It feels like the world is closing in on me.

COTA QUEENSLAND

COTA Queensland's submission

Queensland Parliament Inquiry into Social Isolation and Loneliness
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Hotel Window, Edward Hopper, 1955. Wikimedia Commons[1]

To be alone and to be lonely are not the same thing. We can be as happy in solitude as the lark singing in the vast of the sky, and we can be bitterly desperately lonely in the thick of a crowd. Few among us can for ever escape the pain of being lonely. In this dangerous world those who love are always in peril of it. In a moment we may lose the companion or the companions who walled loneliness away. He or she who understood, who loved and was loved, who needed, and who gave, is gone.[2]

Excerpt from *Loneliness* by Hildegarde Hawthorne (1931)

[1] Image sourced from F. Bound Alberti, Stop Medicalising Loneliness – History Reveals It s Society That Needs Mending , The Conversation (20 Nov. 2019), https://theconversation.com/stop-medicalising-loneliness-history-reveals-its-society-that-needs-mending-127056

[2] Excerpt from H. Hawthorne, Loneliness , Chronicle [reprint from Harper s Bazaar] (15 Jan. 1931).

1. INTRODUCTION

Council on the Ageing (COTA) Queensland is Queensland's peak organisation for seniors, advancing the rights, needs, interests and futures of people as we age. With the large and growing number of older people in our state at the centre, we have worked to influence positive outcomes for Queenslanders for over sixty years. We provide a connection point for older people, their families and communities, organisations, and Governments at all levels to address issues for Queenslanders and co-create change.

COTA Queensland provides independent information and education for older people, their communities, and organisations as well as education and training, advice, and other services to the public and private sectors. We work across diverse issues, including:

- age-friendly communities
- ageism
- age discrimination
- aged care
- cost of living and concessions
- digital inclusion
- emergency services
- employment
- energy and essential services
- health
- housing
- human rights and legal protections
- mental health
- palliative and end of life care; and
- transport.

Our submission will focus on the impact that both social isolation and loneliness have on older Queenslanders, in addition to how the COVID-19 pandemic has exacerbated this impact. The pandemic heightens the existing priorities and draws attention to new or enhanced challenges in the social isolation and loneliness in the evolution of a globally and digitally connected world.

2. BACKGROUND

Social Isolation and Loneliness have most likely adversely impacted people since we first walked on this planet. However, it is only in recent decades that these two conditions have been formally recognised as having a detrimental impact on an individual's mental, physical, and social well-being and that it can occur at any time throughout an individual's life course.

> *Social isolation is a risk across all age groups but the older population is especially vulnerable as a consequence of the social, economic and health changes that accompany later life. These transitions often result in a decline in the quality and quantity of social relationships with age.*[3]

Literature searches reveal that the conditions of social isolation and loneliness and interventions to address these conditions have been well researched over previous decades, however, these conditions are still prevalent today.

[3] A. Beer et al., Regional Variation in Social Isolation Amongst Older Australians, Regional Studies, Regional Science, 3/1 (Mar. 2016), 170-184, https://doi.org/10.1080/21681376.2016.1144481

Defining social isolation and loneliness

The terms social isolation and loneliness are interrelated but describe different concepts. Social isolation refers to the objective absence or paucity of contacts and interactions between a person and a social network whereas loneliness refers to a subjective feeling state of being alone, separated or apart from others and has been conceptualised as an imbalance between desired social contacts and actual social contacts.[4] Loneliness is not one state or emotion but comprised of several strong affective states or feelings such as (but not limited to) anger, sadness, bereavement, and shame.[5] Further, it has been argued that loneliness is a recent concept with its origins in the early 19th century, and that loneliness can also be positive and incorporates the body and the mind.[6]

Social isolation and loneliness is also experienced through our own cultural lens. If we are brought up in a collectivistic culture, we focus on community needs, while in individualistic cultures, we focus on the rights and concerns of the individual.[7] The way we view our relationships, community connections and social supports, will therefore be coloured by our cultural lens and whether we have lower or higher relational mobility.[8] This relational mobility, in essence, highlights that collectivistic cultures form stable relationships earlier and tend not to move outside these longer-term social circles, whereas individualistic cultures form relationships that may change or break down over time more readily, and are more likely to actively build close relationships over time such as acquaintances becoming longer-term friends, offer higher levels of social support, self-disclosure, love and intimacy. [9]

We therefore need to first understand what is happening in society – the interrelated factors – that shape the experience of loneliness for individuals and their unique circumstances (subjective) and how that impacts on their ability to connect with others and access supports (objective). Hence the complexity of understanding loneliness as it is a unique and personal experience which affects people from diverse backgrounds.

International discussion around social isolation and loneliness

The international discussion has highlighted broader cultural understandings and factors at play in social isolation and loneliness, an oft-cited example has been Sweden[10] with the stereotype of being an individualistic culture where, for example, younger people (e.g., in their twenties and thirties) are happy to live in intentionally designed spaces for solo living. In 2018, Australian Members of Parliament, suggested the need for a Minister for Loneliness[11] and a portfolio for Loneliness.[12] In the same year, Britain appointed its first Minister for Loneliness,[13] with recent calls for similar appointments in Germany[14] and Switzerland.

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[4] C. Gardiner, G. Geldenhuys & M. Gott, Interventions to Reduce Social Isolation and Loneliness Among Older People: An Integrative Review, Health & Social Care in the Community, 2 (Jul. 2016), 147-157, https://doi.org/10.1111/hsc.12367

[5] Alberti, *Stop Medicalising Loneliness*

[6] F. Bound Alberti, This "Modern Epidemic": Loneliness as an Emotion Cluster and a Neglected Subject in the History of Emotions , Emotion Review, 10/3 (Jul. 2018), 242-254, https://doi.org/10.1177/1754073918768876

[7] K. Cherry, Understanding Collectivist Cultures , Very Well Mind (30 Apr. 2021), https://www.verywellmind.com/what-are-collectivistic-cultures-27949622

[8] M. Kito, M. Yuki, and R. Thomson, Relational Mobility and Close Relationships: A Socioecological Approach to Explain Cross-Cultural Differences, Personal Relationships, 24/1 (Jan. 2017), 114-130, https://doi.org/10.1111/pere.12174

[9] Kito, Yuki & Thomson, *Relational Mobility and Close Relationships*

[10] International Union of Tenants (IUT), Sweden: Isolation Is Rising In Europe. Can Loneliness Ministers Help Change That? IUT (2 Feb. 2018), https://www.iut.nu/news-events/isolation-is-rising-in-europe-can-loneliness-ministers-help-change-that/

[11] F. Patten, Victoria Needs a Minister for Loneliness , Fiona Patten [blog post] (2 Oct. 2018), https://fionapatten.com.au/news/victoria-needs-minister-loneliness/

[12] F. Patten, Why Loneliness Needs its Own Portfolio , Fiona Patten [blog post] (22 Oct. 2018), https://fionapatten.com.au/news/loneliness-needs-portfolio/

[13] T. John, How the World's First Loneliness Minister Will Tackle 'the Sad Reality of Modern Life' , Time (25 Apr. 2018), https://time.com/5248016/tracey-crouch-uk-loneliness-minister/

[14] E. Schumacher, Berlin, Capital of Loneliness , Deutsche Welle (DW) (17 Oct. 2019), https://www.dw.com/en/berlin-capital-of-loneliness/a-50867492

With the rising suicide rate as a result of the pandemic, Japan recently appointed its Minister for Loneliness.[15] COTA Queensland has recently highlighted the need for a federal minister for loneliness[16] given the impact on multiple and diverse cohorts of Australians. With the pandemic, Germany has been leveraging existing initiatives[17] in the prevention of social isolation and loneliness including multi-generational housing, telephone counselling, and programs around 'contact and community in old age' which focussed on participation of older people. There is also discussion that we live in a 'Loneliness Economy';[18] examples from Japan and the United States exemplify how people of all ages pay for companionship and connection despite being in a digitally connected world. These international discussions and endeavours towards what the United Nations (UN) term 'global coalition',[19] show that social isolation and loneliness is viewed as a universal epidemic that does not discriminate.

Australians impacted by social isolation and loneliness

From a Commonwealth snapshot of high-income countries, between 10 - 30% of adults aged 65 years and older reported feeling socially isolated from others (with the figures showing 25% of Australian adults).[20] Internationally, it has been suggested that of older adults, those over 75 years of age also report higher vulnerability to loneliness.[21]

The latest Australian report *Ending Loneliness Together* indicates that one in four people aged 12 - 89 years' experience 'problematic' loneliness, and occurrence nationwide at approximately 5 million people.[22] This rate has not appeared to change in three years, with an earlier report estimating that roughly one in four Australians experience loneliness[23] (or were currently experiencing an episode of loneliness[24]). Those aged 18 – 25 years and 56 – 65 years showed higher vulnerability to loneliness, however, due to how responses were captured, this may misrepresent groups, particularly older cohorts (e.g. those who are digitally connected and have online access).

The oft-cited The Australian Institute of Health and Welfare report stated that one in ten Australians aged 15 years and over felt they have limited social support, and one in two Australians felt lonely at a minimum of one day per week.[25] These studies and reports contribute to the work undertaken by the Australian Psychological Society (APS) in 2018 which also uncovered that 1 in 4 Australians feel lonely three or more days, and one in four Australians experience social interaction anxiety[26]; further, over half of the population felt they lacked companionship.[27]

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[15] S. Kodama, Japan Appoints Minister for Loneliness to Help People Home Alone , Nikkei Asia (13 Feb. 2021), https://asia.nikkei.com/Spotlight/Coronavirus/Japan-appoints-minister-of-loneliness-to-help-people-home-alone

[16] J. Sinnerton, Call for Dedicated Doctors to Write Scripts for Social Outings , The Courier Mail (19 Jul. 2021), https://www.couriermail.com.au/news/queensland/call-for-dedicated-doctors-to-write-scripts-for-social-outings/news-story/2046bddbdacc028b74f84a5d89d67e3d

[17] The Federal Government informs about the corona crisis , deutschland.de (24 Feb. 2021) [English; original source in German from Die Bundesregierung], https://www.deutschland.de/en/news/german-federal-government-informs-about-the-corona-crisis

[18] The Rise of the Loneliness Economy , Australian Financial Review (11 Sept. 2020), https://www.afr.com/life-and-luxury/arts-and-culture/the-rise-of-the-loneliness-economy-20200825-p55p63

[19] World Health Organization (WHO), Social Isolation and Loneliness Among Older People: Advocacy Brief, (Geneva, 2021), https://www.who.int/publications/i/item/9789240030749

[20] M.K. Abrams et al., Solutions from Around the World: Tackling Loneliness and Social Isolation During COVID-19 , The Commonwealth Fund [blog post] (30 Apr. 2020), https://www.commonwealthfund.org/blog/2020/solutions-around-world-tackling-loneliness-and-social-isolation-during-covid-19

[21] Ending Loneliness Together, Ending Loneliness Together in Australia, (Pyrmont, 2020), https://endingloneliness.com.au/wp-content/uploads/2020/11/Ending-Loneliness-Together-in-Australia_Nov20.pdf

[22] Ending Loneliness Together, R U OK? & The Australian Psychological Society, Pre-Budget Submission 2021-2022. Social recovery beyond COVID-19. Ending Loneliness Together, (Pyrmont, 2021), https://treasury.gov.au/sites/default/files/2021-05/171663_ending_loneliness_together.pdf

[23] Ending Loneliness Together, *Ending Loneliness Together in Australia*

[24] Australian Institute of Health and Welfare, Australian Government, Social Isolation and Loneliness , Australia s Welfare 2019 [Snapshot] (11 Sept. 2019), https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness

[25] AIHW, *Social Isolation and Loneliness*

[26] Social interaction anxiety is defined by APS as anxiety that arises from social interactions, in particular, a fear of being judged negatively by others or of feeling embarrassed. Australian Psychological Society & Swinburne University, Australian Loneliness Report. A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing, (Melbourne, 2018), 7, https://psychweek.org.au/wp/wp-content/uploads/2018/11/Psychology-Week-2018-Australian-Loneliness-Report.pdf

[27] APS, *Australian Loneliness Report*

In contrast to some reports, the APS report further highlighted that Australians over 65 years of age were least lonely (in comparison to younger cohorts). Further, they were in better health mentally and physically, and with lower levels of depression, social interaction anxiety, and engaged in more social interaction than younger cohorts.[28]

The State of the Older Nation (SOTON) 2021 Survey report[29] released by COTA Australia, highlighted the views, life experiences and needs of Australians aged 50 years and over. In relation to social isolation and loneliness, nationwide 23% of older Australians reported they had felt lonely at least some of the time in the past few weeks, and 4% of older Australians reported they had had no contact with anyone in the preceding week. Most older Australians had some form of contact with people in the past week, most likely a family member (83%), friend (71%) or neighbour (48%). Of concern is that 4% claimed to have had no contact with anyone in the last week.

