17th August 2021

Committee Secretary
Community Support and Services Committee
Parliament House
George Street
Brisbane Qld 4000

To Whom it May Concern

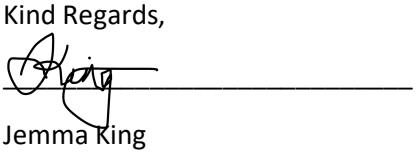
Inquiry into Social Isolation and Loneliness in Queensland

The Australian Health Promotion Association (AHPA) is the peak professional body for health promotion in Australia. It is a member based national not-for-profit organisation with a national Board of Directors, National Committees and State Branches. AHPA provides members an opportunity to exchange information, to progress the profession and to be engaged in professional development included through practitioner accreditation. Importantly, AHPA is active in progressing the health and wellbeing of the individuals, communities and society through advocacy, debate, program development and policy.

AHPA Queensland welcome the opportunity to provide a submission to the inquiry about social isolation and loneliness in Queensland. This submission has been prepared by a working group from the Australian Health Promotion Association (AHPA) – Queensland Branch committee. This submission has been reviewed and endorsed by the wider committee prior to submission. The 2021 AHPA Queensland Branch's view is that social isolation and loneliness (SIL) is a rising concern for the Queensland population, experiences of SIL are far reaching in terms of the number and diversity of people impacted, and this has important implications for the health and wellbeing of the population.

The attached submission is our response to a few of the key terms of reference. The terms of reference for the Inquiry are justifiably wide in the scope. To provide a concise but balanced contribution our focus is primarily on the drivers of SIL and facilitators of social capital and cohesion in Queensland, which we draw out using a socio-ecological model. This model allows consideration of the complex interactions between individuals, the community and broader societal factors, thus allowing a deeper understanding of the issue of SIL. To demonstrate the basis of our views and provide direction for how SIL can be prevented, mitigated and addressed, an overview of the terms used, references and our key recommendations are outlined. Thank you for the opportunity to contribute to this important and timely inquiry. Should you wish to discuss our submission, I can be contacted via the mechanisms below or via our branch email: [redacted]

Kind Regards,



Jemma King

Queensland Branch President

Jemma King
[redacted]
College of Public Health, Medical and Veterinary Sciences,
James Cook University,
Townsville,
Queensland,
Australian 4811

Telephone [redacted]
Email [redacted]

AHPA Queensland Submission

Timeliness of Inquiry

Paradoxically in an increasingly interconnected world, experiences of social isolation and loneliness are commonplace. The most recent estimates suggest that one in four Australians report feeling lonely all or part of the time (Ending Loneliness Together, 2020). The need to address social isolation and loneliness (hereafter shortened to SIL when referred to collectively) has been identified as a priority area and one with public policy implications in a number of countries (e.g. The United Kingdom and Japan) and in certain demographics (e.g. younger and older adults) (Durcan & Bell, 2015; Krug, 2021). Work in these locations and with these groups provides some baseline understanding of the issues, drivers and facilitators for change (Department of Digital, Culture, Media and Sport, 2018; World Health Organization, 2021). The terms of reference for this inquiry include a need to explore unique characteristics or experiences within Queensland related to SIL. However, as a starting point, we will first take the opportunity to connect with the broader evidence and to learn from others' experiences and initiatives. This represents good science and acknowledges the fundamental elements of the human condition which includes the need for connection.

While the imperative to address SIL existed prior to the COVID-19 pandemic, the salience of our existing connections, the capacity to interact with people at a time and means of our choosing, to engage meaningfully and nurture connections have all been brought to the fore. The pandemic heightened a sense of social isolation experienced by many Australians, young and old and is leading to poorer physical and mental health outcomes. Measures of social connectedness were collected by the Australian Bureau of Statistics as part of a household survey in June 2021. The experience for Queensland participation in activities with family or friends was in line with other states and territories not experiencing lockdowns with approximately 88.1% of the sample indicating participation in these activities in the last month (Australian Bureau of Statistics [ABS], 2021a). Results from previous surveys in this series, present a more nuanced understanding of the experiences of the population in 2020. In 2020, the Australian Bureau of Statistics reported that the personal stressor most experienced by Australians during the COVID-19 pandemic was loneliness. In fact, one in five Australians reported feelings of loneliness and social isolation as a result of the pandemic (ABS, 2020). In April 2021, the experience of loneliness had decreased, with one in ten people surveyed experiencing loneliness in the last month. Measures of social connection began to be collected across this time with poor levels of social connection being experienced particularly by people with a disability and people living alone (ABS, 2021b).

