www.endingloneliness.com.au

ENDING LONELINESS TOGETHER

Ending Loneliness Together in Australia

White Paper November 2020

Foreword

Loneliness is a critical issue of our time. Research on loneliness and its detrimental implications for our health and the wellbeing of communities, workplaces and schools is advancing rapidly. We now know that a subjective sense of social isolation - that is, simply feeling lonely - is equally important to being physically isolated.

Many people who feel lonely suffer in silence, as this issue is stigmatising, driven by a fear of being unneeded or looking weak, vulnerable, or inept. While addressing loneliness serves as a potent preventative strategy that combats several poor outcomes, people at the frontline may not readily recognise loneliness as a driver of other issues or may not be resourced to effectively assist.

Many organisations are beginning to direct their time and energy to address loneliness in their communities. However, because this work is largely done in disparate silos, we miss opportunities to collaborate, share knowledge, and pool resources. The latest scientific evidence on what is effective for people who are lonely is not well translated to service providers on the ground or to policies that influence the way we live, work, and play.

Australia remains underinvested in scientific research into loneliness. We are heavily reliant on evidence from other parts of the world. By building the evidence base on the causes, correlates and consequences of loneliness in Australia, we can develop and deliver more effective and sustainable solutions against loneliness, yielding economic, health, and social benefits to our communities.

Partners across industry, government, and academia must work together – with people with first-hand experience of loneliness – to integrate the movement against loneliness in this country. We must work together to destigmatise the experience of loneliness and empower individuals and groups to build meaningful social connections.

Ending Loneliness Together is committed to evidence-based action to tackle loneliness. As allies in a shared vision, I invite you to join us and support us as we set out in pursuit of a national response to ending loneliness in Australia.

Dr Michelle H Lim
Scientific Chair
Ending Loneliness Together

Foreword

One in four Australians have reported feeling lonely all or part of the time. Data collected during the COVID-19 pandemic points to an alarming increase in these numbers. The current pandemic provides us with an opportunity to shine a light upon a serious issue that was experienced at epidemic levels in this country long before 2020 – too many Australians have suffered in silence for too long.

This White Paper captures the seriousness and scale of loneliness in Australia. Through robust evidence-based research, the paper presents loneliness as it is - a serious public health issue with enormous implications for our economy and society. The impact of loneliness on Australian communities is significant; its impact is destructive, yet widely misunderstood.

Ending Loneliness Together is calling for a national loneliness response that is commensurate with the damage loneliness causes to the lives of too many Australians. This White Paper marks the launch of Australia's first national organisation to tackle loneliness – a coalition that will bring together our renowned academic leaders in this field, together with collaborators in the private and not-for-profit sectors. This White Paper warrants widespread attention, and a serious policy and political response.

I want to recognise, in particular, the leadership of Dr Michelle Lim, plus the Scientific Advisory Committee and board members of Ending Loneliness Together. We would not be at this point without their commitment to this cause.

It's so important that there is bipartisan support for action on loneliness. I look forward to working constructively with Dr Fiona Martin MP, the Liberal member for Reid and my Co-Chair of the Parliamentary Friends of Ending Loneliness Together Committee, to advance this vital work. We are committed to working with Ending Loneliness Together to help make this happen.

Mr Andrew Giles MP
Co-Chair
Parliamentary Friends of Ending Loneliness

Contents

Executive summary

Ending Loneliness Together in Australia is the first white paper to highlight the growing problem of loneliness in Australia and its significant impact on the social, health, and economic wellbeing of the Australian community.

This paper brings together the latest research and data on the prevalence of loneliness. It identifies communities that are especially vulnerable to loneliness, and outlines the policy, practice and process pathways that can be modified and adapted to combat loneliness effectively. The impact of loneliness is broad and deep; it cuts across all sectors of our society. Consequently, this paper throws the spotlight of attention on a subset of priority areas in which loneliness is a challenge.

Loneliness is a complex social, health and economic issue that requires immediate and significant attention. Loneliness was already a serious problem in Australian communities before the COVID-19 pandemic began, with some describing it as one of the most pressing public health issues of our time. The COVID-19 crisis has brought loneliness to the fore and serves as a powerful reminder of just how important meaningful social relationships are.

One in two Australians reported feeling lonelier since the onset of the COVID-19 pandemic. The road to recovery from the COVID-19 pandemic will be long and arduous – with significant costs to the Australian economy. There is a need for strong positive leadership across Local, State, and Federal governments in order to make a real impact on combatting this major public health issue facing Australians. We therefore advocate for a National Loneliness Response Strategy to End Loneliness Together.

Three key facts about loneliness

1 **Loneliness is a critical issue of our time**

Loneliness carries risks associated with poorer health outcomes, lower workplace productivity, and decreased quality of life, yet remains severely neglected within our communities. It is not routinely monitored and consequently not well managed.

2 **Loneliness is not equivalent to social isolation**

Loneliness is not equivalent to social isolation. Solutions that reduce social isolation may not reduce loneliness.

3 **Loneliness is a multifaceted issue**

Loneliness is a consequence of a multitude of factors and therefore solutions will differ across different communities and individuals. A one-size-fits-all solution will not work.

Three key recommendations to address loneliness

1 Invest and be informed by Australian-based research

We need to extend the current Australian evidence base to understand Australian-specific factors underpinning loneliness in our community. Significant gaps in the evidence base need specific attention, including work on vulnerable groups.

We need to build a dynamic national database specific to loneliness and its correlates and risk factors. In doing so, we can rapidly translate accurate data to improve current practices and policies.

2 Develop and deliver system-wide frameworks

We need to develop and deliver a National Outcomes Measurement Framework to demonstrate improvement in loneliness outcomes. This tool will facilitate consistency in outcomes evaluation across research, industry, and service delivery sectors.

We need to develop a Meaningful Relationships Framework which can augment current solutions and enable more targeted responses to loneliness.

3 Connect and empower people to take action

We need to integrate the diversity of people who are lonely and build relevant, engaging, effective and safe solutions for different groups of people, including our most vulnerable and marginalised communities.

We need to empower our community and support informal and non-informal initiatives that can make a difference.

Five key calls to action

1 Unite and work towards a common goal

We need to unite and work together across all sectors in order to develop a relevant, feasible, and impactful National Loneliness Strategy.

2 Deliver an evidence-based community awareness campaign

We need to empower people experiencing loneliness to reach out, connect with others in a dignified and non-stigmatising way, and to empower people who can help others.

3 Accelerate the translation of evidence-based practice & policy

We need to harness up-to-date scientific evidence, trialing a range of interventions targeting individuals, local communities, and environmental solutions which can then be rapidly translated and implemented in current practices and relevant policies.

4 Equip service providers

We need to equip health, social, community, aged care and education service providers on how to identify, monitor, redirect, or intervene with individuals at risk of distressing or enduring loneliness.