Those more likely to feel lonely all or most of the time were people who:

- identified as Aboriginal or Torres Strait Islander (50%)
- lived in an aged care facility (28%)
- had experienced bereavement in relation to the death of a partner (25%)
- who identified as LGBIQIA+ (23%).

Queenslanders impacted by social isolation and loneliness

COTA Queensland extracted data from the SOTON 2021 report[30] and conducted an analysis to draw out further insights into how Queenslanders aged 50 years and over understand and experience social isolation and loneliness. This analysis revealed that, on average:

- 22% indicated that they were not content with their friendships and relationships
- 5% indicated they have not had contact with anyone in the last week
- 8% felt lonely all or most of the time.

Of concern was the fifteen percent of respondents who did not feel welcome in their local suburb or town, 16% who did not feel part of their community, and 21% who felt like an outsider. Twenty percent felt they could not trust most people in their community.

In terms of supports, well over half of Queenslanders indicated that support from family and friends (57%) and exercising (57%) were helpful in maintaining their mental health and wellbeing. Good nutrition, maintaining hobbies, connection with nature, and use of technology to stay connected with family and friends were also highlighted as helpful.

The majority of respondents (70%) felt in-person social groups or clubs may help older Australians to feel less isolated or lonely, followed by participation in exercise or outdoor activity groups (67%). Over half felt participation in volunteer opportunities, community events or programs may also assist.

Eleven percent were highly to extremely affected by the pandemic, and Queenslanders reported that multiple things had changed for them personally since the pandemic began. These changes included a decrease in personal income (impacted 20% on average), affected their ability to pay rent or a mortgage on time (20%), and

[28] APS, *Australian Loneliness Report*
[29] Council on the Ageing (COTA) Federation Council, State of the (Older) Nation (SOTON) report, (Barton, 2021), https://www.cota.org.au/policy/state-of-the-older-nation
[30] COTA Federation, *State of the (Older) Nation report*

under 20% indicated an impact to their work hours, physical activity, and ability to engage in volunteer work. In addition, just under 18% had increased their use of technology, their visits to the specialist, allied health professionals, or GP, and increased their use of telehealth services.

Further insights were compiled from the analysis of data from July 2020 – June 2021 which included[31]:

- queries received by COTA Queensland regarding social isolation and loneliness,
- information and data collated from COTA Queensland sourced from surveys, projects, programs and/or initiatives, and
- conversations or forums with key informants from service providers or community organisations, or key roles in local communities (e.g. local council, or those who work directly with vulnerable people), which were conducted by COTA Queensland staff or by volunteer community members in metropolitan, regional and rural areas and included a diverse insights from community providers and community members.

People in the community included people who lived independently at home while others were supported to live at home or resided in a Residential Aged Care Facility. Some participants received or provided informal care to their spouse, partner, friends, or family members. Others received support through the Commonwealth Home Support Programme (CHSP), Home Care Package (HCP), Department of Veteran's Affairs (DVA) and Home Secure Assist. Demographics of community members varied but included, for example, women and men, aged between 50 and 99 years of age, with some community members identifying as living with a disability or chronic health condition, being a carer, or identifying as Aboriginal and Torres Strait Islander, LGBTIQ+ or from a non-English speaking background.

From the SOTON 2021 report – Queensland dataset, and from COTA Queensland's insights, people indicated that they were not accessing support currently or they had no need to access support (and were relatively unaffected or not affected by the pandemic). Queenslanders explained that they found or would find (if they currently did not require support themselves) multiple supports helpful, and those who required supports and accessed supports, particularly if they had or have been impacted indirectly or directly by the pandemic, spoke of:

- the assistance of friends, family, neighbour, and service provider networks (for a wide range of supports including everyday supports such as shopping through to transport assistance, and health care, etc.)
- the value of regular informational supports via different online and offline mediums (including Government updates about the pandemic)
- health and wellbeing support (including allied health; physical and emotional health; physical activities and exercise)
- mental health supports
- general medical and other medical services
- the importance of financial supports (including Government supports)
- workforce (including unemployment in older workforce; unemployment due to impact of pandemic; or re-entering the workforce or maintaining employment)
- community and social supports (local interest or hobby groups including physical and creative activities; service providers; community organisations; community groups or networks)

Having a combination of these supports in place usually made access to services and further support (in general) easier, or they had more options for taking care of their own health and wellbeing or family member's health and wellbeing.

[31] The analysis of the COTA Queensland data is ongoing.

Vitally, not having or having minimal support in place, may hinder and impact on accessibility to key services and support in general (e.g., health and medical appointments), which in turn impacts on the individual's or community members' ability (capacity, mobility, or accessibility) to be active in the community, or to socialise and stay connected through interest and activity groups, social networks, or community initiatives or events. COTA Queensland broadly identified the following key issues from the analysis of existing datasets from 2020 – June 2021:[32]

- Those who receive formal supports e.g., Commonwealth Home Support Program (CHSP) for group social support or domestic assistance, may not eligible for Community Visitors Scheme (CVS). Referrals: COTAQ would refer these individuals to e.g., Seniors Enquiry Line or the Care Army.
- Living on one's own with existing health or medical conditions and experiencing social isolation, unable to access available or existing services and supports.
- Those who do not meet eligibility criteria for supports and 'fall through the cracks' e.g., short-term needs, not eligible for NDIS or QCSS, and those with lack of access to affordable transport options.
- Centres which are taking the brunt of costs for a quality and well-utilised service.
- Experiencing adverse impacts, including feeling like their life was at risk, feeling anxious or stressed on regular basis
- Uncertainty around whether supports were possible with everyone in the same situation
- Wish for normalcy, and there was an acknowledgement of the general feeling of disruption people's lives
- Frustration and distrust e.g., tired of the protests, suspicious of the pandemic (over-hyped or scam), and in some cases was a 'first world' issue, not trust the government (state and/or federal), felt they had not handled the management of the pandemic well (e g., state wide or federally, and that there was lack of clear leadership), and others expressed concerns regarding the 'rushed' development of the vaccine. Others felt that although they were unaffected by the virus directly, they were affected by the enforced regulations.
- People not feeling like they can trust the Government during the pandemic due to decisions made and restrictions imposed, or they feel there is 'fear mongering' or political tactics.
- Existing health conditions were exacerbated yet they felt unable to discuss this with someone or seek support
- Isolation being enhanced due to life becoming quieter during the pandemic restrictions (particularly when life was quiet before). This added to the frustration or feelings of disconnection in not being able to visit family or friends, particularly loved ones who were residing in e.g., aged care facilities.
- Fear of being out and about in the community due to the virus
- Generalised community or societal anxiety re: mass unemployment and economic impact of pandemic; mental health impact of pandemic on existing issues such as homelessness and suicide
- People's ability to celebrate, mourn and connect during important milestones and transitions, and sometimes hindered accessibility to necessary supports at challenging times.
- Accessibility to services and supports marred by small-scale or larger-scale impact of the pandemic e.g., QR Scan/login – frustration (not just with digital literacy) but impact on care responsibilities interstate (families sharing care across borders for ageing family members).
- Travel restrictions, particularly in relation to wishing to connect with family overseas or family or friends located interstate. People wished to be proactive in connecting with friends who live on their own.
- Uncertainty regarding supports available or no support available to them (they report) – due to no supports they feel lonely.
- Anxiety regarding availability of vaccine and vaccination schedule.
- People who felt relatively unimpacted but still reported less socialisation with family and friends and wished for freedom to visit loved ones (or reporting about impact on others and the impact to their ability to visit and connect with others).
- General uncertainty regarding the future, not just with the common documented obstacles such as interstate and international travel restrictions, but general life planning, and feeling a loss of freedom.
- People felt overwhelmed with information and Media as positive or negative influence in understanding current and important information.
- Pandemic as obstacle for moving on with life, particularly for those who felt alone or lonely (e.g. recently bereaved).
- Anxiety or concerns regarding financial support e.g., increase in living costs, pension not adequate to meet all living costs (including medical, health, medication and healthy food), uncertainty regarding options e.g., cashless welfare card; increasing interest rates.
- People who felt unsafe or insecure in their own community and are distrustful of people around them.

[32] COTA Queensland broadly identified the key issues from the data collated and analysed by COTA Queensland, and from the data collated from the Newgate dataset for the State of the Older Nation 2021 report and Queensland dataset analysed further by COTA Queensland. Note: this data was captured during earlier waves of the pandemic in 2020 and in early 2021.

- Navigation and access to daily life supports e.g., hard to navigate supermarkets in person with many people around and feeling uneasy being out and about in the community due to the virus.
- Waitlist for surgeries and specialist procedures; managing existing health issues during pandemic times.
- Workforce issues – early (enforced) retirement due to loss of work hours due to impact of pandemic, self-funded until eligible for the pension.
- Situations where long-term carers for parent or spouse with physical or cognitive decline e g., dementia, mobility issues, and when they pass away – the sudden gulf they are met with in meeting their own health supports particularly social.
- Don't use supports currently or not aware of types of supports they may need.
- Feeling like not sure if others would help if they did require supports.
- Better management of lockdown/restrictions e.g., mask wearing (for and against)

View Appendix A for an overview of the factors and drivers of social isolation and loneliness and Appendix B for a more detailed analysis of the SOTON 2021 report.

Health impacts on those experiencing social isolation and loneliness

In an Australian context, the APS (2018) explained that there is a correlation between higher levels of loneliness and higher levels of social interaction anxiety, less social interaction, decrease in wellbeing psychologically and in quality of life.[33] The combination of loneliness, social isolation and financial stressors are risk factors for deterioration or greater impact on mental health, particularly in relation to suicidal thoughts (QAMH, 2021).[34] QAMH cited Newby's study that reported that 80% of people who have indicated moderate to extreme loneliness also have financial concerns [35] This Australian insight echoes the international research.

The Centers for Disease Control and Prevention notes, "Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are *socially isolated or lonely in ways that put their health at risk."*[36] The National Academies of Sciences, Engineering and Medicine (NASEM) research shows that:

- *Social isolation significantly increased a person's risk of premature death from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.*
- *Social isolation was associated with about a 50% percent increased risk of dementia.*
- *Poor social relationships (characterized by social isolation or loneliness) was associated with a 29% increased risk of heart disease and a 32% increased risk of stroke.*
- *Loneliness was associated with higher rates of depression, anxiety, and suicide.*
- *Loneliness among heart failure patients was associated with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits.* [37]

These interrelated health risks and corresponding evidence have also been backed by the World Health Organisation (WHO), who also highlight health conditions such as diabetes; behavioural and metabolic risk factors such as poor nutrition, alcohol and higher levels of cholesterol; intrinsic capacity factors in relation to cognitive decline, mobility, and daily life activities; elder abuse and general quality of life; and finally, the economic impact through sustaining care with acute and longer-term conditions.[38]

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[33] APS, *Australian Loneliness Report*
[34] Queensland Alliance for Mental Health (QAMH), Wellbeing First, (Stones Corner, 2021), https://www.qamh.org.au/wp-content/uploads/EMBARGOED-Copy-Wellbeing-First-Report-DIGITAL.pdf
[35] J. Newby, K. O Moore, S. Tang & H. Christensen, Acute mental health responses during the COVID-19 pandemic in Australia. PLOS ONE, 15/7 (Jul. 2020), https://doi.org/10.1371/journal.pone.0236562
[36] National Academies of Sciences, Engineering, & Medicine (NASEM), Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System (Washington, DC: The National Academies Press, 2020).
[37] NASEM, *Social Isolation and Loneliness in Older Adults*
[38] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*