Essential public health measures, such as physical distancing and limitations on the visitors, have increasingly meant that individuals are physically disconnected from others. Indeed, these early public health measures were framed as the need to 'socially isolate' when really what was meant was to 'physically isolate' or 'maintain physical distancing' (Aminnejad & Alikhani, 2020). The long-term implications of this distancing and disconnect are starting to emerge but it is essential to acknowledge that these measures may further perpetuate SIL in individuals who were already experiencing SIL. SIL may be experienced anew as a result of measures and continue to exist and influence connection as the world seeks to return to a 'new normal' (Australian Psychological Society, 2020; Clair, Gordon, Kroon & Reilly, 2021; Hwang et al., 2020). Smith, Steinman & Casey (2020) suggested the pandemic has resulted in a social connectivity paradox whereby the actions can both protect and harm i.e. as physical interactions with others increases so does the risk of COVID-19 exposure but decreasing the potential for exposure increases the risk of SIL. While this is

unchartered territory, increasingly digital technologies can help to ameliorate physical isolation and, when used mindfully and with intention, can assist in improving social connections. All is not equal though in terms of accessibility, usability and functionality of digital technologies.

Position of Submission

This submission has been crafted by individuals passionate about health promotion who are active in teaching, research, community development, policy and governance relating to health promotion and public health. As such it is important to recognise the guiding principles that have influenced the submission and our position on the issues. Finding ways to connect people, to ensure that existing connections are meaningful, and that these connections enrich people's lives is essential. In line with this understanding, this submission will focus on outlining the **drivers** of social isolation and loneliness and **facilitators** of social capital and cohesion in Queensland. To situate this discussion, we use a **socio-ecological model**. This model allows consideration of the complex interactions between individuals, the community and broader societal factors, thus allowing a deeper understanding of the issue of SIL.

As a preference to our subsequent points it is important to outline the value stance that influences health promotion practice. **Health promotion** is the "process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with the environment" (World Health Organization [WHO], 2009: 1). The key strategies of health promotion are to advocate (for conditions that are favourable for health), mediate (for coordinated action across multiple sectors for different interests in society and adapt to local needs) and to enable (achieve equity in health through equitable opportunities, resources and control) (WHO, 2009). The implication of this is that health promotion values empowerment, inclusion and co-design. Health promotion identifies initiatives that can and should occur across a spectrum, which includes information provision but also skill acquisition and creating enabling environments. Furthermore, we understand that **social determinants of health**, which are the '*causes of the causes*' influenced the capacity of individuals to connect with others pre-COVID and will continue to do so into the future. For example, individuals who are unemployed may miss opportunities to connect with others in a workplace. As such, individual, community and societal factors all impact (positively and negatively) on social connection, isolation and loneliness. This means that multisectoral, multidirectional interventions are needed to address SIL but these need to involve individuals and communities.

Terminology Used in Submission

Before we present an overview of the driver and facilitators for the inquiry, we want to firstly provide context about the terms we use and how we operationalise these.

> **Loneliness**: "**subjective** feeling that you're lacking the social connections **you need**." (emphasis added) (Murthy, 2020: 8). Other researchers have acknowledged that there are various dimensions of loneliness with implications for assessment and vulnerable population identification (Landmann & Rohmann, 2021; van Baarsen-Heppener, Snijders, Smit & Duijn, 2001). Loneliness is about our internal comfort and experiences amongst our social connections and whether this satisfies our wants and needs. It is about the mismatch between the connections an individual has and the connections they desire. Importantly, feelings of loneliness can negatively influence how you approach, form and maintain relationships (Cann, 2021). An essential aspect of loneliness is that it is a subjective experience and one that is

influenced by an individual's difficulties, experiences and expectations (Cann, 2021). Tailoring approaches to acknowledge this complexity but centring it within the lived experience of individuals is essential. Another widely used definition of loneliness constitutes of social and emotional loneliness: loneliness is a subjective negative feeling associated with a perceived lack of a wider social network (social loneliness) or absence of a specific desired companion (emotional loneliness) (Valtorta & Hanratty, 2012).

Social Isolation: "describes the **objective** physical state of being alone and out of touch with people. Isolation is considered a risk factor for loneliness" (emphasis added) (Murthy, 2020: 9). Isolation can be sought out and enjoyed (i.e. the concept of solitude) and that an experience of feeling alone can occur when surrounded by people – this is described by Murthy (2020) as being "*emotionally alone*" pg. 9. Through a multidimensional concept, Gardner et al. (2018) also define social isolation as the objective lack or paucity of social contacts and interactions with family members, friends or the wider community.

