COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Ms CP McMillan MP—Chair
Mr SA Bennett MP
Mr MC Berkman MP
Mr JM Krause MP
Ms CL Lui MP
Mr RCJ Skelton MP

Staff present:
Ms L Pretty—Acting Committee Secretary
Ms C Furlong—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE SOCIAL ISOLATION AND LONELINESS IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

MONDAY, 11 OCTOBER 2021

Brisbane

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The committee met at 5.01 pm.

CHAIR: Good afternoon. I declare open this public hearing for the Community Support and Services Committee's inquiry into social isolation and loneliness in Queensland. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. I acknowledge my dear colleague the member for Cook, who is a First Nations woman. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all share.

On 27 May 2021, the Legislative Assembly agreed to a motion that the Community Support and Services Committee inquire into and report on social isolation and loneliness in Queensland, with a reporting date of 6 December 2021. My name is Corrine McMillan, the member for Mansfield—which is in South-East Queensland and just a couple of suburbs from the city of Brisbane—and I am the chair of the committee. Stephen Bennett, the member for Burnett, is the deputy chair; he is from the Bundaberg region. The other committee members are: Michael Berkman, the member for Maiwar, which is an inner-city seat; Jon Krause, the member for Scenic Rim, which is a rural seat about an hour and a half from Brisbane in the Boonah and Beaudesert region; Cynthia Lui, the member for Cook; and Robert Skelton, the member for Nicklin, which is on the beautiful Sunshine Coast.

The purpose of today's hearing is to assist the committee with its inquiry into social isolation and loneliness in Queensland. I ask that any responses to questions taken on notice today are provided to the committee by Monday, 18 October 2021. The committee's proceedings are proceedings of the Queensland parliament and are subject to the standing rules and orders of the parliament. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. Media may be present and will be subject to the chair's direction at all times. The media rules endorsed by the committee are available from committee staff if required. All those present today should note that it is possible you might be filmed or photographed during the proceedings by media, and images may also appear on the parliament's website or social media pages. I ask everyone present to turn mobiles phones to silent mode. The program for today has been published on the committee's webpage.

BADCOCK, Professor Jo, Vice Chairperson and Vice Scientific Chair, Ending Loneliness Together (via videoconference)

LIM, Dr Michelle, Chairperson and Scientific Chair, Ending Loneliness Together (via videoconference)

CHAIR: It gives me great pleasure to welcome you from Western Australia. Thank you for giving up your valuable time. We are looking forward to your contribution to our inquiry and to learning of your great knowledge and the great work you have done. I invite you to make an opening statement, after which committee members will have some questions for you.

Dr Lim: I am the scientific chair and chairperson of Ending Loneliness Together, which is a national Australian initiative that aims to raise awareness of chronic loneliness and to reduce the negative effects of loneliness and social isolation in our community through evidence based intervention and advocacy. Ending Loneliness Together is made up of several different kinds of organisations, from not-for-profit to community groups and university partners. We have been doing this work since 2016 and were formalised in 2020. We launched our white paper last year. I am also the co-director of the Global Initiative on Loneliness and Connection, which channels eight different countries and has an emerging partnership with the World Health Organization. WHO is interested in working on this issue on loneliness and social isolation. I invite Jo to say some words.

Prof. Badcock: I would like to acknowledge that I am an adjunct professor at the University of Western Australia so I live, work and play on land whose traditional owners are the Whadjuk Noongar people. As Michelle said, our work is very much based in the evidence. What we know is that the evidence on the detrimental impact of chronic loneliness is really lacking in Australia, so what we have to do at the moment largely is rely on data collected elsewhere. We do know that tackling

loneliness is important because of its significant impacts on health and wellbeing, alongside emerging evidence of negative outcomes for educational achievements and in the workplace. It is a broad-ranging topic and therefore it needs national and coordinated responses to deal with it.

CHAIR: Thank you. The committee will now ask some questions.

Mr BENNETT: I am very interested in the white paper, which I have not read but I will. How do we coordinate those responses you just alluded to? At every level we all have a role to play. What would you do to start to see these strategies rolled out in our communities?

Prof. Badcock: I think one of the first issues from my point of view is that without data we can do very little, so we need to take a look at what data is being collected. It is often very patchy, it is very variable and it uses different measurement tools. We need to get a consistent approach to how we measure loneliness, and that includes loneliness that is being measured at population survey level through to loneliness that is being measured at the community level and loneliness that is being measured by individual professionals, such as clinical psychologists, GPs and so on.

Mr BENNETT: That sounds like a mammoth task and somewhat daunting. We have had some evidence today from professors in Queensland who have some fairly strong statistical data about numbers where they are finding some of those clients that are presenting not only in the health sector but also in the not-for-profits. It is a statement that we all have to try to get that data on the ground. Once you have the data, is that when you roll out specific programs?

Dr Lim: I think the data would provide us with a starting point. More generally, with the work that we are looking at with the World Health Organization and with international partners, there are gaps in our evidence in the way we think about loneliness at the moment. The critical gaps, as Jo pointed out, include the measurement of loneliness but also taking a step back with the definitions of loneliness and social isolation. They are not well defined, which is something that we are working on at the moment. We cannot put a global statement around that because what we know at the moment is that scientists or different kinds of groups define the issue quite differently so we need to focus on what the primary outcome is. A lot of the interventions that are being proposed may actually reduce social isolation but not necessarily do much around loneliness. It is trying to get a consensus strategy—whether it is at a national or state level—with everyone on the same level and understanding the issue, and then developing it, testing and then scaling up interventions that actually make the most sense.

CHAIR: Could you walk the committee through the process of establishing the white paper? Is that a Western Australian publication?

Dr Lim: Just to clarify, Jo is based in Western Australia but Ending Loneliness Together is registered as a charity in New South Wales, and I am in Melbourne. We actually work across the nation.

CHAIR: Could you talk us through how the white paper evolved? What was the impetus and catalyst? Whose decision was it? What was the process through which that happened? What have been the outcomes to date?

Dr Lim: It was a collective decision by the group and we have many different partners working across this issue—both our scientific advisory committee, which is made up of national and international experts, and our industry partners. It was really very much a collaboration piece. We were also working with federal members of parliament who have been interested in this issue for a very long time. As you can see, we also led the development of the federal Parliamentary Friends of Ending Loneliness Together, and we met in Canberra early this year. I cannot remember the date. That was a wonderful meeting with Assistant Minister David Coleman, Dr Fiona Martin, our partners Relationships Australia and UnitingCare, and Mr Andrew Giles, who has been a strong supporter of this issue for a very long time.

The work is a product of years of collaboration and in-person meetings in Sydney. I have travelled extensively for the last four years to meet with partners to gather the understanding and look at what the gaps are within our community and our not-for-profit sector. Also, they are working with the scientists to pinpoint what is actually missing. There is a huge gap between what we see in science and what we see in practice. That is really where we have started to advocate for a national strategy for targeting loneliness and social isolation.

Mr BERKMAN: Thanks very much for taking the time to be with us from a distance. I want to go back to some of the evidence we heard earlier in the context of your observation that we need a national and coordinated response. A lot of the stakeholders involved in this inquiry have pointed to the work of neighbourhood and community associations and organisations—that local-scale

response—and focused on the fact that different communities will need to respond to the social isolation and loneliness epidemic in different ways. How does that fit with the idea of a nationally coordinated response? How would you suggest we reconcile that distinction between the scale of responses we need?

Prof. Badcock: I think you are absolutely right: we are going to need responses that are operating at the individual level, the community level and the national level. Without national data we will not be able to take a look at how different regions compare, how different communities compare and therefore help to prioritise where our resources need to go. It is in that sense that I say we need this to be a national coordinated approach, so that we are using the same assessment and measurement tools across the country so that we can then drill down and say, 'This region out here seems to be having these particular pockets of vulnerability to loneliness that we need to address and target them as a priority group or a priority region.'

Dr Lim: I think the complication with this issue is that loneliness is often a consequence of a multitude of factors, all the way from our brain and biology to our mental health to our ability to access resources within our social environment. We advocate that we trial and test different kinds of solutions on different cohorts, because not everybody would need an individual approach and not everybody has access to a psychologist. Many people do not perhaps leverage off the supports at the community level as much. We also need to think about the way we live with and play within our current policies. We take on this socio-ecological model about how we can tackle loneliness and social isolation and offer a different range of solutions, but they do have to be stemmed in evidence and the latest evidence and the proper definitions of what loneliness and social isolation are.