Ongoing impact of the pandemic

For those who have been impacted by the pandemic, there is concern that any existing vulnerabilities and ongoing lack of access to supports will enhance loneliness and social isolation or increase the risk of loneliness and social isolation, in addition to exacerbating any underlying health conditions or increasing the health risks as outlined above. What has been clear since the start of the pandemic is that older people are not only at an increased life-threatening risk from COVID-19 but also potentially experiencing barriers to accessing necessary supports for pre-existing health conditions (physical and mental), which creates additional mental and emotional stress (QAMH, 2021). For older adults where loneliness is a risk factor for mortality, and with the ongoing impact of lockdowns and physical restrictions from the pandemic, this increases the likelihood of social isolation.[39]

One in two Australians have indicated they have felt lonelier since the onset of the pandemic. For people aged between 18 and 81 years of aged, loneliness increased the likelihood of experiencing a clinical depressive disorder (by eight times) and a clinical social anxiety disorder (by five times). Earlier infectious disease evidence further suggests that mental health issues (triggered by the pandemic) will last beyond the period of the immediate global health crisis.[40]

In COTA Queensland's analysis of the SOTON survey data, it was evident that people have been experiencing adverse impacts, including feel anxious and stressed on a daily basis:

> *I do not know. I feel stressed every time I leave the house in case I bring it home to my vulnerable partner. Someone safe to talk to would be nice. Just to know that there is a contact in case something goes wrong, but it is not needed regularly. I would be more worried if I was on my own.*

In a few cases, some Queenslanders found their existing health conditions were exacerbated yet they felt unable to discuss this with someone or seek support:

> *I don't know. I drink a lot more alcohol and have put on a lot of weight and get crippling panic attacks which never happened before, but I don't want to talk to anyone about it. Because I have a pre-existing psych illness, I find it easier to not talk to anyone because they might section me, and I lose all rights [and will have] no control over my life and choices.*

The pandemic has also impacted on people's ability to celebrate, mourn, and connect during important milestones and transitions:

> *It was hard not being able to have a funeral for my husband. No one could help with this.*

> *My wife died two and half years ago and Corona has removed the opportunity of me meeting someone else.*

Many Queenslanders in regional areas indicated that despite their area being impacted by restrictions they felt that they were impacted indirectly; or relatively unaffected or not affected. Indirectly and interestingly, the responses highlighted how people were accustomed to living pre-pandemic and due to their personality or preferred lifestyle, they did not feel lonely:

> *None - I am an introvert and so don't feel any loneliness due to the pandemic.*[41]

[39] QAMH, *Wellbeing First*
[40] Ending Loneliness Together, *Ending Loneliness Together in Australia.* Respondents were surveyed between March and April 2020.
[41] COTA Federation, *State of the (Older) Nation report*

See Appendices A and B for more insights into the impact of the pandemic on individuals and communities, and how this interrelates with their understanding and experiences of social isolation and loneliness.

Key factors and drivers of social isolation and loneliness

The research over the last five years around social isolation and loneliness is vast. Multiple reports and journal articles have provided insight into cultural, national, and pandemic understandings of these experiences. Social isolation and loneliness is comprised of interrelated factors[42,43] including causes or influences such as:

- **life events** through, for example, relationship breakdowns, mental health experiences, financial pressures, life transitions such as retirement, becoming a primary carer, bereavement through death of a partner/spouse)
- **socio-economic drivers** which are, for example, influenced by diversity (gender, age, sexuality, disability, ethnicity), speaking English as a second language, educational and employment background, occupational status, and income

There are personal or **individual factors** which may influence the prevention/mitigation/experience of social isolation and loneliness. These may include general health and wellbeing (e.g, cardiovascular health, cancer; impairments – sensory, hearing; emotional and psychological – anxiety, depression, dementia), mobility, personality (sometimes certain traits are linked genetically), low socio-economic resources, limited – low education, resilience, cultural or spiritual or religious background, living alone, and digital connectivity and digital literacy with social media and use of technology and the internet (however, it is recognised that digital connections can be 'positive' or 'negative' in impact).[44,45,46]

There are numerous **community factors** which may come into play including the local environment (accessibility, nature of environment e.g., close to park, green spaces, etc.); local economic climate; accessibility to local facilities and services, and importantly to transport networks (public and private services; particularly in rural and regional areas), and impact of traffic congestion; feeling of safety and wellbeing; accessibility to wider communities and neighbourhoods; and vitally, the relationships with family, friends, colleagues and peers e.g., limited or lack of quality or supportive relationships. [47,48,49]

And finally, there are **societal factors** which may influence or impact including Government policies around housing, infrastructure, planning, development, and transport; changes and reform in relation to welfare and social services; the wider economic and political climate; demographic and familial change; changes in pension or income; and Media influences (particularly 'negative' connotations e.g. age discrimination, marginalisation, stereotypes, etc., across different mediums). This may include diverse groups who do not have access or limited access to services and supports e.g., LGBTIQ+, refugees or migrants (less social integration due to complex language and cultural factors which may also be barriers to accessing health and social supports), individuals with

[42] D. Clarke & L. McDougall, Social Isolation [diagram] (Bristol City Council, Government of the United Kingdom, n.d.), https://www.bristol.gov.uk/documents/20182/34732/Social Isolation Diagram_0_0_0_0.pdf/122050ef-a40c-4056-b62d-650f0cdbbe4b
[43] Clarke & McDougall, *Social Isolation*
[44] Clarke & McDougall, *Social Isolation*
[45] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[46] AusMed, Loneliness and Social Isolation in Aged Care [online Continuing Professional Development (CPD) article] (9 Jul. 2021), https://www.ausmed.com.au/cpd/articles/loneliness-and-social-isolation-aged-care
[47] https://www.bristol.gov.uk/documents/20182/34732/Social Isolation Diagram_0_0_0_0.pdf/122050ef-a40c-4056-b62d-650f0cdbbe4b
[48] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[49] AusMed, *Loneliness and Social Isolation in Aged Care*

disability or impairments, chronic health conditions, those carers for others, and older adults in residential care/aged care facilities. [50,51,52]

Some of the risk factors for social isolation and loneliness in older adults[53] are also indicators of higher vulnerability; these include having a low personal income, living with a disability, speaking a language other than English at home, and experiencing bereavement in the past year.[54] In the SOTON 2021 report, the higher vulnerability group was identified as female, aged over 70 years, living in Queensland and outside capital cities. Higher vulnerability has increased since 2018.

Older Queenslanders, especially the 75 – 85+ years of age cohort is estimated to increase substantially by 2036. It is estimated that the Queensland population will comprise 1.01 million of persons aged 65 and over, accounting for 17.7 percent by 2026, 1.35 million (20%) by 2036.[55] It is therefore important to note the existing evidence-based strategies, interventions, and initiatives in addressing the current and future health needs of Queensland's growing ageing population.

3. INTERVENTIONS AND PROTECTIVE FACTORS FOR SOCIAL ISOLATION AND LONELINESS

COTA Queensland believes that the community and societal factors related to the social environment, community services and infrastructure, health and employment could be more effectively dealt with by broad changes to our communities' social, environmental, and economic infrastructures. In addition, interventions to address the problems faced by those currently impacted by social isolation and loneliness must also be developed and implemented. This section will firstly address a community development framework that will assist in addressing the community and societal factors that create barriers to full social integration within our communities. Interventions to resolve individual factors that contribute to social isolation and loneliness will then be discussed.

The provision of an exercise program at the local hall may help individuals to feel more socially connected, however, participation in such programs will not address the underlying community and societal issues within communities that led people to be socially isolated in the first place. The intervention types commonly used in many countries target the individual factors. These interventions are vital to those effected; however, the underlying community and societal factors must also be addressed to help tackle these adverse social conditions.

The framework that COTA believes is fundamental to achieving the level of change necessary to address the community and societal factors identified earlier in this submission is the age-friendly communities' framework. Age-Friendly communities are those that seek to integrate the eight key domains that are essential for achieving a liveable community for all residents; these include:

1. Community and health care
2. Housing
3. Transport
4. Social participation
5. Outdoor spaces and buildings
6. Respect and social inclusion
7. Civic participation and employment

[50] Clarke & McDougall, *Social Isolation*
[51] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[52] AusMed, *Loneliness and Social Isolation in Aged Care*
[53] AusMed, *Loneliness and Social Isolation in Aged Care*
[54] AusMed, *Loneliness and Social Isolation in Aged Care*
[55] Department of Health, Queensland Government, Healthy Ageing: A Strategy for Older Queenslanders, (Brisbane, 2019), https://www.health.qld.gov.au/__data/assets/pdf_file/0035/857519/healthy-ageing-strategy.pdf

8. Communication and information.

Queensland: An age-friendly community

Queensland: An age-friendly community action plan[56] was launched in 2016 by the Queensland Government. The action plan was intended to provide a clear way forward to direct the implementation and delivery of age-friendly communities in Queensland. The actions that were intended to flow from the plan have unfortunately not gained much traction across Queensland.

COTA Queensland believes that the 2016 Action Plan must be reviewed, and the following measures included:

1. Queensland adopts a whole-of-Government age-friendly framework that is supported at all levels of Government and across all agencies.
2. All Queensland Government agencies work collaboratively to consider policies, programs, services, and planning across all eight of the age-friendly domains.
3. The Government works collaboratively with communities to identify and solve issues and create positive change across systems. Local leadership, including the work of community groups and organisations, is valued.
4. The Government provides support across sectors that is flexible and responsive to large- and small-scale community-led priorities across age-friendly domains.
5. The Government shows leadership in addressing ageism, taking a strong stand against stereotyping and ageist attitudes and language, and actively supporting initiatives that bring the generations together.
6. Queensland has an integrated health system for the whole of life that places people at the centre of care. The system ensures equitable access, no matter a person's diagnosis, age, location, or resources. Health is seen as interconnected to other areas of communities including transport, housing, and participation, and the Government encourages, tests, and embeds integrated models that connect these domains. There are clear and navigable pathways to services for diverse and changing needs throughout the lifespan. The Queensland Government leads collaboration across Federal, State, and Local Government responsibilities including co-design with consumers to work towards an integrated system.
7. All Queenslanders have access to adequate, appropriate housing that they can afford and that supports their wellbeing. Housing stock meets the diverse needs of Queenslanders at any stage of life. Housing and home modification programs are flexible to allow people to stay in their home and their community of choice. People have the information they need and are supported to make housing decisions that are right for their future. Homelessness support programs are equipped to ensure access to appropriate housing and other supports and to respond to diverse needs including specialised needs of older people.
8. Affordable and accessible transport options are available no matter where in Queensland a person lives. Transport is designed with reference to all other age-friendly domains to ensure it is accessible for people of all ages and abilities, financial and life circumstances, and effectively and meaningfully supports community participation and access. The Government facilitates and encourages a collaborative process between stakeholders, including consumers, to identify gaps and strategies at the local as well as state level.
9. Queenslanders have equitable and affordable access to reliable internet no matter their location or circumstances and supports are available to increase their capability. Those who are not online continue to have full opportunities for participation in social, economic, and civic life.

[56] Department of Seniors, Disability Services, Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), Queensland Government, Queensland: An Age-Friendly Community. Action Plan, (Brisbane, 2016), https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/seniors/age-friendly-community/qafc-action-plan.pdf

Queensland Government and Social Isolation and Loneliness

COTA Queensland is concerned by the lack of progress made by the Queensland Governments that have held office over the past 20 years in addressing social isolation and loneliness. The seriousness of these two social conditions in respect to the health and welfare of older Queenslanders have been recognised at least since the early 1990s when the *60s and Better* program was first introduced in Queensland.

In 1999, the Beattie Government released a document *Our Shared Future: Queensland's Framework for Ageing 2000 – 2004* which recognised social isolation as a significant issue. The Framework noted that:

> *Social supports and social networks are integral to the overall well-being of all people. While many older people in Queensland are involved in various community and family activities, others may experience a significant degree of isolation. Many factors can contribute to reduced social networks and social contact. Some of these are lack of transport, loss of a partner, ill health, physical disabilities, limited personal finances, changing family patterns, physical location, language barriers and difficulties in finding out about opportunities for social activities.*[57]

In 2002, the Queensland Government established a cross-government project to identify what interventions would best address the growing issue of social isolation, the project was titled *Cross Government Project to reduce Social Isolation of Older People*.[58] This detailed investigation involved a comprehensive literature review, a detailed report which resulted in five interventions being trialled and a detailed evaluation of these trial projects were produced. The project recognised the distinct differences between social isolation and loneliness but chose to address both social conditions under the term 'social isolation'. This project was conducted over several years and identified a range of interventions, despite this no new long-term programs were introduced into Queensland to address social isolation and loneliness.