This submission uses the definition of social isolation and loneliness as encompassing**:** the physical experience of being alone which is undesired by the individual OR the experience of feeling emotionally alone AND this is negatively influencing the individual's capacity to connect with and meaningfully interact with others as desired. This definition encompasses social connections as being purposeful connection with others. Social connections are a resource that can be drawn upon and from which, ideally, all participants perceive some benefit from this connection in the form of emotional and psychosocial support. A final word is that while we encompass both terms for this submission, these are separate concepts which may co-exist and co-occur but can also be experienced separately (i.e. an individual may experience loneliness but be social connected) (Ending Loneliness Together, 2020). This quote elucidates this difference: "*I have plenty of people to do something with but nobody to do nothing with.*" Felicity Green (as cited in Rantzen, 2011).

A key premise of this submission is an acknowledgement that the individuals who make up a person's network (e.g., family members, friends, caretakers, spouse, and neighbours) can play important roles in the person's life and lessen their chances of experiencing social isolation or loneliness. The size or extensiveness of a person's social network is not necessarily important, but rather the rewards of a social network are greatest when the relationships that do exist are of high quality (Chatters et al., 2018). Furthermore, the wider aspects of a community, society and environment can all contribute to the creation of infrastructure and societies that are inclusive and can support people creating meaningful social connections (Consumers Health Forum of Australia, 2021; WHO, 2021).

As such the nature of preventing, mitigating and addressing experiences of SIL need to focus on the contexts in which people live, connect with others and the factors which inhibit and enable these connections.

Magnitude of Issue and Program Overview

There is no one size fits all approach to addressing SIL, and it is important to tailor interventions to suit the needs of individuals, specific groups or the degree of loneliness experienced (Fayoka, McCorry & Donnelly, 2020). As Fayoka et al. (2020) indicate, these assessments of need should involve the individual and/or group, be conducted early and the results of the assessment should inform tailoring of programs and evaluation. It is recommended that the degree and determinants of the individual's loneliness be explicitly explored to design the most appropriate program. This includes sociodemographic factors (i.e. age, poverty, being a carer) and the social environment (i.e.

access to transport, driving status and place or resident). It is also essential to consider the needs of key groups such as individuals with physical disabilities, carers, Aboriginal and Torres Strait Islanders and ethnic minority groups. The timeliness of engaging with vulnerable groups is paramount as the COVID-19 pandemic has disproportionately affected these groups and widened the inequalities that exist in populations (Bu, Steptoe & Fancourt, 2020; Williams, et al, 2021). These groups are likely to have experienced loneliness during the pandemic and to have an even higher risk of experiencing loneliness relative to other groups (Bu, Steptoe & Fancourt, 2020). Interventions to prevent and mitigate SIL during COVID-19 need to be guided through a socio-ecological framework to add knowledge of the complexity of factors associated with experiences of SIL (Henderson, Schmus, McDonald & Irving, 2020; Prohaska, O'Sullivan, Leavey & Burns, 2021). Acknowledging experiences of SIL and determining factors that can address SIL directly is required; alongside building resilience through enhancing social capital and social cohesion (Chen, 2020; Lay-Yee, Campbell & Milne, 2021; Parekh, et al., 2018). To achieve this, a wider consideration of the social environment and factors that contribute to SIL are required (Jennings & Bamkole, 2019). Currently there is limited focus on environmental and structural factors in terms of SIL (Prohaska, et al, 2020). Most research explores experience of SIL at any individual level including the characteristics of these individuals. The implications of this focus are that it narrows the understanding of antecedents, consequences and potential interventions (Prohaska, et al, 2020).

The experience of SIL is widespread and particularly relevant to young adults, older adults and vulnerable groups. To date there is limited data published specific to the Queensland population. While we can draw on data from Australia and from other states such as Victoria, it is essential that research is conducted to better understand the Queensland context. Survey data conducted by Relationships Australia in 2001-2016 flagged that limited social support and emotional loneliness were a relatively common experience (one in ten and one in six, respectively) for Australian adults (Relationships Australia, 2018). Similar findings have been found for young adults in Victoria (Lim, Eres & Peck, 2019). Importantly, programs have been developed to address SIL in Queensland. One of these is the Ways to Wellness Social Isolation Project which is uses 'social prescribing' to link people in the community (Queensland Mental Health Commission, 2019; University of Queensland, 2019). Social connection programs exist in Queensland for a range of different groups including for gender and sexually diverse people (Queensland Government, 2018 & 2020). Furthermore, grass roots community information and sharing of events also exists. One such example, is My Community Directory (My Community Directory, 2021). These examples are reflective of the scope of work being undertaken but do not represent a comprehensive overview of the work being undertaken.