Mr BERKMAN: Acknowledging that we need our responses to be based in evidence and we need more of that evidence to reach that point, I was interested in your observation earlier that there is a risk of addressing social isolation but not loneliness. Is it a case of just needing more evidence or do we know yet how we could guard against that seemingly perverse outcome of addressing one but not the other?

Dr Lim: I love that question. That is a fantastic question that is something we often advocate for, because a lot of solutions we see do indeed reduce social isolation, which is much more of a crude indicator. It is much more obvious to the eye whether they are doing a good job in that area. Having more of a degree of contact or interactions would allow us to make a difference.

In terms of quality, that is something that is not routinely measured and monitored, and people do not understand the difference. An example would be if I were a volunteer. I would see many people in the day but I might just pop in for one minute. We would say we could probably make a difference to reducing social isolation, but whether that person feels more meaningfully connected during that time is something that is not routinely measured or taken into account. What we need to do is augment the current interventions and solutions for social isolation and ensure they can add value to the quality of the interactions as well.

Prof. Badcock: Going back to your comment about why we need a national coordinated response, it is the only sort of area where, if we are all using the same kinds of definition or distinctions between objective social isolation and loneliness, we give our professionals, community workers and general public a better understanding of how to go about changing their own level of social isolation and loneliness. You have to be able to equip them with the resources and the facility to help themselves in this process.

Ms LUI: Professor Badcock, you actually answered the question I had. In terms of social isolation and loneliness not being well defined—I think Dr Lim made a point of that—is it the experts in the field who come up with the definition, working with the vulnerable cohort in the community that are experiencing this? How do we find the balance between what the community is experiencing and what experts in this area define as social isolation and loneliness?

Prof. Badcock: One approach we take is very much that we have to take on board the lived experience of loneliness, which is going to vary across the country, across different age groups, across people with different cultural backgrounds and so on. We need that qualitative information to come back to help us refine our current definitions of loneliness and social isolation, but especially of loneliness because there is emerging evidence now that those cultural differences particularly might influence how we experience loneliness. I think that is an important element of the work that we do. In that regard, we have been in the process of setting up lived experience panels that we can work with, so it is not just a top-down approach based on research or scientific expertise; it actually takes in the views and perspectives of the whole population.

Dr Lim: Just on that point, Professor Badcock and I are working on some clear definitions that we hope the World Health Organization adopts—these are the global initiatives on loneliness and connection. We are defining the terms 'social connection', 'loneliness' and 'social isolation' as three distinct, different constructs and also what they are not. I think there is a lot of confusion about what it is not. Again, it is not depression and it is distinct psychometrically. We have to get the language right. As we progress through this work we hope our members, and our 30 organisational members who are channelling into our network at the moment, would also adopt these same definitions. We will hopefully encourage them to take the same definitions.

Mr BENNETT: I am interested in the Ending Loneliness Together organisation. Who is funding that and what are its terms of reference? Dr Lim, did I pick up that you have been working in this space for four years? Is there a term of reference in relation to when you expect to have the data? What we have heard so far is evidence about placed based solutions and not really a heavy reliance on the academia behind this confronting and serious issue. I was curious about that.

Dr Lim: I think you are picking up the difference between what we see in science and what is being practised. That is clearly one of the areas where we are trying to narrow the gap. A recent meta-analysis in Denmark that looked at 120 types of solutions across the world, including those in the Netherlands that were published in Dutch, has just come out. It is supported by the Mary Foundation, one of our partners. They found that most solutions do make a difference, but the ones with the psychological approaches are the ones that work better. In many ways, as we mentioned, a lot of them are important. Placed based community interventions—things that we can do in our community—are important, but they are distinct and different in terms of their kind and the cohorts. It is not one that has to be favoured over the other but providing that range that is important. I think you asked about terms of reference. I want to get some clarity around that.

Mr BENNETT: Have you some expectation about when you might collect this data? The white paper is a good starting point, but you would turn it into another document at the some point I guess.

Dr Lim: We would love for government to support this agenda. That is something we have asked the federal government to support—that is, coordinating a national strategy across all states and territories. This is something that is ongoing. We are funded by philanthropic sources and our members. In terms of needing further support, we do look to government, whether at the state level or federal level.

Mr SKELTON: You were saying before that loneliness and social isolation should be separated. What is the differentiation, if you do not mind me asking?

Dr Lim: Sure. Jo, you can jump in whenever. This is bread and butter for us. Loneliness is very much a subjective feeling of social isolation. It is more related to the quality and less to the quantity. You can be alone in a crowd, alone in a marriage, alone in groups, alone in the workplace. That is very much focused on quality. Social isolation is very much about quantity—the number of people we see; the number of people we interact with. If you were employed you would be considered less socially isolated. If you were living in a rural area you would be considered more socially isolated. We can see in the data some similarities with how they function. For example, both constructs are quite related to socio-economic status.

Prof. Badcock: It is often helpful to think about those distinctions in particular settings. For example, when we are talking to aged-care service providers they will often say things like, 'How on earth can our aged-care residents be lonely? They have people come in the morning, then they come in again mid-morning and then they come in to assist with changing or to provide food and so on. How can they possibly be lonely?' In their minds they are confusing the difference between feeling lonely and being alone or being socially isolated. This is where this key concept difference is relevant.

Dr Lim: In terms of mortality and morbidity there is no significant difference, so the impact on our earlier mortality is the same with loneliness, social isolation and living alone. We do know that they work synergistically to produce worse outcomes. Ideally, we should be targeting both constructs.

Mr BERKMAN: Given the subjectivity of loneliness as a concept, how do you move from that subjective experience to a more objective measure of loneliness as you were talking about before? That may be too big a question for the remaining couple of minutes. I wondered if you could give us a snapshot of that.

Prof. Badcock: It is a common problem in psychological science but certainly not insurmountable. You can take direct questionnaire type approaches where you simply ask people: 'How often do you feel lonely? How intensely did you feel that loneliness?' That is one approach that is subject to report. One of the problems that has been identified when you use the word 'lonely' in

those sorts of questionnaires is that there is a fair deal of stigma associated with loneliness and that tends to inhibit people in speaking up. An alternative approach is self-report questionnaires, but you do not use the word 'lonely' in the question. You might ask things like: 'Do you feel that you lack companionship? Do you feel close to people?' and so on. They are coming at the issue but not directly using the word 'loneliness'. That is a very successful method for addressing individual differences in how lonely people feel.

CHAIR: Sadly, our time has come to an end. We appreciate the time you have given us this afternoon and certainly your insights. I am not sure whether they have clarified the waters for us or muddied the waters for us, but certainly you have highlighted the complexity of the issue. We very much appreciate your insight and intellect around this very important issue. Thank you so much for the important work that you have done so far across the country. On behalf of the committee, thank you again.

McKENNA-PLUMLEY, Ms Phoebe, PhD Candidate, Queen's University, Belfast; Co-Founder, Early Career Loneliness Research Network (via videoconference)

NOONE, Ms Catrin, PhD Candidate, Durham University; Co-Founder, Early Career Loneliness Research Network (via videoconference)

CHAIR: Welcome. It is wonderful to have you both here. We thank you sincerely for appearing before our committee and for the great contributions you are going to make to our research and our inquiry. Thank you. We will ask that you make an opening statement and then I am sure the committee will have some questions.

Ms Noone: Thank you very much. Good evening, everybody. On behalf of myself and my co-speaker, Phoebe, we would really like to thank you for the opportunity to speak with you today. We would also like to respectfully acknowledge the traditional owners of the land on which this hearing is being held.