The *60s and Better* program has continued to operate and is delivered from 44 centres around the state albeit with minimal levels of funding provided to the community organisations delivering the program. The Queensland Government currently expends a relatively small amount of direct program funding on seniors and that funding goes largely towards elder abuse prevention, legal advice and *60 and Better* groups. The exact amount is hard to determine as the information is not provided within government budget papers in a manner that shows the funding provided to the community excluding government administrative costs. Staffing levels are a useful indicator for the priority attached to a program area; in 2006 – 2007, n= 36 staff were assigned to Support for Seniors Participation out of a total departmental establishment of n = 2,265. This compares with n = 8 out of 1,998 in the 2020 – 2021 estimated actual.[59] Those over 65 years of age comprise 16.3% of the total Queensland population, however, they do not attract that share of Queensland Government social welfare funding.[60]

The Commonwealth Government commenced the Seniors Connected Program in 2019. The intent of the program is to address loneliness and social isolation experienced by older Australians aged over 55 living in the community (or Indigenous Australians aged 50 or over). The program will run from 2019 – 2020 to 2023 – 2024 (terminating 30 June 2024), with a total budget allocation of $10 million.[61]

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[57] Department of Families, Youth and Community Care, Queensland Government, Our Shared Future: Queensland s Framework for Ageing 2000-2004, (Brisbane, 1999),
Queensland Government, Seniors [index – archives], (Brisbane, n.d.),
https://webarchive.nla.gov.au/awa/20090914214919/http://www.communityservices.qld.gov.au/seniors/index.html

[58] C.M. Cartwright & H.P. Bartlett, Cross Government Project to Reduce Social Isolation of Older People, (Brisbane: Australasian Centre on Ageing, University of Queensland, 2004).

[59] Queensland Treasury, Queensland Government, Queensland Budget 2021-22. Service Delivery Statements, (Brisbane, 2021),
https://budget.qld.gov.au/files/Budget_2021-22_SDS_Department_of_Seniors_Disability_Services_and_Aboriginal_and_Torres_Strait_Islander_Partnerships.pdf

[60] Queensland Government, Queensland State Budget 2007-2008 [archives], (Brisbane, 2008),
https://webarchive.nla.gov.au/awa/20080808091553/http://www.communities.qld.gov.au/department/publications/budget/2007/

[61] Department of Social Services, Australian Government, Seniors Connected Program , Communities and Vulnerable People (14 May 2021),
https://www.dss.gov.au/communities-and-vulnerable-people-programs-services/seniors-connected-program

The investment nationally of $10 million dollars over four years to address social isolation and loneliness is like the Queensland Government level of expenditure and that is wholly inadequate. This low level of expenditure by governments enables 'band-aid' only interventions to be applied to two of this nation's major social problems. The Queensland and Commonwealth governments on one hand acknowledge that social isolation and loneliness can cause significant physical and mental health issues for older Australians. These related health issues result in substantial increases in public health expenditure for both levels of government.

While data on the increased Australian health costs are not readily available there have been some studies overseas. In the United States, the AARP (formerly the *American Association of Retired Persons*) in a study determined that*:*

> *[…] By examining Medicare spending data, this study found that a lack of social contacts among older adults is associated with an estimated $6.7 billion in additional federal spending annually*62. While a British study found: …*In conclusion, we found that loneliness and social isolation are likely to be associated with excess health care costs, although one study did find that loneliness was associated with less costs, while social isolation was associated with greater costs. The economic evaluation and ROI/SROI literature found that of the limited interventions assessed (almost all targeting older populations) many were likely to be cost-effective and possibly even cost-saving. The most promising interventions from a cost-effectiveness perspective were those that included increased social contact (e.g., befriending, peer visiting, etc.)*.[63]

Based on these studies alone it is clear to see that substantial increases in funding for intervention programs would in all probability generate proportionately larger savings in government health expenditure. Therefore, COTA Queensland believes that a substantial increase in program funding is required from both levels of government to expand the range of interventions currently available to help reduce the adverse impacts that these two social conditions have on many older Queenslanders. Assisting people to overcome any adverse issues that stem from social isolation and/or loneliness before serious physical and mental health problems arise would surely be a more cost-effective approach.

Effective interventions

COTA Queensland is not able to recommend which interventions would be most effective in the Queensland context. However, based on the information detailed below there have been a broad range of interventions developed and implemented across the globe. Health and Wellbeing Queensland would be the appropriate Queensland organisation to lead a Queensland coalition to develop and implement social isolation and loneliness interventions.

The AARP commissioned research into interventions with the objective of designing a tool that would be an interactive research catalogue of evidence-based practices. They identified the most effective interventions has having a sound theoretical basis and multi-systemic approach, which targeted socially isolated individuals and encouraged active participation of older adults.[64] A comprehensive review of interventions by Gardiner and colleagues noted the following qualities were found in effective interventions:

- adaptability
- community participation
- productive engagement in activities.

[62] L. Flowers et al., Medicare Spends More on Socially Isolated Older Adults , Insight on the Issues (AARP Public Policy Institute, Nov. 2017), https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf
[63] C. Mihalopoulos et al., The Economic Costs of Loneliness: A Review of Cost of Illness and Economic Evaluation Studies , Social Psychiatry and Psychiatric Epidemiology, 55 (May 2019), 823-836, https://doi.org/10.1007/s00127-019-01733-7
[64] NASEM, *Social Isolation and Loneliness in Older Adults*

However, both research teams also highlighted the challenges and limitations of the interventions. For example, Gardiner et al. reported, that despite the range of interventions, there was substantial heterogeneity between interventions they reviewed.[65] The AARP research noted the following persistent challenges to the evaluation of interventions:

- *A limited number of studies quantifying the impact of interventions;*
- *A shortage of randomized controlled trials (RCTs) and quasi-experimental studies;*
- *Variability in the concepts being measured;*
- *A targeting of either the general community or individuals who are "easy to find"; and*
- *Difficulty in recruiting those who are extremely isolated or lonely.*[66]

The WHO's three-point strategy for reducing social isolation and loneliness[67] includes **generating a 'global coalition'** using direct engagement with older people and sector and stakeholder engagement across multiple areas. This model also proposes that through a coalition they can strengthen information sharing and collaboration among UN agencies to raise awareness and draw attention to political priority of social isolation and loneliness so there is proper investment in required resources (financial, technical, and human).

Second strategy involves the **improvement of research and strengthening evidence-based interventions** to gain deeper insights into how social isolation and loneliness is experienced, and which interventions are most effective in mitigating or preventing social isolation and loneliness.

The final strategy includes **the implementation of evidence-based effective interventions (existing interventions and the creation of new ones) and strategies across multiple sectors and multiple stakeholders** to have maximum impact at population level. This includes ongoing evaluation and improvement processes which will factor in costs and benefits, the scope and acceptability of interventions, the resources (infrastructure and workforce) to carry out interventions and maintain the sustainability of interventions.[68]

Importantly, the sustainability of the interventions needs to be considered which means the likelihood of the continuation of evidence-based practices after they have been implemented, particularly after the investment of energy, time and resources.[69]

Further, the research literature shows that the current forms of intervention do not provide a universal panacea for those impacted by these social conditions. The interventions provide varying degrees of assistance to the individual in addressing the adverse effects they may be experiencing; everyone is different and thus will respond differently to the interventions offered.

Examples of social isolation and loneliness initiatives

> *Human distress does not always need a medical response. [….] we need to move beyond current models of care, and pivot to a contemporary whole of community approach that places Wellbeing First.*[70]

We provide below some examples of initiatives (projects, programs, and strategies) that have been designed to tackle social isolation and loneliness. These examples include social prescription, social housing models, and higher-level strategies or policies.

[65] Gardiner. et al., *Interventions to reduce social isolation and loneliness among older people: an integrative review*
[66] NASEM, *Social Isolation and Loneliness in Older Adults,* 175
[67] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[68] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[69] NASEM, *Social Isolation and Loneliness in Older Adults*
[70] QAMH, *Wellbeing First*, 7

COTA Queensland's recent pilot of the *Volunteer Community Peer Program* was linked to the *Planning for Wellbeing*[71] which was delivered by the Older Persons Action Group (OPAG) from May 2019 to June 2020. This pilot program aimed to improve knowledge in general regarding available information and resources for older people, including increasing community knowledge and General Practitioner (GP) awareness of supports and services, engaging older people in conversation (to promote health seeking behaviours) via the Peer Navigators who were stationed in local council libraries; the engagement scope included carers.[72]

COTA Queensland and Moreton Bay Regional Council are partnering to extend the program across the North Brisbane and Moreton Bay regions (currently identifying additional partner sites in addition to Caboolture, Redcliffe and Strathpine) with funding from Brisbane North PHN (*Mental health, social isolation and loneliness support for older people impacted by COVID-19)* from April 2021 – March 2022.

The program has elements of the social prescription approach where individuals who might be experiencing or at risk of experiencing e.g. non-medical stressors related to social isolation and loneliness (including related factors such as finances, housing, and digital or health literacy), mental health issues, chronic and physical health conditions (including higher risk factors for morbidity), and older people, are referred to community services or informational resources or supports. It is thought that this approach may assist in increasing quality of life, wellbeing, community participation and abate or prevent mental health conditions such as anxiety and depression.[73,74]

Another example of social prescription is the *Ways to Wellness Project* which was launched June 2019.[75] This pilot program is currently offered across several suburbs on Brisbane's southside and aims to link patients who are referred by e.g., their GP, to a 'link worker' who then assists in connecting the individual to a community program.[76] Further, the partnership between Queensland Community Alliance,[77] Mt Gravatt Community centre,[78] Mt Gravatt Men's Shed,[79] and the University of Queensland,[80] means that the data collated from this program will be used to better inform Government understanding of social isolation and loneliness and also contribute to the global evidence.

An initiative that has recently attracted national interest is the *Sharing With Friends* model which offers co-housing for older women.[81] The Older Women Co-Housing Association (Qld) Inc. (trading as Sharing with Friends)'s objective is to provision of affordable tailored housing that comprises five private living quarters, with communal areas e.g., laundry, library, entertainment, garden spaces. The business model is an investment amount of e.g., $120,000 from each woman, which then goes towards the construction of the residence.

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[71] Brisbane North Primary Health Network (PHN) & Metro North Hospital and Health Service (MNHHS), Planning for Wellbeing [website] (n.d.), https://planningforwellbeing.org.au/
[72] Council on the Ageing (COTA) Queensland, Volunteer Community Peer Navigator Pilot Program (Bribie Island Library). End of Project Report (August 2021).
[73] Boydell, K., Social Prescribing: Linking Patients with Non-Medical Support , Insight (Medical Journal of Australia, 25 Feb. 2019), https://insightplus.mja.com.au/2019/7/social-prescribing-linking-patients-with-non-medical-support/
https://chf.org.au/sites/default/files/social_prescribing_roundable_report_chf_racgp_v11.pdf
[74] The Royal Australian College of General Practitioners (RACGP) & Consumers Health Forum of Australia (CHF Australia), Social Prescribing Roundtable, November 2019: Report , The Royal Australian College of General Practitioners and Consumers Health Forum of Australia (Nov. 2020), https://chf.org.au/sites/default/files/social_prescribing_roundable_report_chf_racgp_v11.pdf
[75] University of Queensland (UQ), Tackling the Growing Problem of Loneliness and Isolation , UQ News (1 Jul. 2019), https://www.uq.edu.au/news/article/2019/07/tackling-growing-problem-of-loneliness-and-isolation
[76] Ways to Wellness [website] (n.d.), https://waystowellness.org.au/
[77] Queensland Community Alliance [website] (n.d.), https://www.qldcommunityalliance.org/
[78] Mt Gravatt Community Centre [website] (n.d.), https://mountgravattcommunitycentrein.vpweb.com.au/
[79] Mt Gravatt Men s Shed [website] (n.d.), https://www.mtgravattmensshed.org.au/
[80] University of Queensland [website] (n.d.), http://www.uq.edu.au/
[81] Sharing with Friends [website] (n.d.), https://www.sharingwithfriends.org/

Housing Choices Australia Group (Housing Choices) is an independent, national, not-for-profit housing provider for people who have not been able to access the rental market or who have been unable to find a suitable home.[82] They work with community organisations, community members, government agencies and support service partners to provide housing and access to services to maintain health and wellbeing, particularly to those with low incomes or living with disability.

