THE UNIVERSITY OF QUEENSLAND AUSTRALIA | CREATE CHANGE

QLD PARLIAMENTARY INQUIRY INTO SOCIAL ISOLATION AND LONELINESS

This submission is from

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The views expressed in this submission are made on behalf of our research team: Professor Catherine Haslam, Professor Jolanda Jetten, Professor Alex Haslam from the University of QLD, Associate Professor Tegan Cruwys (ANU, Canberra) and Associate Professor Niamh McNamara (Nottingham Trent University, UK) who are working on an Australian Research Council funded linkage project "A community based social identity approach to loneliness", with partner organisation Mt Gravatt Community Centre, Logan Rd, Mt Gravatt, QLD (2019-2022).

The data described in this submission include:

- Service data from **216 clients** referred to Ways to Wellness at Mt Gravatt Community Centre
- Survey (self-report) data from **24 clients** collected at entry to a social prescribing program (Mt Gravatt, Inala Primary Care, or PCCS Gold Coast) and 8 weeks later
- Interviews with **14 link workers** from social prescribing programs around Australia

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Recommendations

1. We recommend that the solution to (and prevention of) loneliness and its driving factors is to **help Queenslanders to develop meaningful group memberships**.
2. Based on evidence presented in this submission as well as international research, we recommend that the best way to do this is through **social prescribing** to community-based group activities tailored to the individuals' interests and needs.
3. A state-wide roll-out of social prescribing could be implemented efficiently and cost-effectively using **existing infrastructure such as neighbourhood and community centres** that have group rooms, kitchen, and bathroom facilities to support social activities and informal socialising opportunities.
4. This infrastructure would need to be accompanied by **funded link worker positions and administrative support** in each location to ensure effective communication between referring stakeholders, participants, and community group providers.
5. Currently, link workers are not registered with the Australian Health Practitioners Regulation Authority (unless they are registered as a member of a health profession) and they come from a diverse range of backgrounds. Therefore, an effective and safe new workforce of social prescribing **link workers will require modular (online) training, mentoring and support** in specific topics such as: mental health, domestic violence, trauma informed care, ethical practice, addictive behaviours.
6. To ensure that suitable referrals are coming to social prescribing services, a state-wide **promotion campaign** will be needed to educate the public and referring agents such as GPs and other health providers about social prescribing and how to engage with it.
7. As for any implementation, it is recommended that **funding be allocated to research and evaluation** so that the QLD Government is collecting data on what works, where, and how; and to inform future finetuning of the social prescribing approach in the QLD context.

A. The impact of social isolation and loneliness in Queensland

Social isolation has been defined as an objective state of having few social contacts. Loneliness is commonly described as 'a painful emotional state resulting from a discrepancy between one's desired relationships and their actual ones'[1]. It is possible to be lonely even when surrounded by lots of people, as is the case for many members of the Queensland community. Social isolation and loneliness have become a global concern, and this has been exacerbated by the COVIC-19 pandemic[2].

International research shows that loneliness has a marked negative impact on individual health and wellbeing. Loneliness is associated with a 15% increased risk for depression, increased rates of substance use[3], 30% increased risk for stroke, 64% increased risk of dementia[4]. These individual health effects of loneliness have a knock-on effect on health and social services. For instance, it is estimated that the top 10% of attenders account for 30%–50% of appointments with GPs[5], and these patients often do not feel satisfied with the services they receive because of unmet social needs.

Among 216 participants so far referred to the Ways to Wellness social prescribing program in Mt Gravatt, 31.7% of referrals were from GPs and 21.1% were from other health care workers, suggesting that around half of the participants were being treated for health conditions. Furthermore, 29.4% had an identified mental health issue.

About half of clients referred to Ways to Wellness said they had social contact with at least one family member or friend, however, ***one third (34.4%) felt they had no social supports***, 10.2% only had social contact with formal supports such as support workers, and 3.3% had only social contact with neighbours or existing community groups.