As we know all too well, loneliness is a major issue globally and impacts on people across their lifespan. There is a rich body of research focusing on loneliness, and attention to this topic has further increased in recent years. This may be partly due to the COVID-19 pandemic, which has changed the landscape of loneliness, moving many social interactions online, reducing face-to-face contact generally and increasing feelings of loneliness for many people. For this reason, loneliness and social isolation have become the focus of global research in various disciplines, with many new researchers joining the field. This is reflective of Phoebe and I, who are both current PhD candidates. We entered this research area shortly before the pandemic, focusing on this topic in the areas of psychology for Phoebe and sociology and social policy for myself. It was for this reason that we developed the Early Career Loneliness Research Network in March of this year. The network aims to build connection and community among researchers at a Masters, PhD and early career level who are focused on research in this topic in an effort to build pathways to collaboration and also to learn from one another. We wanted to create an exchange of ideas in an effort to understand and help with this very prevalent issue, and it was important that we had this early career focused, creative, collaborative, welcoming and nurturing environment for new researchers in order to foster new ways of thinking around this increasingly relevant topic on an international level.

We currently have 49 network members based in a range of academic and non-academic settings including charities, government organisations and research institutes. Reflecting the global nature of this research area, our members are based in countries including the UK, Ireland, Australia, the US, Finland, Israel and India, amongst others. We believe that one of our greatest strengths as a network is the ability to establish connections amongst this wide range of budding experts who are passionate about this area and keen to make a difference. I will pass on to Phoebe to talk a little more about our work and how it might be implemented.

Ms McKenna-Plumley: To date we have hosted a number of network-wide meetings and established a monthly newsletter as well as coordinated a regular writing retreat and also a virtual journal club, where we discuss recent research in the field internationally with an eye to enriching our own research practices. We also hope to hold an international virtual conference focusing on research outputs in the early career community to disseminate findings regarding loneliness and social isolation more widely.

This network was really founded during the height of the pandemic here in Europe when we were feeling disconnected from the field and often from other researchers. We reached out to one another and then to a wider audience on Twitter and were frankly overwhelmed by the positive response internationally from others in similar positions. This really demonstrates the ever-growing and really highly engaged interest in this area which we feel can be supported to make real progress on this topic.

Research into loneliness is needed now more than ever to support the groups and individuals, providing a lifeline to lonely and isolated people in communities in Queensland and beyond. We are supportive of the work of early career researchers could be instrumental to these efforts. We know that many of our members would be glad to engage with policymakers locally and internationally on this topic and we look forward to seeing how connections like this develop as valuable resources for loneliness and social isolation initiatives in Queensland.

We would like to take this opportunity to compliment the Queensland government on its attention to this important issue and for conducting this inquiry. We look forward to seeing how this work may be implemented in government going forward to address loneliness and social isolation among people in your local communities. We have been following the recent hearings and it certainly

seems that this is an issue which many people and organisations are committed to tackling, so we hope that this will be an important step towards creating a happier, healthier and more connected community in Queensland. Thank you very much for listening to Catrin and me today. We would be very happy to take any of your questions.

CHAIR: Thank you very much, Catrin and Phoebe. The work you have been doing, particularly in linking the researchers throughout the world, is commendable. Well done, particularly in these very trying times. We certainly commend you on the work you are doing.

Mr BENNETT: We are hearing that the UK is fairly well advanced in some of the issues. In your research to date, are you seeing very significant differences between jurisdictions and countries or are you seeing similarities?

Ms Noone: I would say similarities, but generally in the UK I am seeing more collaborative type work—myself included. My PhD is a collaboration with a day centre in England so I am certainly seeing more of that type of research, which is not always participatory—it is not always user led—but more collaboration with communities, at least in the UK. I would not be able to say for certain if it was wider than the UK. I have not seen it.

Ms McKenna-Plumley: We carried out some research with a group I work with here about loneliness during the early COVID-19 lockdown and I do not believe there were very significant differences between different jurisdictions, but obviously there is kind of a real range of research often not really looking across jurisdictions, so I am not sure what the final answer on that would be, frankly.

Mr BENNETT: What about place based solutions in other jurisdictions? Are your researchers picking up any ideas about different areas within the UK or even Australia? We are getting a lot of information on place based solutions to the committee inquiry.

Ms Noone: I really would not be able to comment on that, at least with confidence. It is not something my own research projects have covered in depth at least.

Ms McKenna-Plumley: My work would cross jurisdictions. I would not be highly aware of place based solutions within my own work personally. I think obviously linking in with community organisations to try to find things that can work within individual communities is a priority for many researchers. It would not be a key focus of my own work either.

CHAIR: We as Queenslanders have read quite a lot of work that has happened in the UK over the last number of years. I know that the current government in the UK and the previous government were very committed to addressing social isolation and loneliness. Could you briefly share with the committee the work that you are aware of that the government had implemented across the UK that was going to progress the issue and if there are any outcomes to date?

Ms Noone: It is difficult. As we said, we entered the research field not too long ago but just before the pandemic, so we were coming into it knowing that there was a minister for loneliness, it was this huge issue and there was a lot of money going into it, but one of the reasons I actually did the PhD I am doing is that the funding was not going to areas in the right way. The types of initiatives that were being developed for older people—I look at older people—were not as inclusive as I would have liked for the particular group of people that I was working with.

Ms McKenna-Plumley: I think a lot of the initiatives have really focused on different arms of actions. Breaking the stigma is a huge thing which has been discussed in a lot of the reports coming out in different parts of the UK stemming off that new government interest, I suppose. Then a lot of the funding has gone into charity and local organisations, which I think is a great idea to empower people who are already working within those communities. It certainly seems from the hearings that that is something that is possible in Queensland as well. There are already active groups. In terms of outcomes, off the top of my head I do think there has been more discussion about this. You see things like friendship benches where people can sit together and talk and signs across public transport encouraging people to start the conversation. I think that is the work that will be carried forward hopefully with a new minister for loneliness.

CHAIR: Have there been structures put in place by the government, whether it be HR structures or policy structures? Has there been any infrastructure to manipulate the conversation or to progress the issue?

Ms Noone: Not that I am explicitly aware of. It is mostly, as Phoebe said, this push to literally talk about loneliness. We have seen that across the various groups, the various ages. In the postal scheme there was a stamp with 'let's talk loneliness' on it and that is coming back again and then another push around friendship benches. More recently there has been even more come out and that

is to tie in with talking about loneliness again. It is mostly still focused, I would say, on the dialogue and being open about it and getting the discussion going. I have seen few examples of more progressed initiatives, I would say.

CHAIR: It is still at that stage of demystifying the complexity of the issue and challenging the social stigma?

Ms Noone: Yes, and rightly so as well, specifically related to stigma, because that is still a major issue here.

Mr BERKMAN: Thank you very much for joining us from all the way over there. Can you let us know who it is in Australia you are collaborating with as a member of the network?

Ms McKenna-Plumley: I am not sure if we would have permission to name our individual members. We have a couple of members based in different states in Australia who would be PhD and postdoctoral researchers.

Mr BERKMAN: If you are in touch with them anytime soon and they are interested in reaching out, if we could invite them to do that, that would be great. I am interested in the mechanisms for connecting people who are experiencing loneliness through primary healthcare settings. We have heard a bit of evidence today about the potential for specialised link workers to facilitate that engagement from a healthcare setting, connecting people with local community organisations who are well positioned to provide social inclusion and deal with loneliness and isolation. Is that something that has emerged in your research at all and do you have immediate experience with any of that work going on in the UK?

Ms Noone: Social prescribing is something that is major in my research, and that is effectively, as you say, the link work into community organisations, but I look exclusively at day centres and those kinds of difficulties. That is more of a social work background, so some of the difficulties around referrals to day centres and that type of thing.

Ms McKenna-Plumley: I do not work directly with any primary care at the moment, but I am certainly aware of the research. I know you heard from Inala Primary Care earlier today and I think they were talking about some of the research and the massive association between physical health issues and loneliness and the likelihood of increased primary care usage in people who are feeling lonely and how that is perhaps not the best use of a physician's time or the best resource for people who are feeling that way. I think link working has huge potential for directing people to services where they can become more integrated and could certainly be a good way forward.

Mr BERKMAN: Great. Thank you, and goodness you must have been up early this morning to hear the evidence from the folks at Inala.

CHAIR: That is such commitment. Well done.

Ms LUI: Thank you both for your time. I am interested to know your thoughts around the definitions for social isolation and loneliness, if you have experienced any difficulties in identifying the extent of loneliness and social isolation in your line of work and also the difficulties in building a body of evidence based research on the problem. That is probably three in one.