An international initiative is the *Socially Connected Communities: Solutions for Social Isolation* by Healthy Places by Design, which presents key recommendations and action guides for philanthropists, local community leaders and local governments.[83] This includes community-led action and placed-based solutions with the overarching recommendations as follows:

- Design, maintain, and activate inclusive public spaces
- Prioritise connection in transportation systems
- Construct housing environments that build community
- Invest in inclusive practices and community-led solutions
- Make social connectedness a community norm.[84]

Another example of an international initiative through higher-level strategy and policy is *A Connected Society: A Strategy for Tackling Loneliness* by the government of the United Kingdom.[85] The policy framework builds on the pre-existing work of organisations, individuals, and government, and marks the first primary government contribution (published in 2018). Perhaps most important is the approach to working in partnership with a wide range of sectors including e.g., health and voluntary sectors, businesses, local government, and wider society; and their commitment to working with the limitations of the evidence and push forward collaboratively and across departments to find better ways to tackle social isolation and loneliness; and that these solutions include tailored, place-based, and is informed by accurate statistics and analysis.

View Appendix C for a list of further resources and initiatives that contribute towards understanding, mitigating, and preventing social isolation and/or loneliness.

Sustainability of initiatives through participatory (community) engagement and knowledge sharing

COTA Queensland's community engagement has highlighted the value of **participatory engagement**[86] in better understanding local community needs and in bringing forth the collective voice. Surveys and individual feedback are common ways that people's experiences are captured, particularly now during the pandemic, but collective experience where people can find similarities and gain new insights into listening to others is effective. Regular forums or discussion spaces where community members feel safe to share experiences is required.

Sharing with others may enable people to learn more about existing services or supports of which they were not previously aware. COTA Queensland has learnt from the community engagement that people enjoy being a host and participant, they meet new people, find interesting discussion topics, learn new information about how

[82] Housing Choices [website] (n.d.), https://www.housingchoices.org.au/aboutus
[83] Healthy Places by Design, Socially Connected Communities: Solutions for Social Isolation, (United States, 2021), https://healthyplacesbydesign.org/socially-connected-communities-solutions-for-social-isolation/ https://healthyplacesbydesign.org/wp-content/uploads/2021/03/Socially-Connected-Communities_Solutions-for-Social-Isolation.pdf
[85] T. Crouch & J. Wright, A Connected Society: A Strategy for Tackling Loneliness. Laying the Foundations for Change [policy paper] (London: Department for Digital, Culture, Media & Sport, Office for Civil Society, Prime Minister s Office, 15 Oct. 2018), https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness
[86] Participatory engagement refers broadly to forms of engagement that may be recognised in a number of approaches and methods such as participatory action research; participatory community engagement; consumer engagement; client engagement; and in concepts such as codesign, user-centered design (UCD), or participatory design.

people access care, or may be motivated to take further action to better understand ways in which to support other community members or loved ones.

It is important to find a way to sustain interventions, initiatives, and solutions that work, and to prevent these initiatives from disappearing, particularly when there is limited funding and local community organisations will often fundraise or take a grassroots approach to provision of ongoing supports. Concepts such as 'Health Champions' and 'Volunteer Champions' which entails training community members who already have life experience and local knowledge about their communities, are often best placed to connect with local community members. Local government could connect more regularly with small-scale or grassroot initiatives (through e.g. knowledge bearers from the community such as local providers, key informants, local members who are connected regularly with people) and **leverage the valuable knowledge and resources** which already exist, through promotion and funding, while continuing to gather key insights into the issues that impact vulnerable people at risk of social isolation and loneliness.

In addition, having access to **plain language summaries** of the latest research, particularly evidence-based strategies and interventions so those professionals outside the fields of medical and health sciences (e.g., community service organisations; service providers, local community groups) can access and understand the most effective and current approach or methodology to consider incorporating or applying to their program model, project, or community initiative; and that community connectors such as care workers, social workers, allied health and mental health professionals such as counsellors and psychologists, have access to these summaries to share and incorporate in their practice; and community organisations and service providers can also use to better inform part of training, education resources or materials to share with staff and community members. This sits with WHO's recommendation of the translation evidence, so it is more accessible and readily available through appropriate channels[87] so all are aware of the priority issue of social isolation and loneliness in an age-friendly Queensland, beyond government and policy.

To better access inaccessible members of the community particularly those people who have been identified as highly vulnerable, community organisations and service providers can continue to **share stories and experiences** on behalf of these communities and individuals when people are unable to directly provide their experience (e.g. homelessness; no digital literacy; no access to the internet, or lack of access to health and social supports). Potentially vulnerable people may not be aware of practical supports or informational supports, or they may feel overwhelmed about where to begin and who to speak to, or they may feel shame in asking for assistance. Those who are highly vulnerable at home, may be less willing or less likely to leave home to access supports (including instances where e.g. mobility or cognitive impairment are not an issue), particularly during the pandemic, where they may be afraid to be out and about in the community.

4. RECOMMENDATIONS

In light of the current global understanding and national understanding of social isolation and loneliness (what the current evidence tells us), and the earlier issues identified around social isolation and loneliness for Queenslanders, we strongly recommend the inclusion of an age-friendly framework which is also informed by the WHO's Decade of Healthy Ageing strategy regarding social isolation and loneliness.

To the Inquiry, we present five key recommendations along with examples of opportunities for action.

[87] WHO, Social Isolation and Loneliness Among Older People: Advocacy Brief

1. To address the community and societal factors that contribute to social isolation and loneliness the Queensland Government strengthens its approach to achieving age-friendly communities.

This recommendation is further supported or complemented by the other recommendations and opportunities (recommendations 1. through to 5.).

Opportunities:

a. Review of the 2016 Age-Friendly Action Plan to include the range of actions proposed by COTA Queensland in section 3 of this submission.

b. Continue to build on international and national insights into social isolation and loneliness through timely and sensitive, and confidential data capture with appropriate methodologies to better inform our understanding of key issues (and community and societal factors that contribute to social isolation and loneliness for Queenslanders). This includes, where possible, working with other peak bodies and local community organisations to access those who are highly vulnerable and/or not as accessible (or able to participate in community forums/discussions).

c. All-age inclusion across portfolios in Government has previously been recommended to the Department by COTA Queensland, it is recommended social connectedness is also incorporated or enhanced across relevant policies.[88]

2. In consultation with Queensland communities and stakeholders develop and implement a range of interventions that would most effectively assist those impacted by social isolation and loneliness.

As mentioned earlier, COTA Queensland is not in a position to directly recommend which interventions would be most effective. However, there are multiple opportunities to engage appropriate teams in different ways to contribute to and work towards identification of appropriate interventions/strategies or initiatives, and to tailor these to diverse all-age communities and their needs.

Opportunities:

a. There is ongoing community consultation regarding potential interventions/strategies/intiatives to understand the best fit for the local community and diverse cohort, particularly long-term residents who wish to remain in their communities in later life. These insights are shared where possible with not only in submissions to potential funders/funders, with local governments and council, but also beyond to other communities through peak bodies as conduits, or through forums or appropriate discussion spaces at regular times throughout the year, so providers and organisations can learn from each other and share knowledge (and potentially resources), particularly how to address issues and make change through customised (preferably) local supports.

b. Prioritise customised informational supports e.g. digital connection and inclusion for older adults and vulnerable adults. Consideration of how important updates or information regarding social supports can be better relayed to isolated individual in regional, remote communities or in metropolitan areas where digital resources are limited, particularly during periods of restrictions or lockdowns during the pandemic.
    - Consideration of translation of evidence-based strategies or activities to plain language summaries regarding mitigation of social isolation and loneliness, and provision of such information and pandemic related information through digital and hardcopy resources strategically placed in community centres and central meeting points (e.g., libraries, transit centres or public transport hubs, shopping centres, medical centres, neighbourhood centres, local

[88] K.A. Van Orden, Strategies to Promote Social Connections Among Older Adults During "Social Distancing" Restrictions , American Journal of Geriatric Psychiatry, 29/8 (Aug. 2021), 816-827, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7233208/

churches, RSL clubs, etc.). Plain language summaries of research and sharing of stories and experiences, kitchen tables, community forums, and interactive spaces (online and offline), and provisions made for those who are unable to access information or attend sessions.
    - Tailored and customised supports e.g., visual, hearing impaired, English as a second language, different interest groups, life transitions (particularly tailored to vulnerable groups who may have a more challenging time re-entering workforce, community, etc. – bereaved, culturally and linguistically diverse, low income, and living with a disability), and to those people who do not have digital literacy or access to digital devices to navigate existing informational supports.

c. Consideration of how information can be provided to people alone and isolated in their own homes e.g., house visits, hardcopy invitations to forums and discussions, letterbox drop, via the telephone, via a one-stop Hub over the phone and online.
d. That there is no geographic or demographic discrimination with accessibility to services and supports in rural and regional areas, and in suburban and metropolitan areas where still exist issues with accessibility to transport and social and health services and supports.
e. Creation and promotion of (new and existing) data touchpoints in the community - where valuable insights may be confidentially gathered by trained staff in e.g., community centres or local organisations to ensure councils and governments have their ear to the ground about key issues particularly that impact on social isolation and loneliness. Acknowledgement that this is an epidemic that doesn't just impact people affected by the pandemic and doesn't mean that their pre-existing health condition isn't exacerbated or enhanced by the national or statewide impact of the pandemic (e.g., availability of services, workforce turnovers, shortages, etc.).
    - Training well informed or key informant community members as 'Volunteer Champions' to disseminate up to date information regarding state and federal responsibilities and how they can have their say (e.g. individual advocacy; systemic advocacy through peak bodies).

3. Peak bodies such as COTA Queensland to collaborate with independent organisations and committees to better elevate the knowledge around effective interventions. The overall responsibility for the development and delivery of enhanced existing interventions or new interventions to be assigned to appropriate organisations.

Opportunities:

a. COTA Queensland (and interested peak bodies e.g., QCOSS, Queensland Alliance for Mental Health (QAMH)) to discuss key issues around social isolation and loneliness for all-aged communities and older adults with Health and Wellbeing Queensland.

b. COTA Queensland and interested peak bodies to contribute to consultation in order to inform Health and Wellbeing Queensland supported by the Queensland Mental Health Commission (QMHC) (building on earlier insights from key reports including from QAMH's Wellbeing First report, especially those items which have been outlined in this submission such as delay in significant reform, difficult in navigation of available resources and supports, and the cost and impact of mental health issues).

c. Interventions and strategies, once identified (through local community consultation as highlighted above), and backed by appropriately qualified health professionals who have been consulted on the suitability of the interventions and strategies for the intended cohorts in local communities; this would also require consultation with Primary Health Networks (PHNs) and community providers, and peaks such as COTA Queensland would leverage existing partnerships or relationships to better highlight key communities where there are gaps in supports.

4. Ensure the provision of program funding that reflects the scope and importance of the intervention work.

COTA Queensland is aware of a number of funded organisations who are stretched in their capacity (workforce and resources) to implement or apply insights to ongoing work that could contribute to or mitigate social isolation and/or loneliness. In addition, we are aware of funded organisations that are in direct competition with each other for provision of funding. This runs against the 'coalition' approach put forward by WHO's recommendations. Strategic, substantial, and flexible funding for intiatives is required and is a priority not only during the pandemic, but also into the future in a post-COVID-19 Queensland.