5 Develop a national community database

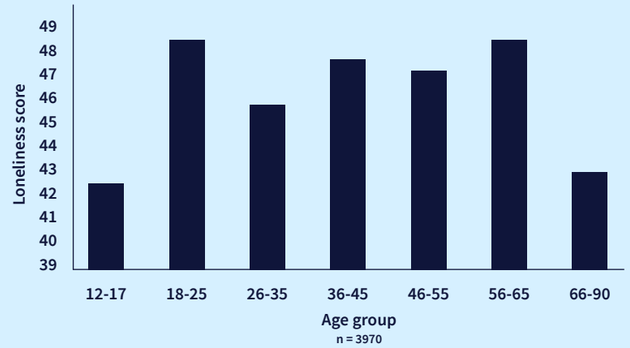
We need to develop a database of community programs designed to reduce loneliness, in order to redirect at-risk individuals to the appropriate local solutions.

1

Understanding loneliness in Australia

Loneliness in Australia

Figure 1 Loneliness across the lifespan



1. Loneliness severity as assessed by the psychometrically- validated University of California Los Angeles Loneliness Scale. Estimates based on pooled data from the Australian Loneliness Report (2018) and Young Australian Loneliness Survey (2019). Acknowledgements to Swinburne University, Australian Psychological Society, and VicHealth.

What is loneliness?

Loneliness is defined as an *aversive and subjective feeling of social isolation* that arises when an individual perceives that the quality or quantity of social relationships that they have is less than what they desire[1]. A substantial body of evidence shows that when people feel lonely, this can have a detrimental impact on their wellbeing, health, productivity, and functioning in daily life.

Loneliness is *not equivalent to social isolation*, which is an objective measure of the number of friends, family, or other social connections that an individual has and the frequency of contact with these social connections[2,3]. While social isolation and loneliness can both occur at the same time for an individual, they refer to different aspects of an individual's social relationships.

One in four Australians report problematic levels of loneliness.

How lonely are Australians?

Loneliness can be difficult to assess accurately due to its subjective nature, stigma, sampling issues, and measurement error. In studies that have used psychometrically robust scales, there is no well-validated cut-off score to help identify who is (or is not) lonely and may benefit from gaining help. However, based on Australian online surveys conducted in 2018 and 2019, it is estimated that at least one in four Australians aged 12 to 89 experience problematic levels of loneliness[4,5]. The estimated prevalence of problematic levels of loneliness[1] is around 5 million Australians at any given time.

Figure 1 shows the severity of loneliness across 3970 Australians – with those aged 18 to 25 years and 56 to 65 years showing increased vulnerability in 2018-2019 online surveys. We note however that these data were collected online and may skew results for the older group. The UK Office of National Statistics indicated that those over the age of 75 years also report vulnerability to loneliness[6].

Loneliness is a signature concern of the COVID-19 Pandemic

More recent data, collected between March and April in 2020, indicate that one in two Australians reported feeling lonelier since the onset of the COVID-19 pandemic[7].

Social restrictions such as physical distancing, the shift to working from home and online learning, increased isolation and restrictions in travel and quarantine are expected to be in place to some degree from 2020-2021 until a vaccine is readily available. We expect that adhering to these physical distancing guidelines in the longer term will add barriers to initiating and maintaining meaningful social relationships and lead to further increases in loneliness.

What makes people vulnerable to loneliness?

Loneliness itself is not a pathological condition, but rather should be seen as a natural signal to build or regain connections with others. However, for some people, reaching out to develop and, or maintain meaningful social connections may be more difficult. Indeed, problematic and enduring periods of loneliness are often a consequence of multiple risk factors, as outlined below.

Social transitions at different ages

Prevalence rates differ from study to study and are sometimes influenced by different measures of loneliness. Although loneliness affects people of all ages, depending on the sample, most studies have identified two vulnerable age groups - namely young people and older adults[8]. Both age groups are marked by developmental or transitional life changes that can increase the risk of, or act as a trigger for, loneliness.

For younger people, typical transitions such as moving away from home or starting university[9] can increase their vulnerability, whereas for older adults, retirement from work, changes in living environment (e.g. moving to retirement living or an aged care facility), bereavement and widowhood, financial pressures, and declining physical health (e.g. chronic illness, physical disability, sensory impairment) each increase the risk for loneliness[10].

Loneliness is the consequence of multiple risk factors and can differ depending on a person's vulnerability and social environment.

Other demographic factors

Single parents, people with a disability, carers, those from low socio-economic backgrounds, those with a migrant background, those who are from non-English speaking backgrounds, and those who live alone, are more likely to be vulnerable to problematic or enduring levels of loneliness.

Socio-environmental factors

Other risk factors for loneliness include socio-environmental factors, such as the culture and climate within workplaces and the way that social communication tools are used. Additional factors, such as urban design, access to community spaces (e.g., parks, libraries, neighbourhood houses) and transport accessibility, are likely to facilitate a person's capacity to initiate and maintain meaningful social connections. However, rigorous research is needed to understand how these factors contribute to the persistence and severity of loneliness.

The stigma of loneliness

While one in four people report feeling affected by loneliness, the stigma of loneliness means that many more people are uncomfortable talking about their feelings of social isolation and disconnection. This means that there are countless Australians living with persistent loneliness who do not access the help that is available in their community. Equally, the stigma of loneliness makes it difficult for service providers to identify, engage with and support people experiencing, or at risk of, loneliness.

No amount of investment in services and interventions to reduce loneliness will be successful unless the stigma of loneliness is also addressed.

In 2010, the Mental Health Foundation in the United Kingdom reported that one in three people (30%) aged 35-54 would be embarrassed to admit to feeling lonely, compared to 42% in younger adults, and 23% of those aged over 55 years[11]. Research commissioned by the UK Campaign to End Loneliness also showed that 92% of survey participants thought that people are scared to admit to feeling lonely. This reluctance to talk about feeling lonely and/or socially isolated adds to the burden of loneliness, so where does it come from?

One line of evidence suggests that people who experience loneliness fear how they will be judged by their community – the social stigma. Such concern may have some grounding in reality. For example, evidence reported by the Campaign to End Loneliness (UK) suggests that people who feel lonely are likely to be judged negatively by the general public[12]. When asked 'What do you think people imagine about those who are lonely?' some of the top responses were 'there is something wrong with them', 'they are unfriendly' and 'it is their fault they are lonely'.

> **There is much to do to overcome loneliness. The huge stigma surrounding it is clear, which is slowing down efforts to combat it.**
>
> **Laura Alcock-Ferguson, Former Executive Director, Campaign to End Loneliness, UK**

Society's attitudes to loneliness can also be detected by examining how lonely people are depicted in mainstream news, television and film. Systematic analysis of media reports of loneliness in older adults shows that it is commonly viewed as an indication of personal failure[13].