Ms Noone: A loaded question. It is very difficult. For me at least, my research at the minute is working on looking at definitions of loneliness and lived experiences and I had not thought that would be the case when I started the project; I thought it would be more a case of measuring the impact of day centres and loneliness. Actually, we had such difficulty in identifying and agreeing what we all meant by the word and even now there is not so much literature on the definitions of loneliness. There are the typical definitions that we all use still, but that can be really complicated when you go into environments where people, for example, use 'social isolation' and 'loneliness' interchangeably. That can be really confusing because they are very different. From what I have seen from my group of participants, there are such differences in the definitions of loneliness being used. If we do not at the start of a project on loneliness agree on a definition, then you can imagine how complicated that can be going forward if you are trying to measure or understand the concept. However, it is very much ongoing and I know there are a lot of other people involved in this conversation, and I know Phoebe is as well.

Ms McKenna-Plumley: Yes. I would say I have had a very similar experience to Catrin, where I came at the research field with maybe my own ideas which were quite led by the literature about the idea of social isolation being this objective situation where a person might have few or infrequent social contacts with other people and loneliness being that subjective feeling which might not be related to the objective situation at all. On the other hand, in doing research—conducting interviews with people—they do use those terms interchangeably. Some people might be reluctant to label

themselves as lonely. They might find it hard to talk about what loneliness means to them, and I think that is certainly something that can be taken into account and I think could be really valuable—that is, the fact that people might not label the experience they are having the same way that we would and it is important anyway to respect and come at that with an equal eye to people who might use the kind of language that we are used to using. Disentangling those two concepts obviously can be tricky, because often people who are socially isolated also experience loneliness but you cannot assume that people who are well integrated do not feel that way too. So I think it is definitely something to take into account.

CHAIR: Very good question, member for Cook, and thank you for that comprehensive response. I was just chatting to the secretariat and that is going to be an important point for us to identify and highlight in our work.

Mr KRAUSE: Thank you for joining us. I have a question about the COVID-19 pandemic. I know that the whole of the UK has been through long periods of lockdown, restrictions and so forth but has come out of a lot of them now. I imagine that would have increased the level of social isolation and feelings of loneliness amongst people. Can you give us any information about how important it is to come through that period for people who are isolated and lonely but also, taking a step back from that, how important you see it is to have a plan to get through these difficult times? One of the things that I have detected in the community in recent months, with the uncertainty around restrictions and so forth here in Australia, is anxiety about where we are going in the future. If you have any thoughts around coming out of lockdowns and restrictions but also the need for plans, that would be a helpful insight, I think.

Ms McKenna-Plumley: I think there has been some kind of government focus on this idea of building back better and coming back from the COVID-19 pandemic with a new focus on trying to tackle loneliness and social isolation, because I think it really has underlined the importance of this issue for people all over the world, really. Obviously, most areas have gone through some kind of period of lockdown and some kind of period of being distanced from loved ones, so I think it has put the issue on the table and is maybe an important time to start thinking about how we can really leverage this as a way to bring that kind of focus on communities and on individuals who might have been feeling this way long before the pandemic or who may have, like you said, gone through a period where they might have experienced loneliness for the first time or in an increased way.

Ms Noone: I think in that same breath a lot of work needs to be done on rebuilding people's confidence as well. The people I have worked with in depth over the course of COVID-19 are older adults, but the confidence they have lost because of social isolation, because of being at home for such a long period of time, means that suddenly they are too nervous to get the bus now. They do not want to even go to their hospital appointment. That is one activity for a whole week when actually they used to live very rich social lives. At the same time, when we are thinking about getting back to a new normal, whatever that is, it has to be incorporating that recognition of what is happening with people in terms of confidence and independence.

Ms LUI: Catrin, you mentioned funding. You felt that funding was not going into the right areas when you started out in your research. I was just wondering if you could expand on that.

Ms Noone: Yes. It is explicitly because I work with a group of older adults from a very specific socio-economic background. At the time I was entering the research area I was very aware of these very exciting initiatives for older people in relation to social isolation and loneliness, but they were things like walking groups or gardening or various things. They were quite exciting and I remember at the time, because I was talking to the same group of older adults I am working with now but not in a research capacity, they were so frustrated. We went through the whole report of the examples of things they are to do and they said, 'I would love to be able to do a walking group but I can't walk. I can't garden because of the arthritis in my hands.' The funding was going to these—and rightly so—innovative methods, but who are we leaving behind? If people cannot fit into these activities—yes, they should be exciting and, yes, they should be engaging—they are not being designed by the people who are going to use them, they are not going to be inclusive enough. I think the funding needs to acknowledge that and work with people to find the solutions that they are going to use and engage with. Really, that is what I meant by it.

CHAIR: How is that funding allocated? Was it allocated to community groups? Was it allocated to individuals through a national health scheme rollout?

Ms Noone: This is what I was told, but there were differences. Sometimes there was some money coming through bids that communities could apply for, but there was some that was going straightaway to these initiatives and activities. I would be happy to look in depth a bit further and let you know afterwards, just to speak with a bit more confidence. I expect that would be more helpful.

CHAIR: Thank you. Phoebe, did you have a comment on that?

Ms McKenna-Plumley: No, but I would agree with Catrin. That was also my understanding—that is, there was some direct provision and then I believe the National Lotteries foundation was available for bids, so I think that many organisations—

Mr Skelton interjected.

Ms McKenna-Plumley: Yes, exactly. Like Catrin said, it might be more helpful for us to come back to you with a solid answer.

Mr BENNETT: I am curious about the network and some of the origins. I think you might have mentioned it earlier, but obviously this is an early career research project. How do you hope to see the research make the difference that you are obviously passionate about?

Ms McKenna-Plumley: I think there is just such a huge excitement behind doing this research, especially when you are early on in your career. It is the first time you have been leading projects like this when you are at a Masters, PhD and early post PhD level. I think it is something that we—Catrin and myself—would talk about a lot. We could see that this was an area that a huge number of early-stage people had a great interest in and we thought there is power in numbers, obviously. There is the possibility to cross boundaries and to talk to people who are coming at this from different disciplines and from different areas which might also obviously, like you would know, have different policy to each other and different ways that it is implemented in different countries. Just trying to leverage that passion into making a difference in terms of research and understanding the international field of research is something we thought could be really useful.

Mr SKELTON: You were saying that it is such a broad spectrum, and obviously it is community and health as well as social work. There are a few networks involved. In terms of funding, obviously there has to be some oversight, bearing in mind it is public funds, but these funds need to be targeted. You have touched on the funding model in the UK, which is similar to what happens here with regard to grants and also some ongoing funding for community centres et cetera. Obviously, for any of this to work, it is something we need to get right. Are you aware of any research or any models in place with some of your other members that seemingly see that funding going into the right hands at a local level?

Ms Noone: I would say unfortunately not. I suspect there might be a few people's research that might end up going that way, but certainly there is none existing. I do not know, Phoebe, if you have anything to add.

Ms McKenna-Plumley: Within our network there are none that I am aware of, but that does not necessarily mean there is none. We might have to go back to the members and see. I do think that program evaluation and rigorous research which looks at how these kinds of funds end up—what impact they end up creating—is a really necessary step in seeing what is working, seeing what funding can be continued and what might need a little bit more effort to get off the ground. I think that kind of program evaluation is important and could be done well by Masters/PhD projects and postdoctoral funding.

CHAIR: Thank you, Phoebe and Catrin. It is sad to say that our session has come to an end. We really do appreciate your contribution and learning from some of your research and some of the work that you have been doing in your respective areas. Thanks again for contributing to our social isolation and loneliness inquiry. The committee would very much appreciate any information you have in relation to funding models and how funding might be distributed across the UK to support the issue for those living in the UK. Thanks again for your contributions. It was lovely meeting you both. Thanks again for your time.

CHIVA GIURCA, Dr Bogdan, Development Lead, Global Social Prescribing Alliance; Clinical Champion Lead, National Academy of Social Prescribing UK (via videoconference)

CHAIR: A very special good morning to you as we come to about six o'clock on a Monday night. We will be finishing work in the next hour and you have started work and have a whole day ahead of you. We thank you sincerely for appearing before our committee today. Our committee looks forward to hearing a brief opening statement from you, followed by, I am sure, some questions. Thank you very much.