Opportunities:

a. In order to truly collaborate, there needs to be regular consultation with funded organisations to learn from them about their resources, capacity and their current successes in terms of engagement with community and reach in tackling social isolation and loneliness. The issues need to be highlighted, and strengths harnessed. Organisations with particular qualities and strengths may be paired with like-minded organisations who do not have the same experience/lacking resources, in order to share e.g., volunteer staff, training, and wider resources, in line with WHO's recommendations on contribution to improvement of evidence and sharing of evidence-based strategies and interventions. Funding could then be allocated according to community needs and issue at hand and then dispersed to funded organisations in that geographic area.

b. Allocation of a realistic, flexible, place-based, and where possible, tailored program funding to the achievement of age-friendly communities. Understanding adequate funding includes sufficient resources for the intervention/strategy/initiative itself plus consideration of workforce (e.g., volunteer staff training, incentives, key informants, community engagement facilitators, qualified allied health or social service support) and online and offline resources required (including reporting requirements back to government and/or funder).

c. Funding and support builds in some way on existing local resources and knowledge. There is respect for and use of local knowledge through key information and providers, and there is sufficient funding for more information and community 'hubs' in the form of community centres or neighbourhood centres, and/or through provision of more informational and referral supports through existing information 'hubs' such as local libraries, RSLs, etc.

5. Establish a Taskforce comprised of representatives of the three levels of government, the community and health sectors to coordinate a whole of community response to social isolation and loneliness.

Opportunities:

a. In consultation with appropriate groups, engage in collaborative cross-sectorial systemic advocacy. Peak bodies often gather (directly and indirectly) valuable data, coupled with 'on-the-ground' highly valuable insights from community organisations and key informants, would provide deeper understanding of social isolation and loneliness, in addition to solutions to access highly vulnerable or (usually) inaccessible community cohorts. Leverage the strengths of the community organisations using their existing capacities and resources e.g., they naturally move between systemic and individual advocacy spaces in reporting what they see and hear to local councils, peak bodies and local governments.

b. The Taskforce respects and utilises the strengths and resources of cross-advocatory spaces and works in line with Age-Friendly frameworks (national and state), including international recommendations from the WHO regarding social isolation and loneliness, and Decade of Healthy Ageing, and state specific

recommendations such as those outlined by QAMH. This may include applying a human rights and age-friendly lens to each decision e.g., What does this look like? How does it work? Who does it impact positively (and negatively)?

c. Focus on local and place-based, and where possible, customised and tailored solutions and supports. This may include looking outside the community and thinking outside the box, or staying local and connecting with e.g., Rotary, Lions, Probus, and networks for diverse cohorts such as FootPrints, using existing networks to bring people together to discuss and chat about their concerns.

d. Prioritisation of transport with affordable, accessible, practical and viable solutions to connect many Queenslanders to required health and social supports, particularly in regional and remote communities and particularly as people age and long-term health conditions impact their ability to drive or mobility. Recommendations for peak bodies, government, and local councils to work with Department of Transport and Main Roads and related local committees e.g. Transport Advisory groups, to better understand the interaction between transport issues, infrastructure and staying connected; where possible with support from local MPs.

5. CONCLUSION

The statistics and the insights present a clear picture that older Australians and older Queenslanders continue to be at risk of or are experiencing social isolation and loneliness. Social isolation and loneliness are experiences which are innate to being human, yet loneliness is also unique to the individual as they transition through life chapters. The potential for multiple and interrelated risk factors makes social isolation and loneliness complex to measure, mitigate and prevent. COTA Queensland's recommendations importantly support not only an Age-Friendly Queensland but also reinforce WHO's recommendations around social isolation and loneliness, namely the approach of creating a 'coalition' using direct engagement with all stakeholders across multiple areas and sectors, and supporting the development and implementation of quality evidence-based interventions, thus contributing to the improvement of existing initiatives and the development of new initiatives that better meet the current and future needs of older Queenslanders.

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APPENDICES

Appendix A – Individual, community and societal factors which interrelate with social isolation and loneliness

The factors presented below are gleaned from the literature regarding older adults[89,90,91] (and are not an exhaustive list). Interventions to combat these factors, or to alleviate the impact of these factors generally means identifying and connecting across individual and relationship interventions, and community and societal-level strategies.[92] Some examples of these kinds of strategies or interventions are also provided in Table 1.

Table 1. Individual, community and societal factors which interrelate with social isolation and loneliness

Risk factor	Example of specific factors and/or adverse effects[93]	Examples of interventions or strategies
Individual		
		Format: One-to-one; in groups Medium: Digital or face-to-face Activities: social skills; psychoeducation; befriending; social prescription; cognitive behavioural therapy; mindfulness
Health and wellbeing		
Physical health (including chronic health conditions or illness)	cardiovascular health; increased vascular resistance	
	cancer	
	alcohol and smoking	
	sleep disorders	
	impairment e.g., sensory loss, mobility, cognitive	
	obesity	
	high blood pressure or cholesterol	
	decreased immunity	
	stroke	
	diabetes	
	poor nutrition and lack of physical activity	
Emotional and mental health	mental health conditions e.g., anxiety, depression, dementia, post-traumatic stress disorder	
	personality (sometimes certain traits are linked genetically e.g., neuroticism)	
	resilience	
	suicidal feelings	
	insecure or unsafe feelings	

[89] Clarke & McDougall, *Social Isolation and Loneliness*
[90] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[91] AusMed, *Loneliness and Social Isolation in Aged Care*
[92] WHO, *Social Isolation and Loneliness Among Older People: Advocacy Brief*
[93] Some of the examples which are also indicated as health risks can be bi-directional – that is, they can be an effect of social isolation and loneliness or contribute to social isolation and loneliness. WHO has highlighted that some evidence can be limited or mixed for some factors; however, there is also an acknowledgement that the interrelation between physical, social, emotional, lifestyle and personal risk factors is inherently complex.

	abuse or domestic violence	
Social health	discrimination and/or stigmatisation (due to diversity factor)	
	living alone	
	language barriers	
	widowhood; not being married; not having children	
Lifestyle (or life events, transitions, or changes)	socio-economic resources e.g., low personal income (Australian context: < $30,000K per capita)*	
	financial pressures	
	retirement or redundancy	
	becoming a primary carer	
	relationship breakdown	
	bereavement through death of a partner/spouse* (family members and friends)	
	moving residences; housing; homelessness	
	reduced independence due to health condition; reduced capacity to engage in daily activities; reduced quality of life	
	loss of licence or unable to drive	
	limited or lack of access to services and supports e.g., transport network, facilities	
Diversity and/or personal (some of which may also be socio-economic drivers)	cultural or spiritual or religious background	
	educational and employment background	
	gender	
	age	
	sexuality	
	living with disability*[94]	
	occupational status	
	ethnicity	
	speaking a language other than English at home*	
	immigrant or refugee	
Community		
		Format: E g., Forums; discussion spaces; workshops; programs; projects Medium: Digital or face-to-face; hardcopy resources

		Activities: Volunteer initiatives; age-friendly community building or development; transport and infrastructure related including built and natural environment; digital connectivity and inclusion
Local environment	nature of environment e.g., close to park, green spaces, beaches, outdoor spaces; feeling of safety and wellbeing; accessibility to wider communities and neighbourhoods e.g, access to footpaths; safety of paths/roads/building (not age-friendly or inclusive of diverse needs); community redevelopment	
Local economic climate	employment; opportunities for participation; financial supports; increased living costs	
Accessibility to local facilities and services	transport networks (access to and availability of public and private services; particularly in rural and regional areas), impact of traffic congestion; health and medical services and supports; social and community services and supports	
Relationships and networks	community connection e.g., limited or lack of quality or supportive relationships with family, friends, colleagues and/or peers; limited access to social/interest/volunteer groups; key informants in community with knowledge to connect to social supports or services; demographic and familial change	
Society		
		Format: E g., Inquiries; consultation; forums Medium: Digital or face-to-face; strategic/policy/legal documentation Activities: Laws, strategies and policies which tackle the digital inclusion; social cohesion; inter- and multigenerational cohesion; socio-economic equality and social norms; and proactively tackles ageism; discrimination and marginalisation (towards building better age-friendly communities).
Government	government policies around housing, infrastructure, planning, development, and transport; no age-friendly focus in planning	
Wider economic and political climate	changes and reform in relation to welfare and social services e.g., changes to pension or income support	
Media influences	'negative' connotations e.g. age discrimination, marginalisation, stereotypes, etc., across different mediums.	

Appendix B – State of the Older Nation (SOTON) 2021 report – Social isolation and loneliness insights

State of the Older Nation (SOTON) 2021 report[95]

This nationwide summary in relation to social isolation and loneliness has been lifted from The State of the Older Nation (SOTON) 2021 report. The report highlighted the views, life experiences and needs of Australians aged 50 years and over. *This survey was administered online and these results might not capture older people that are digitally isolated.*

Specifically in relation to social isolation and loneliness:

- 23% of older Australians reported they had felt lonely at least some of the time in the past few weeks.
- 4% of older Australians reported they had had no contact with anyone in the preceding week.

Most older Australians had some form of contact with people in the past week, most likely a family member (83%), friend (71%) or neighbour (48%). Of concern is that 4% claimed to have had no contact with anyone in the last week.

When asked how often they have felt lonely in the last few weeks, more than half (53%) claimed they never felt lonely, and a quarter (24%) said they felt lonely a little bit of the time. However, close to a quarter (23%) felt lonely either some (16%) or at least most of the time (7%). Those more likely to feel lonely all or most of the time:

- Those who identified as ATSI (50%)
- Living in an aged care facility (28%)
- Experienced the death of a partner / spouse in the last 12 months (25%)
- Those who identified as LGBTQIA+ (23%)

While the majority are content with their personal relationships, one in ten older Australians appear to be experiencing social isolation and there are mixed feelings when it comes to feeling part of a community. When it comes to older Australians' relationships, around three in four agreed that they are content with their friendships and relationships (78%), that they have enough people they feel comfortable asking for help at any time (75%) and that their relationships are as satisfying as they would want them to be (73%). Just over one in ten were neutral towards each of these statements and around one in ten disagreed with them.

Around three in four participants in the survey felt proud of where they live (73%) and welcome in their local suburb or town (72%). They felt they could rely on their neighbours (63%), that people look out for each other (63%) and that they can trust people in their community (62%). A similar proportion also disagreed that they

[95] COTA Federation, *State of the (Older) Nation report*

feel like an outsider in their local suburb (63%). Those who identified as LGBTQIA+ were significantly more likely to agree they feel like an outsider (31%), as did those who are single or separated / divorced (22%), and those who prefer to speak a language other than English (27%). Nearly one in five people disagreed that they know and can rely on their neighbours (17%) or that they feel part of their community (17%).

SOTON report – Queensland snapshot

The Queensland 'deep dive' into social isolation and loneliness came from the national dataset by Newgate. COTA Queensland extracted the data and conducted an analysis to draw out further insights into how Queenslanders understand and experience social isolation and loneliness.

On average 22% of Queensland respondents aged 50 years and over indicated that they were not content with their friendships and relationships, 19.5% indicated they did not have enough people they feel comfortable asking for help at any time, and 20% indicated that their relationships were not as satisfying as they would want them to be.

Eighty-two percent of respondents indicated that they have had contact with a family member in the last week either in person, by phone or text message, or online (e.g. via social media). Sixty-nine percent indicated they have had contact with a friend in the last week, 48% have had a contact with a neighbour, 14% indicated they have had contact with a community/health/aged care service provider, and 4% with someone else**.**

Five percent of Queensland respondents indicated they have not had contact with anyone in the last week. Twenty-three percent of respondents reported they felt 'a little bit' lonely in the last few weeks, and 16% reported they felt lonely 'some of the time'. **Approximately 8% of Queensland respondents reported they felt lonely all or most of the time.**

On average **15% of respondents did not feel welcome in their local suburb or town**, **16% did not feel part of their community, and 21% felt like an outsider.** In addition, approximately, 15.5% of respondents did not feel proud about where they live and 21% felt that people did not look out for each other. Approximately 17.5% felt they did not know or could rely on their neighbour, and **20% felt they could not trust most people in their community.**

Support from family and friends (57%) and exercising (57%) rated highly with Queensland respondents regarding what they found most helpful (personally) in supporting their mental health and wellbeing. **Good nutrition (47%)** was also identified as very important in maintain mental health and wellbeing, followed by **maintaining hobbies** (e.g. music, arts or crafts) **(46%**), **connection with nature (41%)**, and **use of technology to stay connected** with family and friends **(40%).**

Also helpful to older Queenslanders was having pets (38%), consulting their regular (e.g. GP) or another medical practitioner (32%), and religious or spiritual connection (20%). The remaining aspects of life that were identified by as helpful included medication (18%), meditation or mindfulness practice (16%), and/or support from a psychologist, counsellor or other mental health professional (11%). Three percent of Queenslanders mentioned an external social support service such as Telecross, Friendline, Community Visitor Scheme (2%), or a service such as the Red Cross (1%). Four percent indicated another form of support (unspecified) or didn't know (5%).

