combining these approaches and their implementation at scale. This research is needed to determine the longer-term benefits and sustainability of these approaches in supporting public health.

**References**

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