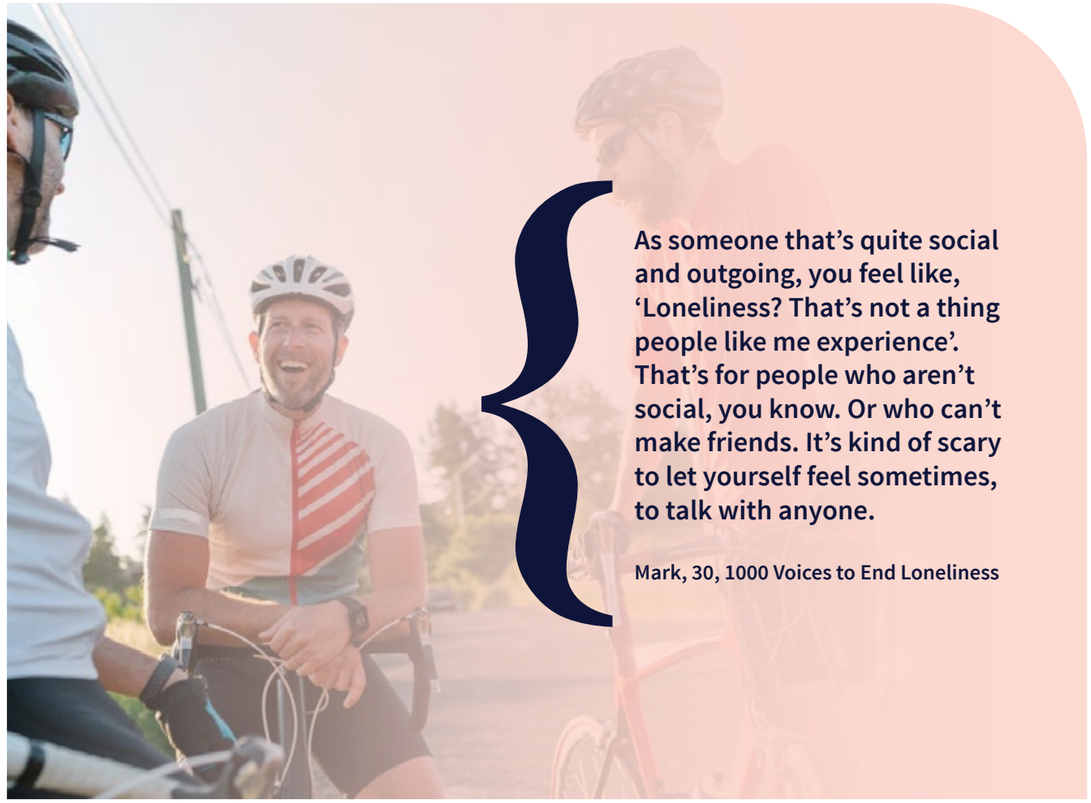
Another line of evidence suggests that a bigger source of stigma about loneliness comes from how lonely individuals judge themselves. This self-stigmatisation of loneliness involves feelings of shame, with women in particular reporting more shame about feeling lonely than men, and feelings of shame about loneliness being higher in younger than older adults[14].

People who self-stigmatise loneliness may also experience a loss of self-esteem and attempt to keep their feelings of loneliness secret – all of which serves to further hinder social reconnection. The evidence highlights that in order to tackle loneliness effectively, there is a need to lift the stigma associated with it. Such efforts need to begin by improving community understanding about loneliness as a normal experience that motivates us to connect with others and repair or rebuild our social bonds.

That loneliness itself is an issue and predicts poorer outcomes across social, community and health factors itself is not in the awareness of our communities. We need to increase the awareness of loneliness and reduce the stigma attached to this experience. In this work, we need to encourage 'lonelier' people to reach out but also 'less lonely' people to reach in to both familiar and less familiar social networks.

Policy Implication

An evidence-based effective community awareness campaign is needed to improve knowledge and understanding of loneliness and challenge public misconceptions of loneliness.



As someone that's quite social and outgoing, you feel like, 'Loneliness? That's not a thing people like me experience'. That's for people who aren't social, you know. Or who can't make friends. It's kind of scary to let yourself feel sometimes, to talk with anyone.

Mark, 30, 1000 Voices to End Loneliness

Loneliness and health

Loneliness is detrimental to health and is a growing public health issue, in both developed and developing countries alike.

Mortality

The body of epidemiological research shows that loneliness is associated with a 26% greater risk of premature mortality and that living alone or being socially disconnected is associated with a similar increased risk of early death[15]. This means that how you feel about your relationships is just as important as the number of social connections you have, or your living arrangements.

I was hospitalised with drug-induced psychosis. My loneliest point lasted about 6 months. I couldn't even leave my house. I felt so distant—like everyone was just going to judge me.

Daniel, 30, 1000 Voices to End Loneliness

Poorer physical health outcomes

It has been shown that loneliness is associated with numerous chronic health conditions. For instance, those reporting loneliness have been found to have a higher incidence of breast and colorectal cancer[16].

Having poor social relationships, defined as both loneliness and social isolation, is associated with a 29% increase in the incidence of coronary heart disease and a 32% increase in the risk of stroke[17]. Furthermore, people who are lonelier show poorer cardiovascular health indicators, such as elevated blood pressure, elevated levels of cholesterol and impaired cardiac function[18].

Having meaningful social connections protects us from early death and poor health outcomes.

Despite the growing evidence, loneliness is not widely recognised or routinely assessed as an indicator of importance in health sectors. There are no clear frameworks to guide General Practitioners and other medical practitioners on when or how to assess, refer, or monitor people who are lonely.

Policy Implication

A framework to guide health practitioners and community organisations is required to identify, assess, monitor, and refer individuals experiencing loneliness to existing services and other informal pathways.

Poor mental health outcomes

Loneliness predicts future poorer mental health severity, including depression, social anxiety and paranoia[19], and increases the odds of having a clinically diagnosed mental disorder, including phobias, depression and obsessive-compulsive disorder[20]. Loneliness is also associated with increased suicidality and parasuicide[21]. Those with severe loneliness are 17 times more likely to have made a suicide attempt in the past 12 months[22].

Loneliness is a precursor to poorer mental health outcomes, including increased suicidality.

Loneliness is also an important problem for those with mental ill-health. For example, in the Second Australian National Survey of Psychosis, 75-94% of people surveyed reported that they felt lonely[23]. Loneliness was identified as being a top challenge to overcome, together with vocational opportunities and financial stability[24], but is rarely seen as a major focus of mental health treatment and psychosocial rehabilitation[25]. In fact, loneliness is more often considered a byproduct of mental ill-health which will end once symptoms resolve. There appears to be limited recognition that one can remain lonely even after receiving mental health care and treatment. Mental health practitioners do not readily differentiate social isolation from loneliness and do not undergo training to identify, monitor or target loneliness as a main outcome of therapeutic treatment or support.

Policy Implication

Loneliness should be an identifiable target in mental health service and funding models and integrated within all mental health professional training.

The value of peer support and lived experience

There is growing recognition of the value of lived experience expertise and this is important in both supporting people who experience loneliness and also in developing innovative ways to respond to loneliness. Peer support workers are individuals who utilise their lived experience of mental distress and recovery to provide direct support to others. Peer support workers are increasingly employed throughout the Australian mental health system, enabling mutual support based on intentional sharing, mutuality, connection and empathy[26].