The **majority of respondents (70%) felt in-person social groups or clubs** may help (in general) older Australians to feel less isolated or lonely, followed by participation in **exercise or outdoor activity groups (67%)**. **Over half (58%) felt participation in volunteer opportunities and community events or programs (59%) may also assist.** Half of the respondents (50%) indicated that a Community Visitor Scheme or something similar may be helpful.

Phone support through volunteer programs as exemplified previously e.g. Telecross or Friendline (37%) and support from a mental health professional (psychologist, counsellor, other) (30%) were identified as potentially useful to older Australians. Twenty-eight percent felt virtual or online social groups may be supportive. Three percent indicated 'other' form of support (unspecified) may be useful, 12% didn't know. Eighteen percent of respondents indicated they were affected personally by coronavirus either socially, financially, physically, mentally or by another way, and **11% were highly to extremely affected by the pandemic.**

Queenslanders over 50 years of age reported that multiple things had changed for them personally, in comparison to before the pandemic, including a decrease in their **personal income (this impacted 20% on average)**, their **ability to pay rent or a mortgage on time (20%)**, the **number of work hours (19%)**, household income (18.5%), physical exercise (18.5%), and volunteer hours (14.5%). The following things had also changed for respondents including an **increase in the use of technology** (17.5% on average), **increase in visits to the specialist and allied health professionals** (17.5%), visits to their General Practitioner (GP) (17%), and an increase in use of telehealth options (17%).

An in-depth analysis was conducted on the final survey item in the social isolation and loneliness 'deep dive' (one section of the survey). There were n = 2,831 Queensland responses to *Q94 - What support would you find helpful in dealing with the effects of the coronavirus pandemic i.e., this could be provided by healthcare providers, community groups, the Government, service providers etc.? Please list as many things as you can think of*. Of these responses, COTA Queensland coded 1,378 responses (approximately 47% of the total responses from Queensland). Data saturation was achieved at around 45% of the analysis (that is, no new themes were found after 45% of analysing the data).

Queenslanders also commented or reflected on their own lives and from these insights, COTA Queensland identified key issues or challenges. For example, it was evident that people have been experiencing adverse impacts, including feeling like their life was at risk, feeling anxious or stressed on regular basis. Further, there was uncertainty around whether supports were possible with everyone in the same situation (nationally and globally). People wished for normalcy, and there was an acknowledgement of the general feeling of disruption to their or others' lives.

Some expressed frustration e.g., they were tired of the protests, they were suspicious of the pandemic and felt it was *over-hyped* or a *scam*, or that the general reaction to the pandemic in an Australian context was a 'first world' issue.[96] Further, some respondents did not show an interest in the pandemic or in discussion of supports (including informational supports). Some did not trust the government (state and/or federal), felt they had not handled the management of the pandemic well (e.g.,

[96] Note: These responses were gathering during the first wave of the COVID-19 pandemic in Australia.

statewide or federally, and that there was lack of clear leadership), and others expressed concerns regarding the 'rushed' development of the vaccine. Others felt that although they were unaffected by the virus directly, they were affected by the enforced regulations.

In a few cases, some Queenslanders found their existing health conditions were exacerbated yet they felt unable to discuss this with someone or seek support. Some commented generally on isolation being enhanced due to life becoming quieter during the pandemic restrictions (particularly when life was quite before). This added to the frustration or feelings of disconnection in not being able to visit family or friends, particularly loved ones who were residing in e.g., aged care facilities.

The pandemic has also impacted on people's ability to celebrate, mourn and connect during important milestones and transitions, and sometimes hindered accessibility to necessary supports at challenging times. Travel restrictions were mentioned quite often, particularly in relation to wishing to connect with family overseas or family or friends interstate. People were also proactive in connecting with friends who live on their own.

Many Queenslanders in regional areas indicated that despite their area being impacted by restrictions they felt relatively unaffected; they were impacted indirectly; or relatively unaffected. Some indicated they were not affected in any way, other than what they were seeing and hearing from the experiences of others in other parts of Australia. Indirectly and interestingly, the responses highlighted how people were accustomed to living pre-pandemic and due to their personality or preferred lifestyle, they did not feel lonely.

Some appreciated the quieter time during lockdown, adapted to the restrictions, or had encountered minimal change to their daily lives. Some had accepted earlier on the nature of a pandemic and the inevitability of learning to live with the 'wait and see game' as time goes on and therefore they were less stressed by the impact of it. In addition, some were accustomed to living and working in isolation pre-pandemic. Respondents also indicated indirectly where they felt lucky from not being affected or from being impacted minimally, or had adapted quickly, and therefore they felt they had minimal issues or needs for supports (or indicated they didn't require supports 'as of yet' or they were aware of types of supports or where to find them if they should require them in the future). Some expressed their hope that it would stay that way for a while longer (not needing supports).

Some people reported they already had supports in place e.g., existing health supports, or family or friend network support, or spouse as a health professional, and that the pandemic was okay for them to navigate, and that they were happy with how everything was being managed and the information being provided by the Government. Others were not affected by the pandemic at all where they resided.

Role of higher vulnerability

Some of the risk factors for social isolation and loneliness in older adults are also indicators of higher vulnerability. In the SOTON 2021 report, the higher vulnerability group was identified as female, aged over 70 years, living in Queensland and outside capital cities. Higher vulnerability has increased since 2018. Higher vulnerability indicators included:

- **Having a low personal annual income** (< $30,000k per capita)
- **Living with a disability**
- **Speaking a language other than English at home**
- **Bereaved in the past year**
- Indigenous
- Experienced domestic violence in the past year
- Experienced homelessness in the past year

The indicators in bold have been identified in the wider literature[97] as being factors or causes that contribute to social isolation and loneliness (see Appendix A. for more information regarding risk factors for social isolation and loneliness).

[97] AusMed, *Loneliness and Social Isolation in Aged Care* provides a summary of key reports which highlight risk factors for social isolation and loneliness.

Appendix C – Social isolation and loneliness resources

Table 2. below provides key resources from international and national arenas, which address and/or provide insight into the experience of social isolation and loneliness, including current or proposed interventions.

Table 2. Social isolation and loneliness key resources

Resource	Year	Team	Type of resource	Source
International				
Measurement indicators of age-friendly communities: Findings from the AARP Age-Friendly Community Survey	2021	Authors: Kyeongmo Kim, PhD, Tommy Buckley, MSW, Denise Burnette, PhD, Seon Kim, MSW, and Sunghwan Cho, MSW	Journal article re: measurement indicators Keywords: Age-friendly community, Environment, Evaluation, Person–environment fit	Shortened URL
Impact of the COVID-19 pandemic on loneliness among older adults	2020	Authors: Alexander Seifert; Benedikt Hassler	Brief research report article	https://www.frontiersin org/articles/10.3389/fsoc.2020.590935/full
Solent Mind - Community Peer Navigator Program	Established 2015	Solent Mind, United Kingdom	Community Peer Navigator Program	https://www solentmind.org.uk/support-for-you/our-services/community-navigation/
Strategies to promote social connections among older adults during "social distancing" restrictions	2020	Authors: Kimberly A. Van Orden, Ph.D.,* Emily Bower, Ph.D., Julie Lutz, Ph.D., Caroline Silva, Ph.D., Autumn M. Gallegos, Ph.D., Carol A. Podgorski, Ph.D., Elizabeth J. Santos, M.D., and Yeates Conwell, M.D.	Journal article re: evidence-based interventions [Open Access] Keywords: Social connections, social isolation, loneliness, COVID-19, cognitive-behavioral therapy, psychotherapy	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7233208/
The effects of social isolation on well-being and life satisfaction during pandemic	2021	Authors: Ruta Clair Maya Gordon Matthew Kroon Carolyn Reilly	Journal article re: prevalence of social isolation during COVID-19 pandemic as well as factors that contribute to individuals of all ages feeling more or less isolated while they are required to maintain physical distancing for an extended period of time [Open Access]	https://www.nature com/articles/s41599-021-00710-3.pdf

Loneliness among older people as a social problem: the perspectives of medicine, religion and economy	2015	Authors: Werner Schirmer Dimitris Michailakis	Journal article re: framing loneliness as social problem using social perspective (theoretical) framework	https://www cambridge.org/core/journals/ageing-and-society/article/abs/loneliness-among-older-people-as-a-social-problem-the-perspectives-of-medicine-religion-and-economy/734A318AEBF326C9A00B9BDFE1EBFDC6
Assessing the impact of the COVID-19 pandemic and accompanying mitigation efforts on older adults	2020	Authors: Peggy M Cawthon, MPH, PHD, Eric S Orwoll, MD, Kristine E Ensrud, MD, Jane A Cauley, Dr PH, Stephen B Kritchevsky, PhD, Steven R Cummings, MD, and Anne Newman, MD	Journal article re: Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults (QAICPOA) (includes three item loneliness scale) [Open Access]	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7188163/
Loneliness matters: A theoretical and empirical review of consequences and mechanisms	2010	Authors: Louise C. Hawkley, Ph.D; John T. Cacioppo, Ph.D.	Journal article re: theoretical and empirical review of evidence that informs interventions to alleviate loneliness Keywords: Loneliness, Regulatory loop, Physiology, Health behavior, Sleep, Intervention	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3874845/
Older people and COVID-19: Isolation, risk and ageism	2020	Authors: Joanna Brooke Debra Jackson	Journal article re: evidence of ageism and ageist discourses during the pandemic which the authors argue compounds experiences for older adults during the pandemic especially in relation to isolation	https://onlinelibrary.wiley com/doi/pdf/10.1111/jocn.15274
What do we know about tackling loneliness?	2018	What Works Wellbeing Organisation (independent collaborating centre), London, United Kingdom.	Briefing (systematic review of review summaries)	https://whatworkswellbeing.org/wp-content/uploads/2020/01/briefing-tackling-loneliness-Oct-2018_0151641100.pdf
Still alone together: How loneliness changed in Aotearoa New Zealand in 2020 and what it means for public policy	2021	The Helen Clark Foundation, New Zealand.	Report (part of Post-Pandemic Futures Series, Volume IV)	https://apo.org au/sites/default/files/resource-files/2021-04/apo-nid311945.pdf https://helenclark.foundation/our-impact/ URL to complete report; accessible version; and easy-read version, in addition to other reports which may be of relevance.
Socially connected communities: Solutions for social isolation	2021	Healthy Places by Design, United States	Report – Underlying approach re: community-led	https://healthyplacesbydesign org/new-report-socially-connected-communities/

			action and place-based strategies	https://healthyplacesbydesign org/wp-content/uploads/2021/03/Socially-Connected-Communities_Solutions-for-Social-Isolation.pdf
A connected society A strategy for tackling loneliness – laying the foundations for change	2018	Department for Digital, Culture, Media and Sport, HM Government; London, United Kingdom	Government strategy	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf
Tackling loneliness	2021	House of Commons Library – United Kingdom Parliament	Parliamentary report	https://researchbriefings.files.parliament.uk/documents/CBP-8514/CBP-8514.pdf
Campaign to end loneliness	Established 2011	What Works Centre for Wellbeing; London, United Kingdom	Campaign. Website with online resources	https://www campaigntoendloneliness.org/
Social isolation and loneliness in older adults: Opportunities for the health care system.	2020	National Academies of Sciences, Engineering, and Medicine. Washington, DC: The National Academies Press.	Consensus study report [Open Access]	https://doi.org/10.17226/25663 https://www.nap.edu/catalog/25663/social-isolation-and-loneliness-in-older-adults-opportunities-for-the
Social isolation and loneliness among older people	2021	World Health Organisation (WHO). Geneva, Switzerland.	Advocacy brief	https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/social-isolation-and-loneliness
Loneliness and social isolation linked to serious health conditions	April 2021	Centers for Disease Control and Prevention, United States	Summary article of current evidence from National Academies of Sciences, Engineering, and Medicine (NASEM), and key resources	https://www cdc.gov/aging/publications/features/lonely-older-adults.html
The lonely century: A call to reconnect	First published 2020	Author: Noreena Hertz – Economist	Example of evidence in book format	https://www.hachette.com.au/noreena-hertz/the-lonely-century-a-call-to-reconnect
Loneliness in Europe United in combating loneliness	n.d.	Loneliness in Europe	Online European initiative – events, conferences, forums; they provide space for policy makers, organisations, researchers, media to present and discuss key matters regarding loneliness	https://www.lonelinessineurope.eu/
Volunteer Health Champions	n.d.	National Health Service (NHS), United Kingdom	Volunteer health or 'practice' champions work towards improving services e g., provide support to services,	https://www england.nhs.uk/gp/case-studies/practice-health-champions/ www.altogetherbetter.org.uk