Inclusivity, Vulnerable Groups and Consultation

There are certain group who may be more prone to experience SIL including: older adults, institutionalised individuals (i.e. prisons), low socio-economic groups, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse people, people with a disability, gender and sexually diverse people and young people (Queensland Government, 2018). Acknowledging that there are groups who might be more susceptible to SIL is important because these should be priority groups for initiatives. There is a need to **actively engage** with these groups to determine the scope of their lived experiences and to tailor services, initiatives and programs to their needs.

Identification of vulnerable and disadvantaged groups and consultation is very important and we suggest that the groups, agencies or organisations which represent their interests are approached to enable their voices to be heard. The physical distancing regulations instituted to control COVID 19 have had a significant psychological consequence for young people and older adults. Both age groups are marked by developmental or transitional life changes that can increase the risk of, or act

as a trigger for, loneliness. Engaging vulnerable groups within society should also be prioritised to enable involvement of these individuals and communities in the design of interventions and their contribution and experiences should be actively sought to enable the creation of a Queensland strategy to address and prevent SIL.

Causes and Drivers of SIL

Causes and drivers of SIL include an array of factors and pertinent to these are the social determinants of health (SDoH), the environments in which people are born, live, work, play and age. Best practice approaches acknowledge the role that the SDoH have on health and wellbeing and as drivers of health inequities (Rural Health Alliance, 2017). It is also imperative to acknowledge the factors which influence the SDoH including social policies, politics and economics. Access to meaningful employment, offsetting the disadvantaged on the social gradient by focussing on the most disadvantaged, reducing stress, improving transport options and creation of social support and community connections are some mechanisms to address the SDoH.

For younger people, typical transitions such as moving away from home or starting university can increase their vulnerability to experiencing SIL. For older adults, retirement from work, changes in living environment (e.g. moving to retirement living or an aged care facility), bereavement and widowhood, financial pressures, and declining physical health (e.g. chronic illness, physical disability, sensory impairment) can increase the risk for loneliness. Loneliness is the consequence of multiple risk factors and can differ depending on a person's vulnerability and social environment. Demographic factors such as single parent carers, those from low socio-economic backgrounds, those with a migrant background and people who live alone, are more likely to be vulnerable to problematic or enduring levels of loneliness.

We expect that adhering to physical distancing guidelines in the longer term will add barriers to initiating and maintaining meaningful social relationships and lead to further increases in loneliness. Focusing on individuals who are typically excluded and underrepresented in society is required (Noel, 2020). Infrastructure and creation of spaces such as parks, recreational areas and community facilities can support people getting out, using and interacting in these spaces (Coutts & Hahn, 2015; Department of Digital, Culture, Media and Sport, 2018; Jennings & Bamkole, 2019). The built infrastructure and natural environments can contribute to the creation of vibrant locations where people both feel connected and the opportunity for informal and formal connection with others is enabled (Coutts & Hahn, 2015). As such physical environments can be health-promotive and mechanisms for social connection and cohesion (Parekh, et al., 2018; Stokols, 1992). Given this, we encourage consideration of the built and natural environment, alongside the range of services available to audit the potential to contribute to or detract from social connections. Technology is often a mechanism by which individuals can connect with individuals, irrespective of their physical location. The promotion of technology for this purpose though should be tempered by acknowledging digital exclusion and the related concept of digital literacy, which influences the capacity and engagement of individuals with digital technologies. There are also issues in terms of broadband connectivity particularly for those residing in rural and remote locations (National Rural Health Alliance, 2017).

Protective Factors

The research shows that there are many **protective factors** that can mitigate against SIL. These protective factors may differ slightly depending on a range of factors such as life stage, employment and length of time in a community.

- The individuals who make up a person's network (e.g., family members, friends, caretakers, spouse, and neighbours) can play important roles in the person's life and lessen their chances of experiencing social isolation or loneliness. Promoting the renewal of existing connections is recommended. While there is always the opportunity to grow an individual's social network this can be more challenging and daunting than focusing on current social networks. It is important to prioritise quality interactions and be open and flexible to the possibility of social interaction with others (Australian Psychological Society, 2020).
- Residing in rural and remote communities can be both a protective factor and driver of SIL. This is related to the size of the population and the sense of community; these can often be tight knit communities that foster a sense of belonginess and life satisfaction (National Rural health Alliance, 2017). It can also be a source of alienation for those who don't fit in to community.
- Socio-environmental factors such as the culture within workplaces, urban design, access to community spaces (e.g., parks, libraries, neighbourhood houses) and transport accessibility, are likely to facilitate a person's capacity to initiate and maintain meaningful social connections.