[1] Perlman, D., Peplau, L.A., 1981. Toward a social psychology of loneliness. In: Gilmour, R., Duck, S. (Eds.), *Personal Relationships in Disorder.* Academic Press, London, pp. 31–56.
[2] Groarke JM, Berry E, Graham-Wisener L, McKenna-Plumley PE, McGlinchey E, Armour C (2020) Loneliness in the UK during the COVID-19 pandemic: Cross-sectional results from the COVID-19 Psychological Wellbeing Study. PLoS ONE, 15(9): e0239698. https://doi.org/10.1371/journal.pone.0239698
[3] Ingram, I., Kelly, P. J., Deane, F. P., Baker, A. L., Goh, M. C. W., Raftery, D. K., & Dingle, G. A. (2020). Loneliness among people with substance use problems: A narrative systematic review. *Drug Alcohol Rev*. https://doi.org/10.1111/dar.13064
[4] Holwerda et al. (2012). Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL) | Journal of Neurology, Neurosurgery & Psychiatry (bmj.com)
[5] Vedsted P, Christensen MB. (2005) Frequent attenders in general practice care: A literature review with special reference to methodological considerations. Pub Health, 119(2):118–137.

B. The causes and drivers of social isolation and loneliness, including those unique to Queensland

The social prescribing project is informed by a social identity theoretical framework, which views loneliness as resulting from a lack of meaningful group memberships (such as family, school, work, cultural, faith, and activity-based groups). ***Such group memberships matter because they inform who we are – our social identities – which are the basis for our health and wellbeing***. It makes sense from this perspective that certain subgroups of the population (such as young people who have left education, the unemployed, new mothers and single parents, immigrants, older adults) are more vulnerable to loneliness because these individuals are transitioning between, or excluded from, the usual social groups and communities that people belong to.

Common issues that prevent people from socially connecting include ***low income (poverty), caring duties, transport, and mobility issues.*** In our sample, 10% indicated they had no transport options; 39% could only use some combination of other transport options such as taxi, bus, or friends or family members. In addition to these transport restrictions, 23.9% disclosed a mobility issue.

Mental health issues such as social anxiety and mistrust (often secondary to trauma) are barriers to social connection, and these may have worsened with COVID-19 related social distancing and lockdowns. These same barriers have been echoed in other studies of link worker mediated social prescribing.[6]

> *"I always feel detached from everyone, as though I'm there with them, I'm participating and acknowledged but there is an impenetrable glass wall between us. It makes me feel not just isolated but also conspicuous." – Male Client, Gold coast*

Our study also highlighted that ***domestic violence was a barrier to engaging in social groups.*** Persons in violent relationships experienced continued attempts from their partners to isolate them from their usual social contacts, with difficulties persisting even after they had left that relationship. These included feeling that the social groups their partner had knowledge of put their safety at risk, and that people often relocated following violent relationships, which further isolated them from their community and social support systems.

> *"Definitely anxiety in experiencing domestic violence knowing my ex knew where the group was"* – Female Client, Gold Coast

[6] Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., . . . Halder, M. (2019). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. BMJ Open, 9, e033137. https://doi.org/10.1136/bmjopen-2019-033137

Some migrant and refugee persons described the difficulty of fitting in with others and the loneliness experienced ***when you are not around people from your own culture***. People referred to the difficulties of transition into a new culture and the isolation felt due to separation from family members and cultural groups exacerbated by the pandemic. ***Language barriers*** for this group can also present systemic problems with access to readily available groups as translation services are not regularly available for these types of activities. Often the only option is for a family member to attend as that bridge.

> *"But I think, for a lot of people, that the first step to even join or pick up the phone or try and use their English is a big barrier. And language, just on its own, is a big barrier to join groups. A lot of the groups don't have interpreting services and, yeah, I guess that's just really tricky for a lot of our people."* – Link worker, Brisbane

The pandemic meant there were rapid changes to how people interact. Existing groups moved online leaving people with ***low technological literacy or limited access to devices or the internet isolated***. For many, particularly older persons, groups that they could have accessed to improve computer skills have not been consistently available to them, such as computer courses run by the library because of the pandemic.