> **I always found myself being alone in the most important times. That's a lonely process. Being human is that connection with others—being able to talk things through.**
>
> **Sonya, 48, 1000 Voices to End Loneliness**

Researchers are now becoming more aware of the value of having people with lived experience actively engaged in all aspects of research processes to facilitate engagement and innovation, and ensure people who have experienced loneliness and mental distress have a voice in developing solutions[27].

Policy Implication

Peer to peer models of support that can facilitate mutual support can further augment current models of care within mental health services. But significant investment is required to trial effective peer support models that can be easily integrated in current service delivery models.

Loneliness in children, adolescence and young adulthood

While loneliness is often depicted as a problem for older adults, it is increasingly clear that this is only part of the picture. Children, adolescents, and young people are particularly vulnerable to feeling lonely. For example, recent UK research indicates that 11.3% of children age 10-15 years reported that they were "often" lonely, and that this was more common among younger children aged 10 to 12 years (14.0%) than among those aged 13 to 15 years (8.6%). Minimal data is available for school-aged children in Australia. However, in the Young Australian Loneliness Report, young people aged 18 to 25 years reported significantly more loneliness than adolescents aged 12 to 17 years[4].

> **You don't talk to your best guy friend like, 'Hey bro, I'm just feeling really sad right now'. You don't do that when you're a teenager. Instead, you're like, 'When are we hanging out?' I learnt to repress, rather than being okay with it.**
>
> **Ade, 27, 1000 Voices to End Loneliness**

Loneliness in children and adolescents plays out in poorer mental and physical health outcomes, including increased rates of anxiety, depression, suicidal ideation, and substance use[28, 29]. Such effects are expected to increase as physical distancing and home-schooling continues in response to curbing COVID-19 infection rates[30]. There is also a growing recognition that loneliness in children can have a negative impact on students' attendance and engagement at school, academic attainment, and overall school experience.

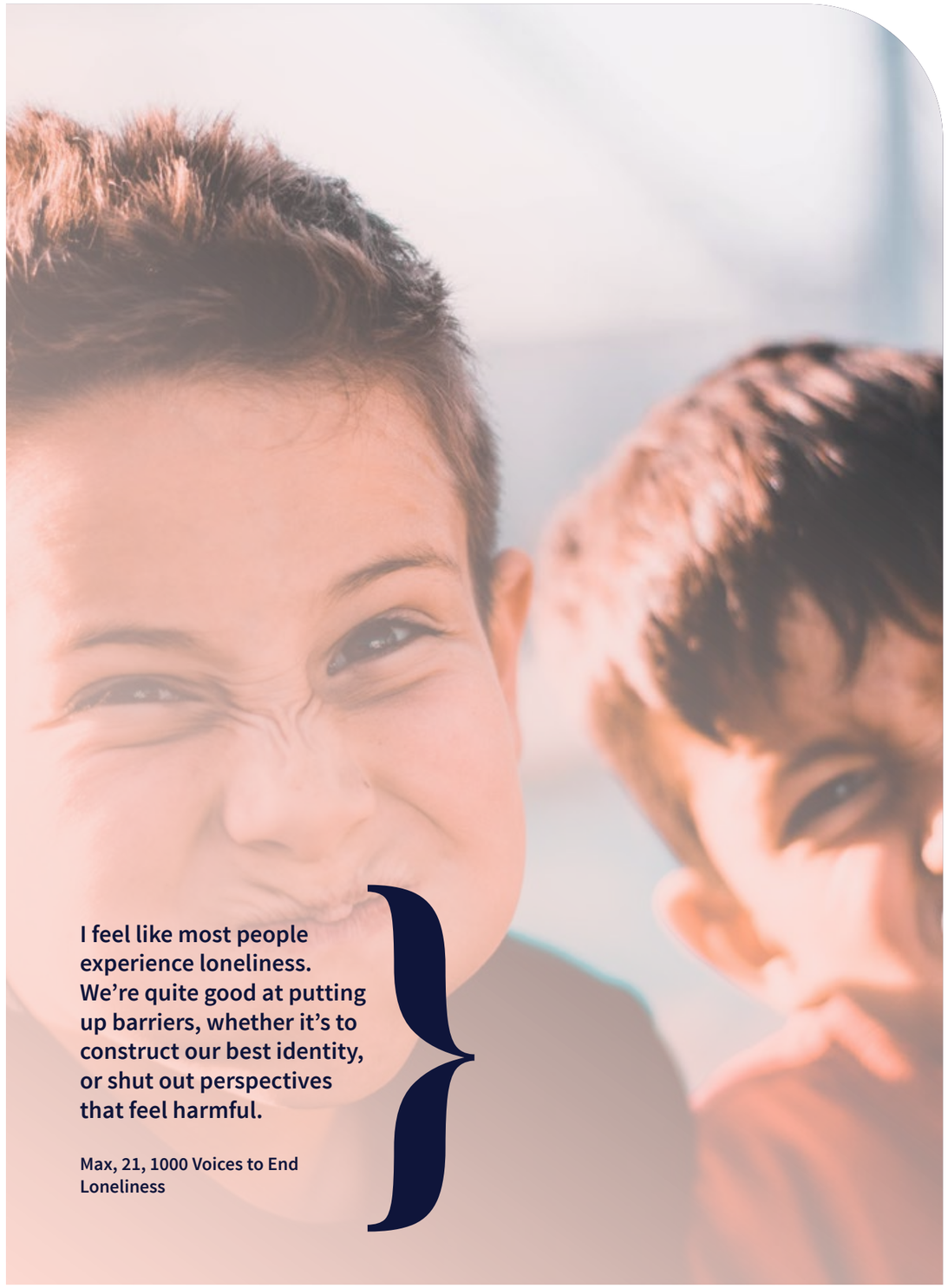
Based on this growing evidence, there is increasing value in teaching preventative measures within school, vocational, and higher education institutions. In these programs, educators can help implement evidence-based strategies to tackle loneliness in vulnerable young people.

Learning about the consequences of loneliness, how to cope when it occurs and the skills to reconnect with others may have a positive, life-long impact for future generations. Efforts are now underway to develop an evidence-based teaching curriculum to achieve these goals. Integrating teaching about the value of social connections and relationships will benefit young people in Australia but will also require an ongoing systematic investigation.

A holistic approach that can address the educators' own social wellbeing, and equipping services that support children, young people, and families (e.g., maternal and child health, playgroups, youth groups) is more likely to be effective as the young person is embedded within a complex social network.

Policy Implication

Guidance on loneliness and belonging must be integrated into a national school curriculum. An effective evidence-based approach to loneliness in children, adolescents, and young people should be embedded within school curriculum and uniformly adopted within the education sector.



I feel like most people experience loneliness. We're quite good at putting up barriers, whether it's to construct our best identity, or shut out perspectives that feel harmful.