What Works, Why and How will that Influence Queensland Specific Approaches

We assumed there are some characteristics of the Queensland population and environment that are both protectors from and drivers of SIL. It is important to acknowledge that these are 'assumed' as we couldn't find robust Queensland-specific evidence. The presence of vulnerable population groups, lower socio-economic areas, housing and geographical characteristics (including population density, geographical distances and community cohesion because of these factors) are all factors that could potentially contribute to SIL. Noting that these are not unique to Queensland but apply more generally to Australia. The weather, accessibility to green and, depending on location, blue spaces, health promoting urban spaces, availability of community organisations and groups, cultural diversity, multigenerational households, internet connectivity, sense of community (particularly found in smaller towns) are some general factors which may be protective for Queenslanders against SIL. The subsequent discussion will focus on the state of knowledge about what works and how this could be used to address and prevent SIL in Queensland.

As has been demonstrated, there are various initiatives developed to address SIL in other contexts. These typically centre around community focused initiatives and targeting specific vulnerable groups. Yet, improved evidence around what works and what programs are being run effectively, meaningful involvement of communities, political prioritisation through policy creation, enhanced funding and mechanisms to scale up effective interventions are required (Consumers Health Forum of Australia, 2021; Durcan & Bell, 2015; Ending Loneliness Together, 2020; WHO, 2021). Prioritisation for strengths-based and place-based community grass roots programs is required and initiatives to improve connections. Learning from interventions from other countries indicate that low-tech community-based programs, high-tech digital approaches, nurse-led care coordination models, social prescribing and proactive national policies to reduce loneliness. Each of these approaches could be useful here in Queensland.

Leveraging Technology to Enable Connection

As we emerge from and adjust to the new order of things resulting from the COVID-19 pandemic, we need to learn to reengage and interact. Essential to this, from the perspective of preventing, mitigating and addressing SIL, is the need to use existing connections and broker new ones. Technology can be a useful conduit to enable connection, particularly when physical distance is

required. Social media is a popular mechanism to grow connections and to foster sociability. While social media is often perceived as a double-edged sword, in that it can cultivate connections but can also result in the potential for bullying and harassment as well as unrealistic portrayals, comparisons and interactions, there is the potential for social media to be harnessed as a tool to protect against SIL. If technology is used to address SIL, these initiatives should co-occur with building technological and digital literacy and improving access to the internet. This is essential, as all individuals should have equal access and the possibility for their connections to be enhanced. Use of technology should not be limited to those who can afford fast and reliable internet, large amounts of data, or those who are technology literate. There are various types of technological platforms available with varying degrees of complexity to wield and engage. The need to tailor approaches to technology usage and the platform may differ by life stage and technological literacy. Resources to support this technological development do exist (COTA Queensland, n.d.).

Preventative Health Investment

AHPA Queensland would like to see continued investment in all the areas indicated above. A failure to invest in interventions and strategies to prevent and mitigate SIL will have significant implications for health and wellbeing and health care utilisation (WHO, 2021). We are firm believers in the need for preventative action and advocate for enhanced investment in health promotion as a cost-effective investment prioritising the health of the population.

Priorities Moving Forward: Essential Components of a Qld Strategy

- The key components of a **state-wide strategy** will require a focus on the following priorities: enabling communities voices and co-design in strategy development, learning from the lived experiences of the population and acknowledging the wide range of contextual but modifiable factors which contribute to SIL, and the need for coordinated efforts.
- Data and evaluation: Ending Loneliness Together (2019) should inform more comprehensive evaluation (including impact assessment) of strategies to reduce loneliness among different population groups and provide a vehicle for disseminating this evidence to frontline service providers. Ending Loneliness Together (also known as the Australian Coalition to End Loneliness) is a national initiative established in 2017 to coordinate evidence-based action to tackle loneliness in Australia. A broad network of scientists acknowledge the lack of evidence in the Australian context, including prevalence rates, predictors, consequences and maintenance factors associated with loneliness. This is especially so regarding the diverse factors across multiple domains – social, psychological, economic, community, health, and service utilisation – that may be impacted by and/or contribute to loneliness. Queensland-specific data is also needed.
- Health system engagement and beyond – multisector. Services and agencies working outside the health system have contact with some of the most vulnerable members of the community. They play an important role in identifying and responding to SIL. Local councils, health care providers and community service organisations have central roles to play in these efforts. A first step to developing meaningful social relationships amongst community members is to design and build safe environments for people to come together to interact
    - General practitioners (GPs) are often gatekeepers who can identify individuals who may need support to connect with others. There is a need to update loneliness and social isolation referral pathways, including for social prescribing, to reflect the different ways in which support can be accessed