> *"Without having access to computer or phone when I've been down at Mum's and stuff… and yeah it can be quite isolating because I'm used to talking to my girlfriends, they send me message on and off all day, but sometimes you're not in a position where you can do that. Yeah, at times I felt quite isolated."* – Female participant, Brisbane

> *"There was no Internet there and there wasn't even a TV antenna so we couldn't even watch normal TV and it was just me and [my daughter] and …she was like having drug withdrawals from online, and I was having withdrawals from online and luckily the library was nearby and we could buy DVDs and stuff but yeah there was that lack of, you know, availability of online of keeping in contact with even just my sisters and stuff."* – Female participant, Brisbane

C. The protective factors known to mitigate social isolation and loneliness

Simply bringing people together does not result in the development of friendships and increased social support networks[7]. Previous attempts to reduce social isolation and loneliness have included interventions designed to improve people's social skills, programs to create support groups for those who are isolated, and programs that create opportunities for more social interaction. However, a review of 50 studies evaluating these types of interventions have shown little evidence that they reduce levels of loneliness[8].

The social identity approach to health (a.k.a. the 'Social Cure') has over a decade of research evidence[9] indicating that ***membership of meaningful groups that the person feels highly identified with produces a sense of connectedness and supports health and wellbeing. We believe that social prescribing is the best way to do this.*** While there is no widely agreed model for social prescribing, schemes commonly involve three components: (1) a referral into the program, generally via a GP or other health or social care professional; (2) a series of consultations with a link worker; and (3) supported connection to local groups and community organisations[10].

The UK is currently leading the global alliance for social prescribing. The UK model has embedded social prescribing into primary care services in local commissioning districts. They have mobilised a new workforce of 1,700 link workers as part of the National Health Service Long Term Plan[11]. Initial findings indicate that social prescribing decreases participants' loneliness and increases social and community connection, increases wellbeing, and improves various indicators of mental and physical health[12,13].

Social prescribing is a relatively new concept in Australia. There are diverse social prescribing initiatives, some embedded in primary care, some funded by workers insurance or private health insurance, and others embedded in community services. We summarise initial evidence about social prescribing in QLD in the next section.

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[7] Stevens, N. A. N. (2001). Combating loneliness: a friendship enrichment programme for older women. *Ageing and Society, 21*(2), 183-202. https://doi.org/10.1017/S0144686X01008108
[8] Masi, C. M., Chen, H. Y., Hawkley, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. Pers Soc Psychol Rev, 15(3), 219-266. https://doi.org/10.1177/1088868310377394
[9] Haslam, C., Jetten, J., Cruwys, T., Dingle, G. A., & Haslam, S. A. (2018). *The new psychology of health: unlocking the social cure* (1 edition. ed.). London, New York: Routledge.
[10] www.gspalliance.com Global Social Prescribing Alliance: International Playbook (2021).
[11] www.longtermplan.nhs.uk
[12] Chatterjee, H. J., Camic, P. M., Lockyer, B., & Thomson, L. J. M. (2018). Non-clinical community interventions: a systematised review of social prescribing schemes. Arts & health, 10(2), 97-123. https://doi.org/10.1080/17533015.2017.1334002
[13] Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., . . . Halder, M. (2019). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. BMJ Open, 9, e033137. https://doi.org/10.1136/bmjopen-2019-033137

D. The benefits of addressing social isolation and loneliness, examples of successful initiatives

In Queensland, there are rising numbers of ***social prescribing programs*** in the community, located at and utilising ***neighbourhood and community centres***. These community-based programs provide connections to the broader community and wider referral pathways. There are at least three formal social prescribing programs, including Ways to Wellness (Mt Gravatt), All for One Wellness (Redland), and Social Plus (Primary and Community Care Services, Gold Coast). Engaging people into meaningful group activities can take time, but with the right supports to attend they can reengage with the community and begin to increase feelings of connectedness.

> *"It has taken 6 months before I actually really engaged in a conversation. In saying so, it's an anxious situation still, for me. I don't trust people and I'm not sure that I can ever fully overcome that but in this group there's no judgement so some days we may or may not talk. The group is good for my creativity and socially to keep somewhat connected with society and others that understand these challenges."* Female participant, Gold Coast

Link workers perform a unique role in helping clients to overcome the causal factors described in section B. Strategies include providing advocacy and links to external services and creating space and time for a person to engage.