Max, 21, 1000 Voices to End Loneliness

Loneliness in older adulthood

Loneliness in older adulthood is an issue that is widely recognised across different global initiatives. Recent results from a representative Australian sample indicated that 46% of older adults (aged 65 years or above) reported feeling that they lacked companionship at least sometimes[5]. Similar results have been found in the UK and in a separate Australian sample, where 32% of older people reported feeling lonely sometimes and 8-9% reported feeling lonely often or always[31]. Rates of emotional loneliness are highest in Australians aged 75 years and above, estimated to be 19% in 2016[32].

While not all older adults are lonely, older adults may be particularly prone to loneliness due to life changes that commonly occur later in life, including the death of a partner, family or friends, retiring from work, financial pressures, deteriorating physical health, increased likelihood of living alone, and generally having fewer close personal relationships. Conversely, living with others, being married, having a confidant regardless of whether it is a friend, relative, or neighbour, are all protective factors that reduce the risk of loneliness in older adults[33, 34].

Importantly, older adults who are lonely have a higher risk of functional decline and cognitive impairment. Lonely older adults have a 58% higher risk of developing dementia compared to their less lonely peers[35]. Loneliness is also an independent risk factor for admission to long-term care, after taking into account established risk factors such as age, depression, dementia, disability and social isolation[36].

I think feeling the warmth and the love of a family makes all the difference. I wasn't alone in those sad moments. Other than getting into bed, those are the hardest times. I'd stuff my pillows to one side of the bed so if I roll over at night I have something to touch.

Carol, 73, 1000 Voices to End Loneliness

Empirical research evidence surrounding the extent of loneliness in residential aged care facilities is remarkably scant. Some studies have indicated that the prevalence of loneliness in long-term care facilities varies between 37% and 72%, with rates of 'severe' loneliness to be approximately double that for aged care residents compared with community-dwelling residents[37]. Recent visitor restrictions introduced during the COVID-19 pandemic, along with interruptions to residents' daily activities (e.g., cancellation of group activities and communal dining) means that loneliness is likely to have increased. Yet, despite the negative consequences for quality of life, health and wellbeing, addressing loneliness in this sector has not been prioritised.

A wide range of interventions have been developed to tackle loneliness among older people, including increasing community participation including volunteering. A consistent finding is that adaptability, a community development approach, and productive engagement all contribute to the success of interventions[38].

Policy Implication

Work collaboratively with older people to develop protective and tailored strategies against distressing levels of loneliness, including a focus on building stronger social networks across the ages, within their communities and catering to specific social needs. We also require significant coordination within community residential and aged care settings to address loneliness in older adults who are lonely.

Lonely communities

Those who live alone, especially in urban areas, are more likely to feel lonely[39]. Similarly, those who have less frequent contact with neighbours or interact with fewer people in their communities are more likely to experience feelings of loneliness[40].

In the Australian Loneliness Report, it was found that Australians are more likely to have contact with and call on friends and family for help, but rarely look to their community for assistance. A third of Australians (34%) have no neighbours they see or hear from on a monthly basis, and nearly half (47%) report that they have no neighbours they can call on for help[5].

Despite the challenges experienced by those who are isolated and lonely within their communities, it is at this level that many opportunities for building meaningful social connection are available. The establishment of accessible and inclusive spaces and places that foster social connection is one part of the puzzle. Alongside this is the need to raise public awareness about loneliness in order to catalyse action to bring together people in communities. The COVID-19 pandemic of 2020 saw an array of creative grassroots actions to overcome the isolation brought about by lockdown regulations, revealing a reservoir of local energy and capacity that might be harnessed to support those experiencing enduring loneliness.

Local councils, health care providers and community service organisations have central roles to play in these efforts. A first step to developing meaningful social relationships amongst community members is to design and build safe environments for people to come together to interact.

> **I felt lonely here for a longer period. I felt a sadness inside; an emptiness. Missing the people we love. When you're a foreigner, you always go back to the people you left behind.**
>
> **Sara, 47, 1000 Voices to End Loneliness**

Policy Implication

That Federal, State, and Local Governments and other key stakeholders can increase valuable social opportunities and purposeful activities so that people can be encouraged to engage in meaningful social interactions.

From there, valuable opportunities for social connection can also be created by opening up pathways to engagement with community centres, sport and leisure clubs, religious organisations, hobby and interest groups, civic associations and a range of other local groups and services. Indeed, the evidence indicates that facilitating involvement in purposeful activities within a group environment is an effective strategy for reducing both social isolation and loneliness[41]. Specifically, using strength-based approaches to build positive social connections, including through volunteering and interest-based activities is more likely to increase a sense of meaning and purpose in people's interactions.

One emerging approach that has gained popularity is the use of social prescription which has been adopted in primary health care in the United Kingdom. This involves identifying and referring individuals with health and social needs to activities available in their local communities, often via a link worker who can provide tailored advice and support[42]. While these types of interventions reduce social isolation, the impact on loneliness is unclear. This model requires further exploration and evaluation in the Australian context, and its implementation will be facilitated by the availability of clinical assessment tools to identify those experiencing loneliness who may benefit from engagement with a local program or activity.

Policy Implication

Existing social prescription models should be designed to not only reduce social isolation but to also reduce loneliness.

Any initiatives at the community level need to move forward with an understanding that the factors contributing to loneliness, and the strategies that may be beneficial for addressing these, will vary according to a person's life stage, cultural background, social history, and mental and physical health status, among other factors.

One size certainly does not fit all in regard to acceptable and suitable strategies for reducing loneliness. This highlights the need for actions to be informed by careful needs assessment, and the value of working with local organisations and community members in developing appropriate solutions.

Lonely workplaces

Approximately 37% of Australian workers feel lonely[43] while nearly a quarter do not engage in any activities to connect them with their colleagues[44]. The flow-on impact on workplace safety, absenteeism, employee retention, and business productivity means that workplace loneliness is also a significant issue for the Australian economy.

Workplace loneliness affects any employee regardless of age, gender, culture or level of seniority, from the newest intern to the chief executive officer[45]. National and international research findings indicate that loneliness in the workplace has a negative effect on both employees and the organisations employing them.

Loneliness is associated with poorer job performance and job satisfaction, lower organisational commitment and reduced creativity. Lonely employees report more workplace errors, take more sick leave and have a stronger intention to quit[46].

The COVID-19 pandemic has also meant a rapid and widescale shift to working from home. The rapid changes in the design and structure of Australian workplaces, including increases in remote working, a shift to the 'gig' economy, and greater casualisation in employment[43], can increase the risk of feeling lonely. While intended to maintain productivity, emerging evidence suggests that such shifts to the way we work have also created a range of interconnected problems, including loneliness and lack of social connection, lack of creativity and motivation when working at a distance, and decreased employee loyalty[47]

Workplace loneliness is an unpleasant feeling that occurs when employees are dissatisfied with the relationships they have with the people they work with, and the organisations they work for.