    - Befriending schemes (often delivered by volunteers) are an example of a grassroots initiative. The national Community Visitors Scheme, Queensland Community Care Network and the Wesley Mission Queensland's Group61 are some examples of befriending schemes which aim to boost social connections amongst older adults and those experiencing mental health concerns. It is important to raise awareness of SIL and reduce the stigma about these experiences.
- Sustainable and bipartisan political commitment is required.

Summary of Key Points: Recommendations

- The environment and structural factors influence the experience of SIL. Therefore, focusing only on individual characteristics limits our understanding of the antecedents, consequences and interventions that can address these wider socio-ecological contributors. Use of a socio-ecological approach moving forward is required.
    - This includes the need for place-based interventions.
- There is a need to focus on social connections via enhancing social capital and cohesion. Considering ways to naturally enhance these across all dimensions (i.e. at individual, community and society levels) can be protective to mitigate against SIL.
- Engaging with vulnerable groups within society should be prioritised and their contribution and experiences should be actively sought to enable the creation of a Queensland strategy to address and prevent SIL.
- Partnering across government, with industry and community is required.
- Focusing on vulnerable groups within society is required whilst also acknowledging that SIL can be experienced by all. Experiences can be compounded by existing social inequalities that exist within society. Therefore reducing the stigma and enhancing opportunities to build social cohesion are key.
- There is a need to improve evidence of what works and what programs are being run, to engage communities, political leadership, enhanced funding and mechanisms to scale up effective interventions at national and Queensland levels.
- The potential to leverage technology to enable connection is pertinent whilst physical distancing measures are in place during the pandemic but there is a need to also bring people physically together. Enabling meaningful technological engagement, promote digital literacy and ensure internet equity should be a priority to ensure people are empowered to maintain connections.

Next Steps and Suggested Resources to Review

There are a range of approaches developed and outlined elsewhere that can be used to inform a SIL prevention strategy for Queensland. Some instances of these were used to inform our submission. Using a life course approach and acknowledging the socio-ecological nature of SIL is imperative with Durcan and Bell (2015) suggested as a key resource to be consulted.

References

Aminnejad, R., & Alikhani, R. (2020). Physical distancing or social distancing: that is the question. *Canadian Journal of Anesthesia, 67*, 1457-1458. https://doi.org/10.1007/s12630-020-01697-2

Australian Bureau of Statistics. (2021b). *Fewer Australians experience loneliness in April* [Media Release]. Released May 18, 2021. https://www.abs.gov.au/media-centre/media-releases/fewer-australians-experience-loneliness-april

Australian Bureau of Statistics. (2021a*). Household Impacts of COVID-19 Survey*, June 2021. Retrieved August 5, 2021. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/jun-2021/49400DO001_2021%20-%20Tables%201-30%20%2011%E2%80%9320%20June%202021.xlsx

Australian Bureau of Statistics. (2020). Loneliness most common stressor during COVID-19. Released May 18, 2020. https://www.abs.gov.au/articles/loneliness-most-common-stressor-during-covid-19

Australian Psychological Society. (2020). Loneliness and social isolation in time of COVID-19. https://www.psychology.org.au/getmedia/2612f989-0299-4b54-9ebe-b38977b87e7f/20APS-IS-COVID-19-Loneliness-P1.pdf

Bu, F., Steptoe, A., & Fancourt, D. (2020). Who is lonely in lockdown? Cross-cohort analyses of predictors of loneliness before and during the COVID-19 pandemic. Public Health (London), 186, 31–34. https://doi.org/10.1016/j.puhe.2020.06.036

Cann, P. (Host). (2021, May 18). Loneliness Explored: Psychology and loneliness [Audio podcast]. Campaign to End Loneliness. https://play.acast.com/s/9044f86f-6aa9-59b6-b643-5690b3702287/60898efccfb9e813fa7a692a

COTA Queensland. (n.d). Social isolation and loneliness. https://www.cotaqld.org.au/policy-advocacy/social-isolation-loneliness/