Dr Chiva Giurca: It is a pleasure to meet you. I should be the one thanking you for the kind arrangement, seeing as you have been there the whole day. It is for a great cause. I am delighted to be here. I am hoping to bring a bit of a clinician's perspective of the impact of social prescribing on loneliness by sharing some of the work that we carried out together in the UK.

As you may have heard already from the UK colleagues, social prescribing officially became policy two years ago and has been emphasised as one of the core pillars of the English national healthcare system and the long-term plan, the roadmap launched by the government. The government has already surpassed its target of appointing over 1,000 link workers, also known as community navigators or social prescribers, to ensure that the psychological and social patient needs are met in addition to the biomedical ones. As I am sure many of my colleagues have already said, we insist on differentiating social prescribing from simple signposting.

By way of background, the National Academy for Social Prescribing was set up by the government to support the establishment and delivery of social prescribing. In collaboration with partners, we have built several programs supporting the agenda of tackling loneliness including a £1.8 million Thriving Communities Fund awarding small grants to community organisations across the UK and aiming to support social connectedness and to help communities cope with COVID-19.

Other programs include a national academic partners network conducting evidence summaries, not only assessing patient outcomes but also looking at the economic impact of social prescribing on loneliness. My colleagues have also developed an innovation accelerator for knowledge exchange, an ambassador program, a clinical champion program and the aforementioned Global Social Prescribing Alliance, which is aiming to facilitate shared learnings across the globe including partners in Australia, of course. As part of this, we have developed a social prescribing playbook showcasing the building blocks of what good social prescribing looks like and reflecting on the challenges and limitations with examples from the UK and beyond its borders. I will share a link to this document should you be interested in finding out more at the end of the meeting.

Finally, short-term solutions come and go, but if we want long-term, systemic change, perhaps the most important comment I would like to end my opening statement with is the need for a complete culture shift in the way we deliver health care that is focused beyond firefighting and beyond delivering acute care. There should be a focus not only on meeting the psychosocial needs of our patients but also on enabling health creation that starts at the heart of our communities, enriching the toolkit of healthcare professionals on the front line and equipping the future generation with the skills to navigate the ever-changing demographic.

Although I wish I could share only positive findings from England, there are some harsh truths. One of them is that we are truly struggling from a workforce perspective. In the UK I have the pleasure of leading a social prescribing champion scheme for over 20,000 junior doctors and medical students, and we are witnessing firsthand the effects of an increasing population, with numbers of those aged 60 or above set to double by 2050 and, therefore, increasing numbers of chronic diseases with limited tools to support those one in four patients who perhaps attend an appointment for pure social reasons, many of whom lack social connection and are isolated.

For the future generation, for healthcare professionals to feel prepared, social prescribing provides hope—hope to support the lonely, to connect them to local activities and to hopefully bridge the inequality gap and tackle the social determinants of health. Many thanks. I look forward to your comments and questions.

CHAIR: Thank you, Dr Bogdan. There was a lot of information in there and certainly a lot of information that the committee is very interested in hearing more about.

Mr BENNETT: Today we have heard a lot about social prescribing, and it is really exciting to hear about some of the solutions. I am curious about your comments. I think you said that you have been doing it in the UK for two years with a thousand link workers engaged. I am keen to see your interpretation of some success in statistics. I did pick up that you talked about a large increase in population which may be an issue. I am happy to hear your comments.

Dr Chiva Giurca: Absolutely. That is a fantastic question, especially with what we see at the moment with increasing long-term conditions as well. The government set the target of 1,000 social prescribers, which was surpassed, and they have since appointed another 500 link workers because they were supporting primary care to deliver the service. There are different ways to look at it, and I think one of the helpful things to share with you at the end of this is the evidence summaries put together from the UK, which is six core areas where the academic partners have put together all the evidence around not only the economic side but also the patient outcomes.

From the patient perspective there are several studies. There is one recent one I will mention as an example. Alexis Foster and colleagues published a recent study involving 10,000 patients. They looked at social prescribing as an intervention and they found that 72.6 per cent of the participants felt less lonely, using the loneliness scale that they assessed with study with. They also reported a wide range of benefits including an increase in confidence as well as general wellbeing and having more purpose—they felt they had more purpose themselves.

I think it is also interesting from a service provision idea—the idea of freeing up time for the healthcare professionals, which for me is huge. There is something to say that the biggest barrier to personalised care and finding out what truly matters to people is time—spending time with them and being there for them. Especially in the UK with 10-minute appointments—and I am sure in Australia it is very similar; we have very short appointments with our patients—often we get the remark from our colleagues, 'Where do we find the time?' I would always challenge that. I would say that education is the biggest barrier to personalised care because in a recent survey provided by the Royal College of General Practitioners 59 per cent of all GPs considered social prescribing to be reducing their workload. Interestingly enough, it was only those who were trained in social prescribing early on, both in medical school and later in their training. That is fascinating from a workforce perspective.

Then there comes the economic side of things, and I am sure the numbers show this in Australia as well. In the UK alone, there was a study from the London School of Economics in 2017 quantifying £6,000 per person in terms of costs associated with loneliness and their care. If you add that together, I think the study from LSE showed a total of £2.5 billion per year in the UK alone spent on loneliness. The same study I mentioned earlier looked at the return on investment and the outcome was that for every pound invested through social prescribing they had a return of £3.42, so three times return on investment.

CHAIR: I am interested in the assessment tools or the methodology you use to gain data on clients' condition. We have heard a bit about some of the assessment tools that may or may not be recommended and the importance of gathering data. Could you talk to us a little bit about those tools that you use in the UK?

Dr Chiva Giurca: Absolutely. I think when the conversation started around six or seven years ago—I remember that I was still in medical school; I was very young at the time—there was this constant debate around evidence gathering or service provision and involving link workers from the beginning. I think it is very interesting and very important to acknowledge how deeply rooted social prescribing is within some of the wider principles for which evidence has been around for over 25 years. By that I mean the shared decision-making model that has been around for more than 20 years, the biopsychosocial model that has been pushed around. We know about the positive benefits of exercise and diet. It is very difficult, because social prescribing arrives as a new intervention which is multifaceted but then expands as wide as climate change and other principles around. Therefore, we have hit various barriers and boundaries when we are assessing it. But within the hospital we have witnessed firsthand its benefits. This is the conversation that always arises in conferences around the evidence, and we are hoping to build that robust database. I think the summaries that have been put together are a first step.

There are various assessment tools. The loneliness scale that I mentioned in the previous study was the UCLA loneliness scale that they graded participants on, although there is a risk for subjectivity, as you can imagine. You rely on the participants to give you those details. To put my academic hat on, the best studies that we have done, from an academic perspective, are the mixed methods studies. You then look at it from different angles and you do not just look for self-reported outcomes. You also look at the more objective outcomes as much as you can. This is, again, a conversation that will probably be taking place over the next few years. We are hoping for the global alliance to standardise the evaluation outcomes and put together better toolkits.

The academic partners network in the UK, which is slowly moving towards the Global Social Prescribing Alliance to involve partners from around the world, is essentially collating datasets from different parts of the world and has put out a call for action for studies that exist in different languages and in different countries to avoid duplication of work, to try to translate that into a common language and to try to build better studies with larger samples on the data that people acquire across the globe.

I wish I could answer that in full and I wish I could say there is a perfect way to assess this, but, as my other colleagues might have mentioned, the evidence remains one of the difficult things to assess in an intervention that is patient focused and where there are so many confounding variables. One thing I would say, however, is that, when you peel the onion and when you look at the core of social prescribing and why it works and why I am insisting on not calling this signposting, we know that telling people what to do never works. I used to do this in hospital and we all used to do this as clinicians—telling patients to exercise, to stop smoking or to get more connected—but we know that simply psychologically does not do the trick. When involving social prescribing, where you have a designated person who has been employed to look at and understand the true needs of the person, connect with them and then have a menu of activities and then accompany the individual along the way, it just seems to build upon the previous principles of motivational interviewing and shared decision-making, which, again, are deeply rooted within evidence.