> *"[It's] having that ongoing encouragement and that ongoing problem solving if a barrier was to present itself, helping the client work through that barrier, practical things, such as budgeting for public transport or taxis, if that's their mode of transport, and then also addressing their other stuff they've got going on at the same time. So, if they've got housing concerns or DV and things like that, trying to address that first so that they're a bit more willing to start engaging, I guess, in the extracurricular stuff."* – Brisbane Link Worker

Having a link worker as part of social prescription provides comprehensive support to motivate and offer minor counselling to overcome barriers, including the capacity to take clients to groups to offer support and reduce social anxiety. The link worker, therefore, is a crucial element as part of a successful social prescription program.

> *"So we've found by going with them, we had a much higher success rate at actually settling somebody into a new activity or program than if you gave them a telephone number and said, "Phone them." Quite often that might not have been followed through."* – Link worker, Victoria

Link workers are currently not an AHPRA accredited health profession and the link workers we interviewed were from a range of backgrounds in nursing, social work, counselling and other health and social care professions. They are professionals based in community sectors or primary care practices with their primary role to support a person's access to community health and social resources. This usually occurs through a one-on-one co-development process to create a comprehensive tailored approach for reconnection with the community.

> *"So it's kind of a holistic approach to meet people where they are and work with them. Remind them of the good, listen and acknowledge their weaknesses" – Link worker, Gold Coast*

Through this, link workers utilise diverse methods of communication, planning, and adaptation to clients' needs to ensure a person-based approach. This ensures that people are given the opportunity to have any other primary needs met and address other barriers that may prevent them from re-engaging with the community.

> *"[We] engage with different types of services to keep them as functional as possible in the community. So, different type of services can be government agencies, for example, Centrelink, or it can be non-government agencies, for example, a domestic violence prevention centre or a centre against sexual violence or homelessness shelters and things like that." – Link worker, Gold Coast*

Ways to Wellness service

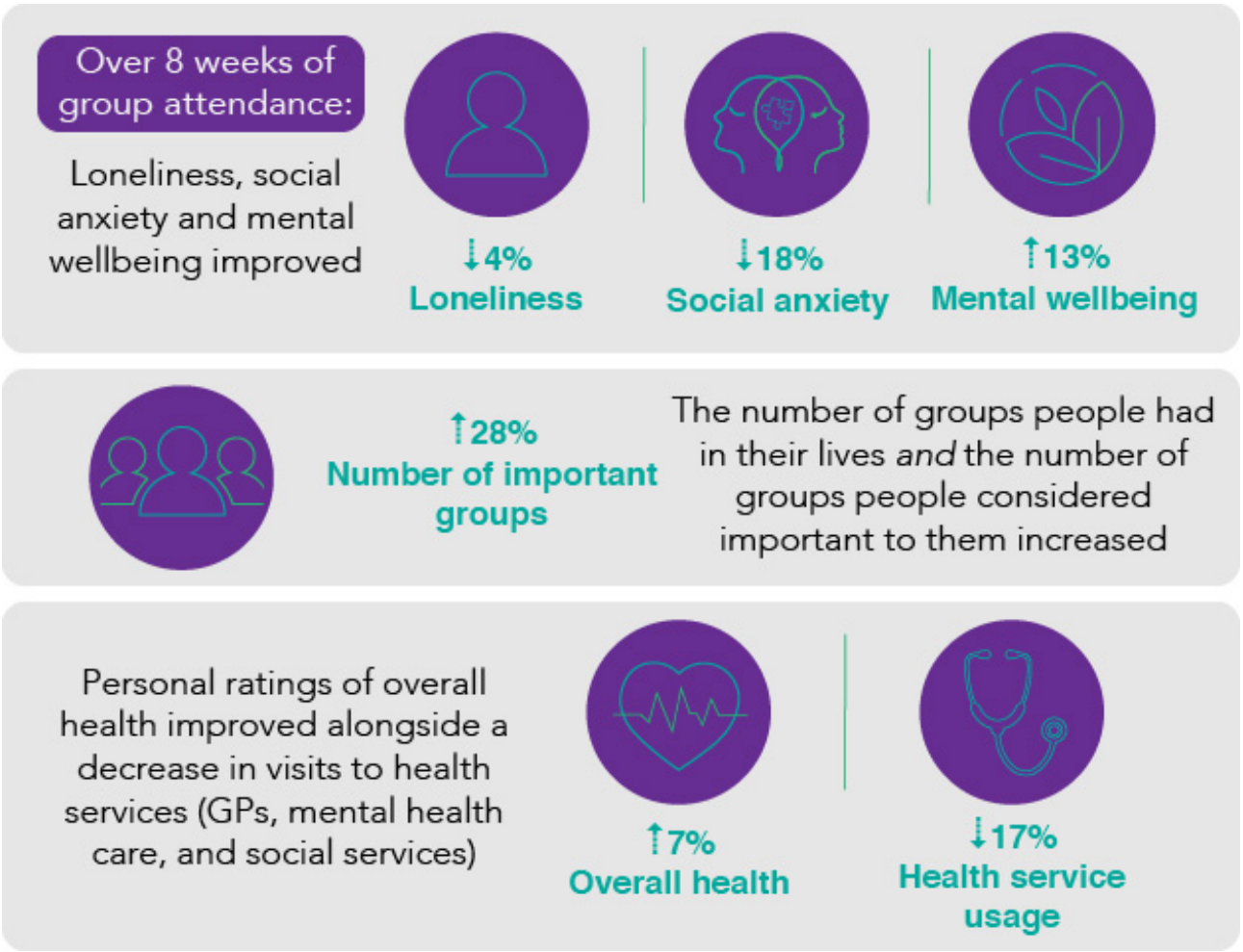
Of the 216 contacts to Ways to Wellness, 169 clients successfully completed the intake process and were supported through Ways to Wellness. On average, the time from referral to last contact with a client was 4 months (this includes clients still enrolled in Ways to Wellness). ***The average number of contacts with clients was 8***, and these ranged from 1 to 33. They included phone calls, meetings at the community centre, home visits, and attending groups with clients. Link workers also had on average 1 unsuccessful contact with clients, and this ranged from 0-9.