Chatters, L. M., Taylor, H. O., Nicklett, E. J., & Taylor, R. J. (2018). Correlates of Objective Social Isolation from Family and Friends among Older Adults. Healthcare (Basel), 6(1), 24–. https://doi.org/10.3390/healthcare6010024

Chen L. K. (2020). Older adults and COVID-19 pandemic: Resilience matters. *Archives of gerontology and geriatrics*, *89*, 104124. https://doi.org/10.1016/j.archger.2020.104124

Clair, R., Gordon, M., Kroon, M., & Reilly, C. (2021). The effects of social isolation on well-being and life satisfaction during pandemic. *Humanities and Social Sciences Communications, 8*, 28. https://doi.org/10.1057/s41599-021-00710-3

Consumers Health Forum of Australia. (2021). Loneliness though leadership roundtable report. Canberra: Australia. https://chf.org.au/sites/default/files/chf_loneliness_roundtable_final_report_v2.pdf

Coutts, C., & Hahn, M. (2015). Green Infrastructure, Ecosystem Services, and Human Health. International Journal of Environmental Research and Public Health, 12(8), 9768–9798. https://doi.org/10.3390/ijerph120809768

Department of Digital, Culture, Media and Sport. (2018). A connected society: A strategy for tackling loneliness – laying the foundations for change [Policy paper]. London, England: United

Kingdom Government. https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness

Durcan, D., & Bell, R. (2015). *Local action on health inequalities: Reducing social isolation across the lifecourse*. Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-reducing-social-isolation-across-the-lifecourse

Eicher C., Kawachi I. (2011) Social Capital and Community Design. In: Dannenberg A.L., Frumkin H., Jackson R.J. (eds) Making Healthy Places: Designing and Building for Health, Well-being, and Sustainability (1st ed). Island Press, Washington, DC. https://doi-org.elibrary.jcu.edu.au/10.5822/978-1-61091-036-1_8

Ending Loneliness Together (2019). About Australian Coalition to End Loneliness. Available from: www.endingloneliness.com.au

Ending Loneliness Together (2020). Ending Loneliness Together in Australia. https://www.endingloneliness.com.au/resources/whitepaper/ending-loneliness-together-in-australia .

Fakoya, O. A., McCorry, N. K., & Donnelly, M. (2020). Loneliness and social isolation interventions for older adults: a scoping review of reviews. BMC Public Health, 20(1), 129–129. https://doi.org/10.1186/s12889-020-8251-6

Gardiner, C., Geldenhuys, G., & Gott, M. (2018). Interventions to reduce social isolation and loneliness among older people: an integrative review. Health & Social Care in the Community, 26(2), 147–157. https://doi.org/10.1111/hsc.12367

Henderson, M.D., Schmus, C.J., McDonald, C.C., & Irving, S.Y. (2020). The COVID-19 pandemic and the impact on child mental health: A socio-ecological perspective. Pediatric Nursing, 46(6), 267-272, 290.

Hwang, T. J., Rabheru, K., Peisah, C., Reichman, W., & Ikeda, M. (2020). Loneliness and social isolation during the COVID-19 pandemic. *International Psychogeriatrics*, *32*(10), 1217–1220. https://doi.org/10.1017/S1041610220000988

Jennings, V., & Bamkole, O. (2019). The Relationship between Social Cohesion and Urban Green Space: An Avenue for Health Promotion. International Journal of Environmental Research and Public Health, 16(3), 452–. https://doi.org/10.3390/ijerph16030452

Krug, E. (2021, July 21). *Seeking shelter from social isolation and loneliness under the tree of friendship [Commentary]*. World Health Organization. https://www.who.int/news-room/commentaries/detail/seeking-shelter-from-social-isolation-and-loneliness-under-the-tree-of-friendship

Landmann, H., & Rohmann, A. (2021). When loneliness dimensions drift apart: Emotional, social and physical loneliness during the COVID-19 lockdown and its associations with age, personality, stress and well-being. International Journal of Psychology. https://doi.org/10.1002/ijop.12772

Lay-Yee, R., Campbell, D., & Milne, B. (2021). Social attitudes and activities associated with loneliness: Findings from a New Zealand national survey of the adult population. Health & Social Care in the Community. https://doi.org/10.1111/hsc.13351

Lim, M.H., Eres, R., & Peck, C. (2019). The young Australian loneliness survey: Understanding loneliness in adolescence and young adulthood. Iverson Health Innovation Research Institute & Centre for Mental Health, Swinburne University of Technology. https://www.vichealth.vic.gov.au/-

/media/ResourceCentre/PublicationsandResources/Social-connection/The-young-Australian-loneliness-survey-Report.pdf?la=en&hash=94F3B075524F419C67901C4E5741F2DF9D29BF2A

Murthy, V. (2020). *Together: Loneliness, health and what happens when we find connection*. Profile Books.