			run patient groups and help connect the practice with local voluntary groups.	
Social Isolation and Loneliness in Older Adults	October 2020	Administration for Community Living; The Centers for Disease Control and Prevention; The Health Resources and Services Administration; and the National Institute on Aging at NIH.	Focus on Aging: Federal Partners' Webinar Series (YouTube)	https://youtu.be/tKOAO09PsFU
Short Report: Social Isolation, loneliness and COVID-19	May 2020	Social Wellbeing Agency, New Zealand Government	Working Paper re: insights nature of social isolation and loneliness, and impact of pandemic around experiences of social isolation and loneliness	https://apo.org.au/sites/default/files/resource-files/2020-05/apo-nid305785.pdf
Australian				
Social recovery beyond COVID-19 A National Strategy to Address Loneliness and Social Isolation Ending Loneliness Together	2021	Partnership with R U OK? and the Australian Psychological Society.	Pre-budget submission	https://treasury.gov.au/sites/default/files/2021-05/171663_ending_loneliness_together.pdf
State of the Older Nation (SOTON) report	2021	COTA Australia	National survey report (Newgate research data)	https://www.cota.org.au/policy/state-of-the-older-nation
Why we need a minister for loneliness	2021	Sydney Morning Herald	Commentary (news)	https://www.smh.com.au/national/why-we-need-a-minister-for-loneliness-20210224-p575ej.html
Queensland Alliance for Mental Health - Wellbeing First	2021	Queensland Alliance for Mental Health	Report – current evidence and recommendations	https://www.qamh.org.au/wp-content/uploads/EMBARGOED-Copy-Wellbeing-First-Report-DIGITAL.pdf
Preventing social isolation in later life: findings and insights from a pilot Queensland intervention study	2012	Authors: Helen Bartlett Jeni Warburton Chi-wai Lui Linda Peach Matthew Carroll	Original research article Keywords: social isolation loneliness ageing older people public policy interventions evaluation	https://www.cambridge.org/core/journals/ageing-and-society/article/abs/preventing-social-isolation-in-later-life-findings-and-insights-from-a-pilot-queensland-intervention-study/09D84ADE5655B690ABC5C503F96174F0
Tackling loneliness	2018	What Works Wellbeing	Report	https://whatworkswellbeing.org/wp-content/uploads/2020/01/briefing-tackling-loneliness-Oct-2018_0151641100.pdf

Infrastructure for Social Connection	2021	Authors: Karg, A., De Cotta, T., Farmer, J., Aryani, A., Knox, J., Adler, V., & Kamstra, P. Swinburne Social Innovation Research Institute, Swinburne University of Technology	Report – findings and recommendations Prepared for the Inner South-East Metropolitan Partnership working group; researching the existing assets for creating social connectedness and identifying interventions	https://apo.org au/sites/default/files/resource-files/2021-07/apo-nid309682.pdf
Social isolation and loneliness – a neighbourhood house perspective	2020	Neighbourhood Houses Victoria	Report – summary of evidence and impact of neighbourhood houses	https://www.nhvic org.au/Handlers/Download ashx?IDMF=788b274c-ac2b-4901-a655-eb425dfd2d65
Social isolation and loneliness among older Australians	October 2015	Aged and Community Services Australia (ACSA)	Issues Paper No. 1	https://www acsa.asn au/getattachment/Publications-Submissions/Social-Isolation-and-Loneliness/1015-Social-Isolation-and-Loneliness-Paper.pdf.aspx?lang=en-AU
Healthy ageing: A strategy for older Queenslanders	2019	Department of Health, Queensland Government	Statewide Strategy	https://www.health qld gov au/ data/assets/pdf file/0035/857519/healthy-ageing-strategy.pdf
Sharing with friends	2021	Older Women Co-Housing Association (Qld) Inc. Trading as Sharing with Friends.	Example social/shared/co-housing initiative	https://www sharingwithfriends.org/
Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the household income and labour dynamics of Australia survey	2018	Relationships Australia	Working paper – findings from survey	https://www.relationships org.au/pdfs/copy of Anepidemicofloneliness20012017.pdf
Seniors can extend their life by staying connected	2020	Finley Regional Care	Example of article/blog post for older adults regarding tips to mitigate or prevent social isolation and loneliness	https://www.finleyregionalcare.com.au/seniors-can-extend-their-life-by-staying-connected/
Loneliness and social isolation in aged care	2021	AusMed	Online article (summary of evidence)	https://www ausmed.com.au/cpd/articles/loneliness-and-social-isolation-aged-care
Volunteer community peer navigator program	2020 (established)	COTA Queensland in partnership with Moreton Bay Regional Council and Brisbane North Primary Health Network	Example of initiative – pilot program	https://planningforwellbeing.org.au/
Group61 – Through friendship to mental health	Ongoing	Group61, Wesley Mission Queensland	Volunteer mental health befriending program	https://www.wmq.org.au/mental-health-services/group61
Healthy and Active Moreton	Ongoing	Moreton Bay Regional Council	Example of wellbeing initiative – local council	https://www.moretonbay.qld.gov.au/Services/Sport-Recreation/Healthy-Active

		Queensland Government	Webpage resource	https://www.qld.gov.au/community/getting-support-health-social-issue/avoiding-social-isolation
Social Isolation Project	Ongoing (established 2018)	Ways to Wellness Organisation – Mt Gravatt Community Centre	A whole community approach to ending social isolation through a social prescribing network – focus currently on Brisbane Southside	https://waystowellness.org.au/about/
Ending Loneliness Together	Ongoing Report – 2020	Ending Loneliness Together	Campaign White paper - report	https://endingloneliness.com.au/ https://endingloneliness.com.au/wp-content/uploads/2020/11/Ending-Loneliness-Together-in-Australia_Nov20.pdf
Nightingale housing			Grassroots initiative for housing	https://nightingalehousing.org/
Public phones (free use)	2021	Telstra	Large corporate initiative	https://exchange.telstra.com.au/why-were-making-payphones-free-for-calls-around-australia/
COVID-19 Support Line for older adults	2020	Department of Health, Australian Government	Provides information and support to older Australians, their families and carers.	https://www.health.gov.au/contacts/older-persons-covid-19-support-line
Blokes, BBQ, Bonfires, Beer, Bonding, Bull#%*	Established 2017	6Bs	Grassroots community led initiative (not formally registered organisation and no formal funding received) with focus on men's emotional, psychological, and mental health, particularly for regional and remote communities	https://www.6bs.com.au/
Men's Shed	Established 2007 (conceptualised 2005)	Australian Men's Shed Association (AMSA)	Community-led initiative Community-based, non-profit, non-commercial organisation with focus on advancing the well-being and health of men	https://mensshed.org/find-a-shed/
Queensland linked to national and international network	Established in 1985 (Australia wide); Queensland was incorporated in 1993	Older Women's Network Queensland (OWNQ)	OWNQ is part of a worldwide network looking after the needs and interests of older women	https://www.ownqld.org.au/about-us/

Housing older women: Collaborating to create innovative housing solutions	Ongoing	QShelter	Regular forum	https://web-eur cvent.com/event/84070ade-f203-475f-8d9a-79f2b76712c5/summary?environment=production-eu
Housing Choices	Established 2009 (?)	Housing Choices Australia Group	Housing provider:	https://www.housingchoices.org.au/aboutus
Women's Property Initiative – Social housing	Established 1996	Women's Property Initiative	Housing provider: Longer-term housing solution in prevention and mitigation of homelessness	https://wpi org.au/about/what-we-do/
Urban Coup – Co-housing	Established 2011 (?)	Urban Coup	Housing provider: Shared community spaces, community owned facilities, and privately owned dwellings	https://www.urbancoup org/
Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing	2018	Australian Psychological Society (APS)	Report	https://psychweek.org.au/wp/wp-content/uploads/2018/11/Psychology-Week-2018-Australian-Loneliness-Report.pdf
Community engagement hub – Social Isolation and Loneliness	Launched July 2021	COTA Queensland	Online portal for community Community members and service providers (and interested parties) to visit and complete survey and ideas wall; contains some information and resources	https://cotaqld.engagementhub.com.au/social-isolation-and-loneliness
COVID-19 Mental health service for older Australians	Established 2020 (?)	Footprints (Community organisation)	Social Wellbeing Program – informational supports; referral pathways (social prescription); interventions which are targeted at over 65 years of age (and over 55 years of age for Aboriginal and Torres Strait Islander people) within Brisbane South area who are experiencing social isolation and/or loneliness due to impact of pandemic or who are at risk with mental health	https://footprintscommunity.org.au/mental-health/
NSW carer support needs: Coping in the context of COVID-19	June 2021	Research Centre for Children and Families, University of Sydney	Report – builds on evidence review by Associate Professor John Gilroy and Sue Pinkham	https://www sydney edu.au/content/dam/corporate/documents/faculty-of-arts-and-social-sciences/research/research-centres-institutes-groups/nsw-carer-support-report-jun2021.pdf

		Authors: Collings, S., Wright, AC., Wardle, I., Wilkinson, D., Gilroy, J., & Pinckham, S.	about the support needs of carers of Aboriginal and Torres Strait Islander children in out-of-home care	*The Conversation* article: How caring for children can help Aboriginal Elders during lockdown (theconversation.com)
Social isolation and loneliness	September 2019	Australian Institute of Health and Welfare (AIHW), Australian Government	Snapshot from reports and data	https://www aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness
Black Dog Institute	Ongoing	Black Dog Institute	Organisation that provides social prescribing programs (as part of wider scope of resources). Website with resources and information for diverse cohorts	https://www.blackdoginstitute.org au/
Open Arms – Veterans and Families Counselling	n.d.	Australian Government	Community and Peer Program Peers work with veterans, family supports, community agencies and mental health clinicians. Community and Peer Advisors complement other services and programs.	https://www openarms.gov.au/get-support/community-and-peer-program
Fun and Ageless	n.d.	Returned Services League (RSL) - Currumbin	Community Program Opportunities to work, play, learn, collaborate, and innovate together including monthly program of diverse activities and events.	https://www currumbinrsl.com au/community/
MindSpot	n.d.	MindSpot organisation	Digital Mental Health Clinic Provides resources, online assessment,	https://mindspot org.au/
Your Mental Wellbeing	2020	Queensland Health, Queensland Government	Website with resources including information, suggestions for activities, COVID-19 support	https://mentalwellbeing.initiatives.qld.gov.au/?fbclid=IwAR1hJuVrtX_0gqwiJcpbGmmQJoAWmLmO1T8Uv4wQD4ew10PYcQUG5CC844c
Telehealth Penpal program Physical exercise	2020	Australian Ageing Agenda	Articles re: general, physical and social health supports	Clinic launches free aged care telehealth counselling Pen pal programs help reduce social isolation Working out boosts residents' wellbeing

Communication package	2020	Aged Care Guide	Article re: roll out of communication package for older Australians	https://www.agedcareguide.com au/talking-aged-care/government-injects-6-million-into-communication-package-for-older-australians
One Good Street – neighbourhood/community networking	Established 2018 (?)	One Good Street	Neighbourhood/community network to mitigate social isolation and loneliness in older adults. Streets are recognised as 'Good Streets' and then register online through One Good Street activities. Offers practical flexible and regular activities in local neighbourhoods.	https://onegoodstreet.com.au/
Study future-proofs technological needs of older people	May 2020	Healthcare Practice and Survivorship Program, Griffith University	Study launched by the Menzies Health Institute Queensland Australian Aged Care Technologies Collaborative with objective to increase the efficiency, effectiveness and quality of care of older adults in ageing services through technology. Conducting surveys re: older persons' technological needs and use of technology.	https://news.griffith edu.au/2020/05/20/study-future-proofs-technological-needs-of-older-people/