Mr BERKMAN: We very much appreciate your time this evening, Doctor, although it is morning for you. You referred to some of the emerging challenges and limitations of social prescribing. We have heard a lot today and it sounds incredibly promising as an avenue to address social isolation and loneliness. Can you give us a snapshot of what those challenges and limitations are as they are emerging in the research?

Dr Chiva Giurca: Absolutely. As we look more towards the community to support the medical model, one of the first things that comes to mind, and a comment that often comes up in conferences and different areas, is the idea of funding, not necessarily for the healthcare system or for the link workers and social prescribers. That is a completely separate topic. More so it is for noticing gaps in opportunities for funding and developing new initiatives within the local community.

I think it cannot be understated the importance of ensuring that the local ecosystem is built before social prescribing is being delivered as an initiative. We have seen different areas across the UK where link workers are struggling because there are not enough opportunities within the community. In the UK, funds such as the Thriving Communities Fund, which you can look at, tries to do just that. It tries to find gaps of opportunities within the local community, especially those most impacted by COVID or those most at risk of social determinants, and provide them with extra seed funding to develop the local community infrastructure. I think that is very important. It is crucial to realise that social prescribing will not exist unless there are those community support groups and unless they are being supported, otherwise it feels like we are shifting some of the patients from A&E into the community. For us in A&E it might be a great idea, because those are usually frequent attenders, like we said, who most need social connection, but then we also find the workforce gap within the newly appointed social prescribers.

Another limitation is training and education for the social prescribers and the link workers. Now in the UK we are at a stage where it is not so much about noise making and it is not so much about getting people to implement social prescribing; now it is more 'do we walk the talk?' and 'how do we make sure that we support the social prescribers to have enough capacity to deliver for those patients?' because we are now tempted to, even inappropriately, refer patients to them, and we have noted some of those things arising. From my perspective, those would be the biggest barriers—as well as, of course, education for the workforce to ensure they make appropriate referrals, to make sure they know that these services exist within the community and to involve them from the beginning.

One of the positive aspects that builds on the barrier is the idea that it truly acts as a vehicle for tackling social determinants of health and health inequality. It really puts the emphasis on the tribe that is being built within the local communities. It is simply empowering local individuals to meet healthcare professionals halfway, rather than seeking healthcare experts to solve problems when people are already ill. For us, the younger generation we know are going to be around for a long time delivering healthcare services, it provides a lot of hope and it provides reassurance that, yes, there will be more people and, yes, there will be more chronic diseases, but we are causing the cultural switch and trying to involve people—and not just the one-third who are already sick but the two-thirds who are currently well and who can take a bit more ownership of their health, when able to and when empowered to do so.

There is a fascinating model that I am sure you have heard of called the Frome Model. Frome is a place in England. It is beautiful what has happened there. I am hoping that is where we are slowly moving towards. They have developed a whole ecosystem around the local community where they have started training the police service, firefighters, hairdressers, cab drivers to be aware of the facts around and the impacts of mental health. We know that 60 per cent of appointments are about mental health. They provided extra training free for everyone within the community. They have these community connectors, who could be anyone within the local community, who may notice when

somebody is lonely and could then refer them further from there. We are now talking about placing the ownership of health into the hands of the people. I think that is a beautiful model that I personally hope to see more of across the world.

CHAIR: What was the name of that program again, Doctor Bogdan?

Dr Chiva Giurca: It is called the Frome Model. I can link you with some of the people there. Jenny Hartnoll is one of the people leading the movement in Frome, England. It is community connectors that are being built. It is a small community place. It is the first place where they started to look at the wider ecosystem, providing a future view where people from the community can get involved themselves. Something fascinating happened, because everybody thought they could contribute a bit more so you then have a shift from patients who are struggling from loneliness, with chronic pain and being on a cocktail of six or seven pills and de-prescribing those medications, removing those medications steadily, because of their social connections. Then once they got better they became leaders themselves. They reached out to the general practices and the doctors locally and asked whether they could be involved in sharing their examples and being patient leaders and supporting others. It is a beautiful circle of the community feeding into the healthcare system.

CHAIR: That is really exciting. Thank you for sharing that with us. In my community of Mount Gravatt we have a context where anyone can refer to our link workers, but at this point in time we have not engaged in any training of community groups, community members, police et cetera. That model sounds very thorough. Certainly we will go away and do some research on that model.

Ms LUI: Dr Bogdan, you mentioned Thriving Communities. Could you give some context around that?

Dr Chiva Giurca: Absolutely, yes. It is a beautiful initiative looking at funding the local voluntary care sector with the idea in mind of the barriers that I described earlier. It is simply there to support local voluntary communities, safe and social enterprise projects that bring together place based partnerships. Essentially, those have been set across the sectors: the arts and heritage, creativity and culture, sports, nature, financial wellbeing as well as community advice and the wider social enterprise sector. The way it has been built is that it is done in partnership with collaborators such as the healthcare system, NHS Improvement, Historic England, Natural England and the Arts Council England. A wide range of partners contributed to the overall funding of £1.8 million. What happened is that there was an application form of small grants of between £25,000 to £50,000 for those most affected by COVID-19 and where there will be a purpose to enrich the local community and to support the development of future programs and the local community.

To give an example from the local sector, in Leeds there is an arts and social change organisation called Space2. They are working with the Yorkshire Cricket Foundation and the Feel Good Factor, plus a range of other partners around the city, on a social prescribing program to deliver the activities that tackle social isolation and improve wellbeing and support communities. Those include getting people together in art classes, getting them to meet each other—there were Zoom classes over COVID-19, using technology—as well as getting people involved in sport within the local community.

The most beautiful idea around the Thriving Communities program is empowering the local communities to build those opportunities, because one of the most common things that happens is they get left out. We get to pre social prescribing and say that it will be great to have it, but then they feel the burden on their shoulders because they may not be able to deliver it without appropriate funding. Those projects are great evidence that a little support can make them feel valued and involved and will empower them to enrich the local services even further. If a strategy is developed, it can really empower and put them at the core of health needs within the local community.

Mr BENNETT: Your introduction was very comprehensive, but I missed some the programs that you listed. You mentioned Thriving Communities and Learning Together in your introduction. There were some others that sounded very interesting. Can you mention those again and give a brief indication of what they are about?

Dr Chiva Giurca: Absolutely, yes. As with everything, I am trying to get as much in to share as much learning as possible. One of the main programs is the Social Prescribing Champion Scheme. This is something that I personally hold very dear because it started looking at the future workforce. There is a component of it that looks at the future health of professionals, including students, young trainees and doctors, and it involves all medical schools within the UK. We have had the pleasure of launching it in Australia with the support of the Australian Medical Association. Some of the medical

students there have taken the model and replicated it and are providing training for the future generation. For me that is particularly important because, as I said, it builds onto the long-term change and the system change that we are looking for.

The Champion program, which we are currently developing together with the healthcare system, aims to not only enrich the noise-making opportunities for how social prescribing can support loneliness but also provide extra support within primary care, especially where the pressure is on at the moment, as you can imagine, with the waiting lists and people wanting more face-to-face appointments and where the service is struggling a little. We are trying to get champions who know about social prescribing to connect with link workers, map out problems together and then find solutions together. We are hoping to build on that integrity within the community, primary and secondary care and aid integration of the services as well.

One of the other programs that I mentioned earlier was an ambassador program that facilitates learning. It is very similar to the Champion program, but it is more focused around sharing good practice through podcasts and learning, which you can also find online.

Perhaps the most exciting initiative and the one that will evolve and actually change the way in which we formulate social prescribing is the Global Social Prescribing Alliance, which is developed in collaboration with the WHO and the United Nations as well as the World Health Innovation Summit. It is exciting because there are over 25 countries within that group, all of which are pioneering and moving forward with the idea of social prescribing and using it to change that culture that I mentioned and to look at long-term systemic change. The model is not the same everywhere. We know that in Portugal, for example, they started adding further education for social workers instead of hiring new link workers. They simply looked to the social workers they already had, added extra training and then supported them to become social prescribers. In Canada it is very similar, with community navigators similar to the UK.