My Community Directory. (2021). My community directory. https://www.mycommunitydirectory.com.au/

Noel, N. (2020). Minorities, migrants and social exclusion during COVID-19. New York University Center on International Cooperation. https://cic.nyu.edu/publications/covid-19-minorities-and-social-exclusion

Parekh, R., Maleku, A., Fields, N., Adorno, G., Schuman, D., & Felderhoff, B. (2018). Pathways to age-friendly communities in diverse urban neighborhoods: Do social capital and social cohesion matter? Journal of Gerontological Social Work, 61(5), 492–512. https://doi.org/10.1080/01634372.2018.1454564

Prohaska, T., Burholt, V., Burns, A., Golden, J., Hawkley, L., Lawlor, B. A., Leavey, G., Lubben, J., O'Sullivan, R., Perissinotto, C., van Tilburg, T. G., Tully, M., Victor, C., & Fried, L. (2020). Consensus statement: Loneliness in older adults, the 21st century social determinant of health. BMJ Open, 10(8), e034967–e034967. https://doi.org/10.1136/bmjopen-2019-034967

Prohaska T, O'Sullivan R, Leavey G, Burns A. (2021) A public health approach to loneliness and isolation among older adults. In: Scrimshaw SC, Lane SD, Rubinstein RA, Fisher J, eds. The SAGE handbook of social studies in health and medicine, 2nd edn. London: Sage, in press.

Queensland Government. (2018). Avoiding social isolation. https://www.qld.gov.au/community/getting-support-health-social-issue/avoiding-social-isolation

Queensland Government. (2020). Staying connected in your community. https://www.qld.gov.au/seniors/recreation-staying-connected/social-connection-leisure/staying-connected-your-community

Queensland Mental Health Commission. (2019). Reports highlight social isolation and loneliness. https://www.qmhc.qld.gov.au/media-events/news/reports-highlight-social-isolation-and-loneliness

Rantzen, E. (2011). Lonely Britain. *Daily Mail*. https://www.dailymail.co.uk/femail/article-2048488/Lonely-Britain-When-Esther-Rantzen-wrote-Mail-aching-loneliness-received-overwhelming-response-heartfelt-understanding.html

Relationships Australia. (2018). New research shows depth of Australia's loneliness epidemic. https://www.raq.org.au/media/new-research-shows-depth-australias-loneliness-epidemic

Rural Health Alliance. (2017). Social determinants of health. https://www.ruralhealth.org.au/advocacy/current-focus-areas/social-determinants-health

Smith, M. L., Steinman, L. E., & Casey, E. A. (2020). Combatting Social Isolation Among Older Adults in a Time of Physical Distancing: The COVID-19 Social Connectivity Paradox. Frontiers in Public Health, 8, 403–. https://doi.org/10.3389/fpubh.2020.00403

Stokols, D. (1992). Establishing and maintaining healthy environments. Toward a social ecology of health promotion. The American Psychologist, 47(1), 6–22. https://doi.org/10.1037//0003-066X.47.1.6

University of Queensland. (2019). Tackling the growing problem of loneliness and isolation. https://www.uq.edu.au/news/article/2019/07/tackling-growing-problem-of-loneliness-and-isolation

Valtorta, N., & Hanratty, B. (2012). Loneliness, isolation and the health of older adults: do we need a new research agenda? Journal of the Royal Society of Medicine, 105(12), 518–522. https://doi.org/10.1258/jrsm.2012.120128

van Baarsen-Heppener, B., Snijders, T. A., Smit, J., & Duijn, M. A. (2001). Lonely But Not Alone: Emotional Isolation and Social Isolation as Two Distinct Dimensions of Loneliness in Older People. *Educational and Psychological Measurement*, *61*(1), 119–135. https://doi.org/10.1177/00131640121971103

Williams CYK, Townson AT, Kapur M, Ferreira AF, Nunn R, Galante J, et al. (2021) Interventions to reduce social isolation and loneliness during COVID-19 physical distancing measures: A rapid systematic review. PLoS ONE 16(2): e0247139. https://doi.org/10.1371/journal.pone.0247139

World Health Organization. (2009). Milestones in Health Promotion: Statements of Global Conferences. https://apps.who.int/iris/handle/10665/70578

World Health Organization. (2021). Advocacy Brief: Social isolation and loneliness among older people. Geneva: World Health Organization.