Many Australians spend a large proportion of their life at work, emphasising the need for a much greater focus on employee health and wellbeing. Finding better ways of designing workplaces to reduce loneliness and build stronger connections with co-workers will have a significant benefit on employee wellbeing and organisational productivity.

> **I didn't know there was such a thing as a returning expat. You come back — and nobody really thinks like you anymore.**
>
> **Parthena, 55, 1000 Voices to End Loneliness**

Policy Implication

We need the National Workplace Initiative to assist businesses to address workplace loneliness and support employees to develop and sustain strong connections between co-workers. This includes workplace policy changes around the impact of working from home and to safeguard against loneliness in a new COVID-19 working environment.

The economic cost of loneliness

Recent studies have revealed the economic cost of loneliness to health and social care services. In 2017, the costs to Medicare in the USA arising from loneliness and social isolation were estimated at $6.7 billion annually, while UK data suggest that the average cost of loneliness in older adults was around £12,000 per person, over 15 years[48]. Likewise, interventions that effectively reduce loneliness were estimated to result in cost savings of £1,700/person in a general population cohort, or £6,000 in those who are lonely most of the time, over ten years[49]. Similar cost estimates are currently lacking in Australia.

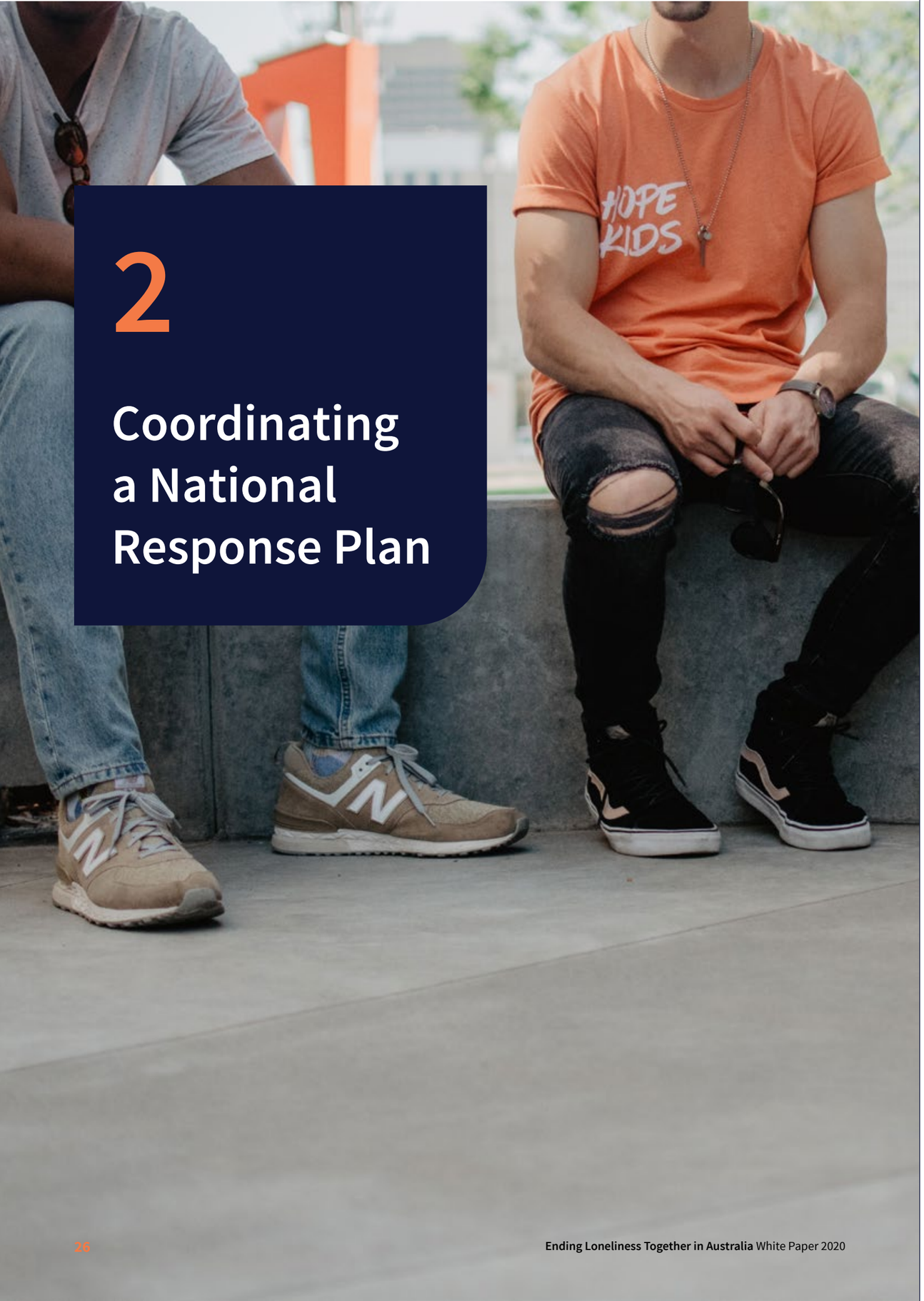
These increased costs of health service use may be related, in part, to the chronic health conditions associated with loneliness. Accordingly, the evidence shows that lonely people are more likely to visit their physician and have increased rates of hospitalisation and emergency department visits[50, 51]. However, loneliness predicts increased health service use even after accounting for the presence of chronic illness. That is loneliness in older adults is associated with higher rates of physician visits[52], even after controlling for other health conditions. These findings suggest that frequent contact with GPs and other health care providers may be more directly related to the experience of loneliness. The increased use of health care services by people experiencing loneliness could be providing the social connection and support that is felt to be missing[53].

Identifying approaches that are not only effective in alleviating loneliness but also cost-effective needs to be a priority for government and health care providers to ensure optimal service delivery. However, a recent review highlights the lack of economic evaluation studies in Australia[54]. One Australian modelling study evaluated the cost-effectiveness of an educational program in older women experiencing loneliness and the provision of computer and internet training as part of a volunteer visitor scheme. Overall, there were likely considerable returns for every dollar invested[55], although these interventions need to be further evaluated to ensure that they do indeed deliver what the current limited evaluation studies are suggesting they can deliver[56].

Further, the costs of loneliness arising from reductions in workplace productivity and lowered educational achievement remain unknown, therefore evidence-based information to guide policy and practice is sorely needed.

Policy Implication

We need to assess the economic burden of loneliness and identify the cost-effectiveness of different interventions that are designed to address loneliness.



2

Coordinating a National Response Plan

A coordinated national response plan

While ending loneliness completely may not be possible, we can and we must work together to greatly reduce distressing and enduring levels of loneliness.

Loneliness is an issue that people identify with but it is at risk of being trivialised as it remains a widely misunderstood and poorly addressed issue. It is more important than ever to address loneliness as we progress beyond the COVID-19 pandemic. We need to rectify public misconceptions about the significance of loneliness and radically enhance our current models of care in order to increase impact and sustainability.