72% of people were referred into groups available in the local community. While some of these clients are still in the program and are yet to be referred, approximately 20% were referred onto other services to assist with primary or other needs.

At least 58% of those that were referred to groups attended at least one group program. However, we assume this figure to be higher as some people were happy to refer themselves and did not require further assistance other than knowing what groups were available.

Preliminary outcomes of social prescribing

Our analysis of data from the pre- and +8 weeks surveys collected from 24 social prescribing clients to date indicates that the social prescribing approach is working, and that ***increasing meaningful group memberships may lead in the longer term to decreased loneliness and improved health and wellbeing.***



E. How current investment by the Queensland Government, other levels of government, the non-government, corporate and other sectors may be leveraged to prevent, mitigate and address the drivers and impacts of social isolation and loneliness across Queensland

A state-wide roll-out of social prescribing could be implemented efficiently and cost-effectively using existing infrastructure such as neighbourhood and community centres that have group rooms, kitchen, and bathroom facilities to support social activities and informal socialising opportunities. This infrastructure would need to be accompanied by funded link worker positions and administrative support in each location to ensure effective communication between referring stakeholders, participants, and community group providers.

Currently, link workers are not registered with the Australian Health Practitioners Regulation Authority (unless they are registered as a member of a health profession) and they come from a diverse range of backgrounds. Therefore, an effective and safe new workforce of social prescribing **link workers will require modular (online) training**, **mentoring and support** in specific topics such as: mental health, domestic violence, trauma informed care, ethical practice, addictive behaviours.

To ensure that suitable referrals are coming to social prescribing services, a state-wide **promotion campaign** will be needed to educate the public and referring agents such as GPs and other health providers about social prescribing and how to engage with it. This should be extended to stakeholders in departments of health, communities, housing and also NGOs given that loneliness is a cross departmental issue.

Finally, it is recommended that **funding be allocated to research and evaluation** so that the QLD Government is collecting data on what works, where, and how; and to inform future finetuning of the social prescribing approach in the QLD context.