We know that countries all around are slowly starting to get commissions to embed this as policy as part of their national governance initiatives. Wales, for example, has been commissioned to do that work and other countries are following. It is beautiful to see people from around the world tuning in and trying to host a wide range of datasets and support the data-acquiring sets and to share that knowledge using a global platform that we hope could change the way in which we support people who are lonely and disconnected.

CHAIR: Thank you, Dr Bogdan. On behalf of the committee, I cannot thank you enough. The work that you have shared with us is substantial. The projects and the initiatives you have spoken about have given us a lot of food for thought and a lot of further research to investigate. We thank you sincerely for your great leadership of this very important issue, particularly in the UK but also globally. Thank you sincerely for your time this morning. We wish you well. We know that you will have a very successful career ahead of you. Thank you so much and all the very best wishes from us to you. Keep doing the great work you are doing.

Dr Chiva Giurca: Thank you very much and best of luck. Thank you for being there so late in the evening.

HEWINGS, Mr Robin, Program Director, Campaign to End Loneliness UK (via videoconference)

CHAIR: Thank you sincerely for giving up your time to support the work of this committee. We ask that you make a brief opening statement, after which the committee will have some questions for you. Thanks again for your contribution to our inquiry.

Mr Hewings: Thank you very much for having me. In my opening three minutes I just want to talk briefly about who we are as an organisation. We are called the Campaign to End Loneliness. We are focused on trying to reduce chronic loneliness—the most problematic and damaging type of loneliness. The reason we think it is such an important issue is that loneliness cuts so deep into people. It matters so much for their wellbeing. It also has really important effects on their long-term mental and physical health.

In the UK we have had a national loneliness strategy for the last few years. We think it is going to bring good things, too. The reasons for that are that, firstly, this is a really important issue to people. Politicians say that it is reflected a lot in their post bag and generally when they are out and about. I think people are pleased to see politicians addressing it and also that the government can do something about it. This is not just something that we sing songs about; as an organised part of society there are things that can be done about it.

The UK government covers a reasonable size population. They have focused on trying to show leadership on this issue, to reduce stigma and to improve the evidence base about what you can do about loneliness. It is a relatively new issue and there is still a lot more that we do not know, although we are finding out more all the time. Also, they have focused on trying to embed loneliness in other policies through government. We think that is a very good set of things for the government to do because they are things that they can actually do.

A central government is not going to be able to pull every lever, because this is an issue for which there is a role for government, there is a role for local government, there is a role for health services and charities, and there is a lot we can do in our individual lives. We think there is a real role for improving people's understanding of this issue and also their understanding of the different risk factors, many of which fall out of the immediate reach of what a loneliness strategy can do something about, but understanding them is really important for doing effective work in this area.

The key thing, in terms of risk factors for loneliness, is still the transitions—those clusters when we are younger, when people are moving for work or for education, relationships changing much more and also when people get older, particularly going into their late seventies, eighties and nineties when they might be more likely to have ill health, to be disabled or to be bereaved, which is probably the single most important risk factor for loneliness.

That is a very quick whistlestop tour of who we are, what we think the experience of our loneliness strategy has been and a very top level of risk factors for loneliness. I know that there are a number of other areas you are looking at as a committee.

Mr BENNETT: It is important to understand the organisation and the campaign. How are you funded and could you give us some information about the numbers? I am really interested in some of the campaigns. Could you maybe talk to the success of some of your campaigns?

Mr Hewings: Yes. We were founded about a decade ago. Essentially, there were a lot of organisations and charities that were interested in loneliness and there were also a lot of academic researchers working in this area. We were formed as being a place where they could come together and meet up. Also, we could then disseminate the evidence that was being generated in more academic research but also shared practice and case studies that people working on this issue were creating but had no way of disseminating better.

The core thing is that we are a campaign, not a service. We are very deliberately quite small. When we were founded there were two or three of us. Then we had a period when we were a bit bigger and we were also doing more on-the-ground work and public-facing media work. We have since shrunk back down to four of us, focusing on those areas of building the evidence, bringing together the community of people who work on loneliness and making the case for action.

I think are a number of things in different areas. The biggest single success, I think we would say, is the growth in interest and understanding of this issue. There are those things where we have contributed to a successful campaign but there have also been others such as Age UK, the Red Cross and individual politicians who have championed this issue. We do think we have helped to bring out why this is something that you need to take seriously and is something you can do something about.

More individual things to do with us are when we found people using our evidence and coming to our events really readily. For example, about six years ago we developed something called the Promising Approaches framework to tackling loneliness. This was a way of thinking about the various different things you could do to tackle loneliness and how they were not in competition but they fitted together very importantly. The success of that is that it is not just us who use that but also various other organisations. In my first week in the campaign I saw one of the civil servants who worked on tackling loneliness using that framework to describe what it was that you could do about this issue.

We have had a really important run through COVID. It was a really dynamic time and people were coming together to share ideas which we could then put together and disseminate. We found people coming to our events a great deal and downloading our work a lot as well. It is in those ways that we know we are doing a good job. The most important thing we are doing is probably facilitating a very collaborative effort around this whole area.

Mr SKELTON: It is evident from things people have said, including yourself, that the COVID-19 pandemic has brought loneliness more into focus because people were housebound et cetera. Do you think they are any worse off than they were before COVID or do you think COVID might have given impetus to your campaign and raised awareness?

Mr Hewings: What has happened for loneliness has probably been a lot more complicated than I would have guessed in March 2020. I think I would have guessed that it would have got worse. What happened was that for some people it definitely did get worse and it got worse as it went on. In the early stages of lockdowns and it being quite dramatic, there was an increase in people who said that they were sometimes lonely—quite a big increase—and a lot of people who said that loneliness was affecting their wellbeing. We know this because the Office for National Statistics was doing a weekly survey of this.

There was not a big increase in people saying that they were chronically lonely—people saying they are 'always or often' lonely, which is what we worry about because that goes with longer term health effects in mental and physical health. Also, it is harder to get out of it. The thing about loneliness is that when you are lonely you think about your social relationships more negatively and you can get into a downward spiral where you lose confidence, you dwell on things much more and it is much harder to brush off sleights or disagreements or whatever. It is that 'always or often' loneliness that we are really worried about.

In the first summer of 2020—your winter—we were thinking everyone has thought about this a lot and it has affected people's wellbeing but it has not been the category of loneliness that we are most worried about. Then what we found going into the end of 2020 and the beginning of 2021, when in the UK we had another set of lockdowns, was that chronic loneliness went up. It went up by over a million people in Britain. That is quite a lot of people. It seems that as things have opened up things have gone back to normal. We think things are probably not completely back to normal yet. What is hard for us to understand and to know is how quickly people have been able to bounce back and how specific it was. If COVID went alongside something else going wrong in your life—if it left you unemployed or an older person perhaps became deconditioned and lost physical strength, which we think has been a real issue—then it may have been harder for them to get out of being lonely.

Mr BERKMAN: We very much appreciate you joining us from all the way over there, Robin. From what you have said and from previous witnesses, it seems pretty clear that our government response needs to focus on both public education and collaborative ways to address this issue. The last witness we heard from has a particular specialisation in social prescribing, but he equally discussed with us this example from Frome in the UK which was, by the sound of things, a much broader community response—both of them relatively structured. Can you compare and contrast the efficacy of that medicalised social prescribing type response with the bottom-up community responses, or is it simply a case of throwing everything at it that we can?

Mr Hewings: I think there is a bit of that, actually. I was talking about this Promising Approaches framework, and I think that is quite important. My answer to the question is essentially to quickly talk about that framework. What that framework is about is starting off with someone who is or is at high risk of being lonely. The first job is to find them. The second job is to then listen and understand and support them in doing whatever it is that they would like to do, so essentially do social prescribing. That is what we call connector services, social prescribing, community link workers—essentially people who will find people who are lonely; if you have gone through social prescribing then I will not go through it—but really understanding and listening to them and helping them think about what they would like to do to engage. Obviously that does kind of imply, if you have social prescribing, that people are able to get to the things they want to do, so there is the transport available to them.