Loneliness is also an issue plagued with common misconceptions. These misconceptions can also lead to ineffective strategies and solutions. There is robust evidence that loneliness is a consequence of multiple risk factors, from health (physical, mental, cognitive, brain, biology, genetics), to demography (age, gender, living alone status) and socioenvironmental factors (workplace, digital use) to name a few[57]. Furthermore, as predictors of loneliness differ from person to person so, too, will the solutions.

We should consider the complexity of this issue to be more targeted in our response. A Conceptual Model of Loneliness[57] that accounts for the synergistic interplay of risk factors and underpinned by a socioecological framework is already available. Details of a guide on how to use this will be made available on our website.

There is no one-size-fits-all solution and therefore we will need to consider different forms of solutions that can make an impact across different levels of society, from the individual, to their relationships, to the communities they live in.

Because of these complexities, Australia needs a coordinated national response, driven by evidence-based action and solutions to combat the growing issue of loneliness. We need to unite to understand how loneliness differs from social isolation in order to make a real impact on the available solutions. In doing so, we can reduce the economic burden of loneliness through improvements in health, community cohesion and the development and delivery of effective solutions. To make an impact, loneliness as an issue requires significant investment and efforts across Local, State, and Federal government levels.

A coordinated national response driven by evidence-based research and solutions needs immediate implementation.

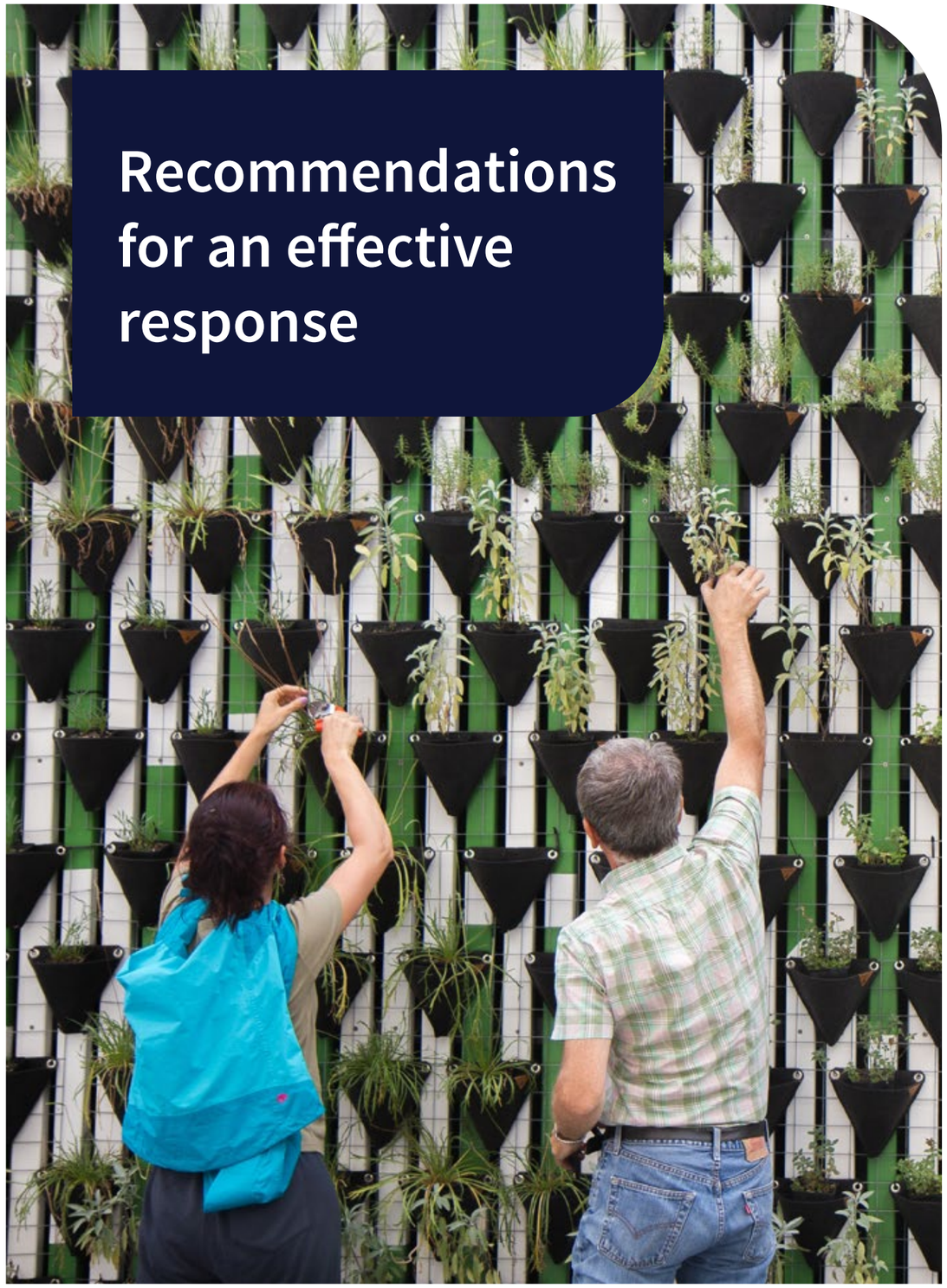
One step towards a coordinated plan is to increase multi-partisan support across all levels of government, and to bring together advocates who can champion the issue across all sectors from health, community, social services, aged care, industry and academia.

Loneliness should be identified and recognised as an important issue across all levels of government and have multi-partisan support before we can even consider a dedicated government portfolio, similar to that of the UK Minister for Loneliness. In doing so, we can better scale the capacity of the workforce for tackling loneliness, ensure rapid translation of the existing evidence into community, social, and health practices, and foster evidence-based policy making.

Loneliness affects all Australians and we urge all levels of government to invest time, attention and funding in developing and implementing a comprehensive, coordinated national response which can unite all sectors. Once we adopt a unified understanding of this issue, we can then work together to take proactive steps towards developing and delivering effective informal and formal solutions.

We detail six recommendations across three areas that will allow us to respond more effectively in this coordinated response.

Recommendations for an effective response



Invest and be informed by rigorous evidence-based Australian research

1 Extend the current Australian evidence

Currently, there is no investment in rigorous scientific loneliness research within Australia and much of the evidence stems from other countries. Australia has its own regional and context-specific factors that need to be accounted for. Furthermore, loneliness is underexamined in specific cohorts (e.g. carers, those who are economically disadvantaged, multicultural community groups, Aboriginal and Torres Strait Islander peoples).

Fields such as urban design and planning, health and social economics, and workplaces are all areas that require more evidence-based research. There is much to learn about how we can harness digital technology to develop and maintain meaningful social relationships especially as the digital divide narrows and an increased acceptance of using technology to communicate becomes more widespread. Innovative tools should not just increase social networks but also be designed to facilitate meaningful and purposeful social interactions.

2 Build a national database to facilitate effective translation into practice

Existing epidemiological datasets should incorporate psychometrically validated measures of loneliness and avoid relying on single-item measures prone to biasing prevalence data. Loneliness is also an issue that is highly conflated with a wide range of factors such as poor mental health and physical health symptom severity, and specific demographic factors including socioeconomic status.