It may be the case that at the very least they will find out about things through the internet, so there is real value in digital inclusion. Particularly through COVID, obviously, that was useful way of staying in touch with each other. It is also that their broader built environment is supportive of community engagement. People can feel lonely if they cannot walk about where they live, if they feel threatened. There is actually a relationship between proximity to green space and loneliness. You think they are two quite different things in a way, but actually if you feel comfortable and welcome where you live, and greenery is obviously a part of that, that actually is kind of really helpful for loneliness.

Finally, it is that there are those things in your community that you can do. That might be going to groups of whatever nature—different types of social groups. It could be a cricket club, a church or a stamp-collecting club—just the whole rich range of things that people do together and volunteer together. There is an endless list, really. They might be things that are more one-to-one things. Particularly for people who are quite housebound through something like bereavement, befriending can be really helpful. Sometimes what people need is support with that kind of psychology of loneliness. Social prescribing done well is a very psychologically informed thing to do. People sometimes may need extra support to help them think about why they are feeling lonely and understand those emotions. We did a big report on this about a year ago, looking at the various ways in which you can use psychology to help people to be less lonely.

The point of that is that these things all fit together. There is no point having amazing social prescribing if there is nowhere for people to go to and they cannot get there or find out about it even if they could get there. These things are complementary. I think the value of thinking about it like that is that you can think, 'Well, if you have the community thinking about it across the whole population, you can think, "Where are our gaps?"' The gaps very often will be in that social prescribing community link worker area. I think it is really well focused on loneliness rather than broader, fuzzier kinds of things. It might be the case that the big issue is transport. That is also useful for particular providers. If you are running buses it is probably not a good idea if you suddenly try to do social prescribing, but if you are running buses you can link in with the social prescribers and the people running the groups so you can see how you can help people and see how to fit into that broader ecology.

Ms LUI: What your thoughts are around how to measure loneliness? Do you have a view on that?

Mr Hewings: Yes. It is not an easy thing to do and there are dilemmas about it. We did a report a few years ago, which still basically stands. There are two main academic measures: one is the UCLA loneliness measure and the other is the De Jong Gierveld loneliness measure. The UCLA one can be a bit shorter—it can be done in three questions—and it gives you an idea of how lonely someone is. De Jong Gierveld's is similar but it is structured to give you a sense of whether the loneliness that people feel is more to do with a lack of their closest social relationships or is more in that broader set of friends. There is also one that we created that uses more positive language, so it tends to be a little bit easier for people in services to ask, and there is a single-item scale that you can put into other surveys that you are doing more recently—like the one I was talking about from the Office for National Statistics in their weekly COVID survey that they have been doing. They have different pros and cons in terms of what they tell you, how onerous it is to ask, and the big dilemma really is when it feels appropriate to ask it.

For a relatively formal service like social prescribing being done through GP surgeries, the idea is that you might ask people loneliness questions when you are already asking them lots and lots of other questions about their address and all those types of other monitoring type things, and that feels reasonably comfortable. But if, say, you are providing a befriending service or a social group, saying 'Before I can let you in, answer my 10 questions, some of which are quite personal' is a harder ask. I think there is no perfect way of doing it. If services can find ways to ask people these questions, that is useful because it will help to understand what you are doing.

The other thing in relation to measuring loneliness is just to be careful: loneliness is a deep emotion and it matters a great deal to people but it is not necessarily very easy to fix. If someone is lonely because their partner of 50 years died six months ago or a year ago, you really want to help them and do something really useful but it will not be very easy to say that they are suddenly going to be not lonely anymore. It is a deep problem and it is not going to be something where it is always realistic to think you will get some dramatic shift.

Just thinking about some of the questions that are asked in the UCLA survey, the first one is, 'Do you feel that you lack companionship?' Just think about what it would mean to say, 'Yes, I always feel that I lack companionship' or 'I sometimes feel that.' That is quite a big shift in your life. When

you unpack what loneliness is, you can see why it matters so much to people and why it is important to do things about it, but when you are measuring it do not expect that a couple of weeks of chatting to someone is going to really transform their loneliness measures.

CHAIR: That is a great point, Robin. Thank you. That was a really comprehensive response to the member for Cook's question.

Mr BENNETT: We have heard a number of accounts, both in Australia and the UK, that for every pound it is saving the health sector three pounds. Are you campaigning on that issue about where the funding is allocated to? You are talking to politicians here and I guess that is why I am going there. Would you like to comment on that?

Mr Hewings: We are not just introducing this as an organisation. This is quite a young issue and there is still a lot we do not know, and quite a lot of what we do not know goes into the kind of health economics of loneliness. I used to work in diabetes. In diabetes we had 20- or 30-year follow-ups where we could model really nicely what doing something here would mean in 20 years time. We are not there with loneliness. I think there is evidence that if you reduce loneliness you have some big effects on social return on investment type things.

In relation to shorter term, cashable savings, I think that is where social prescribing really comes through because, essentially, it reduces healthcare usage in primary care quite quickly. Essentially, people often go to see a GP, which in the UK costs about £35 per 10-minute appointment, when actually the reason they are going is not that they need to see an extremely experienced healthcare professional; their real issues are not clinical but social. Having a link worker who has the time to really spend with someone to sort out those social issues means that they are coming to the GP less.

The one place where I think there is the strongest economic evidence, particularly in the short term, is around social prescribing; otherwise, I think it is really about value, not about savings. There are value arguments that people really, really, really hate being lonely. If you ask them to rank loneliness alongside other states, as it were—having a chronic mental health condition, not being employed—loneliness comes really very, very high up. The only thing that is ahead of chronic loneliness is having a life-limiting chronic illness. That gives you a sense of how much this matters to people. There has been some monetisation work. There is a way in which Treasury measures things through its green book, and the value in that exercise of a year of someone being not lonely relative to someone being chronically lonely is about £9,000 pounds. Monetisation of how it feels is really high. It is not the case that I can tell you, 'Yes, if you put on a social group you will be seeing savings in your accident and emergency department a year later.' We are not there yet. If you install social prescribing, you are installing value.

Mr BERKMAN: We heard a moment ago the challenges and limitations of social prescribing that line up very much with the answer you gave to my last question. Specifically, though, the previous witness identified funding of groups in the local community as being one of those real limitations. If those organisations that social prescribers would seek to tap into to offer that social support are not themselves adequately funded then it all falls in a heap, is my sense of the issue raised. We have heard a lot of evidence from neighbourhood and community centres in this inquiry that they are themselves already quite seriously underfunded, or at least they are not meeting the kinds of demands for support that already exist. How important is it, would you suggest, that those groups see increased funding so that they could take on a role within a social prescribing framework?

Mr Hewings: This is one of the evaluation things in the rollout of social prescribing in England. I think the answer is that we are not quite sure yet. I think it depends on, as it were, the people. Sometimes someone might have got into a rut, social prescribing got them out of it and then if they are taking part in a community group they may be contributing to it as a volunteer and so you are really potentially increasing capacity in those groups, not it being a drag. There may well be people who have quite a lot of other needs. If you have people who are quite physically disabled, for example, you need to go and pick them up in the bus and if that bus is broken down and you cannot buy a new one then you have a problem.

I think it is definitely an important point in the abstract. Exactly how it filters down I do not think we know and I think it is very locally determined. I think it depends on the client mix in the field and at an England level I do not think we know that lack of funding for community groups is a really big barrier to social prescribing or not. It is clearly the case that the better the offer and the richer the offer the better it will be for people. If you say, 'Well, there is only one thing you can do,' that is clearly massively less compelling than if there are five or 10 things that people might be able to do.

CHAIR: Robin, thank you sincerely for your time tonight. I know that the committee has thoroughly enjoyed your contribution. On behalf of the committee I suggest that we have learned so much from you. Thank you for giving us your time this morning. We wish you well with your future endeavours and thank you again for your examination.

Mr Hewings: It has been an honour to speak to you and thank you for a really thoughtful set of questions. I am really looking forward to reading your report when it comes out. If I can help in any other way, let me know.

CHAIR: That concludes the hearing. On behalf of the committee I would like to thank all of the witnesses and stakeholders who have participated today. I would also like to thank and take this opportunity to acknowledge the many submitters who have engaged with this inquiry. Thank you to our Hansard reporters, as always. A transcript of these proceedings will be available on the committee's parliamentary webpage in due course. I declare this public hearing closed.

The committee adjourned at 7.03 pm.