In developing a dynamic national database specific to loneliness, we can generate more accurate solutions which reflect the differential impact of loneliness on our community. This national database will allow us to monitor the course of loneliness over time and focus on different vulnerable communities.

Scientific experts in loneliness hold a robust body of knowledge and evidence that is not always accessible to nonacademic industries. While loneliness is a topic that resonates with everyone, it is plagued with misconceptions and simplistic solutions. It is crucial to engage scientific experts who are up to date with the latest evidence, who can conduct rigorous research, and who can translate high quality data into practice and policy.

Develop and deliver system-wide frameworks

3 Develop a National Outcomes Measurement Framework for loneliness

Australia requires a National Outcomes Measurement Framework to better support and equip communities and organisations dedicated to addressing loneliness. As more communities and organisations attempt to address loneliness, both the absence or inappropriate measurement and evaluation of programs will mean that we cannot accurately determine levels of safety, impact, or cost-effectiveness.

Anecdotal evidence or poor-quality data cannot be taken as a reliable indicator of program effectiveness. Further, there is the potential to exacerbate social exclusion and elicit distress if individuals take up solutions that do not adequately cater to their social needs and preferences.

In order to facilitate comparisons across samples, we recommend where practical, to use the loneliness measures recommended for service delivery providers and academia within the forthcoming Loneliness National Outcomes Measurement Framework.

4 Develop a Meaningful Relationship Framework to underpin current solutions

Because loneliness is a complex issue, we require a more innovative and up to date framework to address loneliness within current models of practice and care. Improving the quality of relationships should also be a focus – as opposed to a sole reliance on increasing the number of social ties.

It is well established that our social needs are highly complex – individuals vary where they place value within social networks and these change over the life course. Furthermore, there are also social relationships that may cause stress, conflict, or do not meet the individual's social needs.

In order to facilitate the development and maintenance of meaningful relationships, a framework needs to promote healthy relationship practices such as increasing reciprocity, trust, empathy, and positive shared interactions. There is evidence that shows that these practices can increase closeness between two people and improve the quality of ties.

Connect and empower people to take action

5 Connect with the diversity of lonely voices

What '*causes*' loneliness in one person will differ from another. By integrating the voices of people with a lived experience of loneliness across different contexts, we can better design and deliver more consumer relevant solutions. This includes participatory research and human-centred design practices, including establishing a lived experience panel that can work alongside Ending Loneliness Together and their stakeholders.

We need to ensure the voices of people going through social transitions, across different ages, multicultural backgrounds, and First Australians are all well represented in order to design, develop and trial effective and engaging solutions, as well as to appropriately advocate for the diversity of our communities.

6 Empower our community

Community has an important role to play in ending loneliness and forming meaningful relationships are a crucial foundation from which individuals and communities can thrive. Broad community awareness is necessary to reduce the stigma associated with loneliness and empower Australians to support those experiencing it.

A movement that is inclusive, diverse and multi-faceted can engage all Australians in ending loneliness. Such a movement requires a combination of grassroots, informal and relationship-based initiatives as well as more formal government policy and program interventions.

Five key calls to action

We have identified five key calls to action that we can address now – many of which can be delivered via a coalition group such as Ending Loneliness Together.

1 Unite and work towards a common goal

Ending Loneliness Together can bring together all stakeholders including people with a lived experience, advocates of vulnerable groups, all levels of government (Local, State, and Federal), academia, and not-for-profit to corporate sectors to unify their understanding and approach to addressing loneliness. We can work together to develop a National Loneliness Strategy that is relevant, feasible, and impactful across all sectors.

2 Deliver an evidence-based community awareness campaign

We need to increase awareness of loneliness as an issue in our community. In this work, the community empower people experiencing loneliness to reach out and connect with others in a dignified and non-stigmatising way. Additionally, awareness campaigns should also empower others to help those more vulnerable. Specific messaging around building social connection can be nuanced across different cohorts of people and it is crucial to work with advocates and a variety of end-users and stakeholders.

3 Accelerate the translation of evidence-based practice & policy

Scientific evidence and knowledge are not always readily available to civil society and other stakeholders. Consequently, many are reliant on anecdotal evidence and may be uncertain about what works, what holds potential, what does not work or may even cause harm. A strategic approach is therefore required to facilitate the translation of the latest evidence to ensure the maximum benefit across all sectors. A database of this latest evidence and how it can be applied within our current systems and practices should be developed in collaboration across academia, government, and service providers.

4 Equip service providers

For more targeted responses, we should equip current health, social, community, aged care and education service providers on how to identify, monitor, redirect, or intervene with respect to individuals at risk of distressing or enduring loneliness. We can do so via direct training of practitioners and workers who see individuals who are lonely and further support them through delivering sector-specific resources.

5 Develop a national community database

A national database of all community programs and services tackling loneliness should be developed. We can map programs by areas, with specific attention to program type (e.g., from low to high intensity), target cohorts (e.g. older people) and level of evidence (e.g., evaluated or not). The database will help existing service providers to redirect at risk individuals to the appropriate local solutions.

References

1. Peplau L, Perlman D. Perspectives on loneliness. In: Peplau L, Perlman D, editors. Loneliness: a sourcebook of current theory, research and therapy. New York: John Wiley and Sons; 1982 [cited 2020 Nov 16]. p. 1-20.
2. De Jong Gierveld J, Havens B. Cross-national comparisons of social isolation and loneliness: introduction and overview. Can J Aging / La Revue canadienne du vieillissement [Internet]. 2004 [cited 2020 Nov 16];23(2):109–13. Available from: http://dx.doi.org/10.1353/cja.2004.0021.
3. Cornwell EY, Waite LJ. Social disconnectedness, perceived isolation, and health among older adults. J Health Soc Behav [Internet]. 2009 [cited 2020 Nov 16];50(1):31–48. Available from: http://dx.doi.org/10.1177/002214650905000103
4. Lim MH, Eres R, Peck C. The young Australian loneliness survey: understanding loneliness in adolescents and young adults. [Internet]. Swinburne University of Technology, VicHealth; 2019 [cited 2020 Nov 16]. Available from: https://www.vichealth.vic.gov.au/loneliness-survey.
5. Lim MH, Australian Psychological Society. Australian loneliness report: a survey exploring the loneliness levels of Australians and the impact on their health and wellbeing [Internet]. 2018 [cited 2020 Nov 16]. Available from: https://psychweek.org.au/2018-archive/loneliness-study/.
6. Office of National Statistics. What characteristics and circumstances are associated with feeling lonely? [Internet]. 2018 [cited 2020 Nov 16]. Available from https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10.
7. Lim MH, Lambert G, Thurston L, Argent T, Eres R, Badcock JC, et al. Survey of health and wellbeing – monitoring the impact of COVID-19. Swinburne University; 2020 [cited 2020 Nov 16]. Available from: https://www.swinburne.edu.au/media/swinburneeduau/research-institutes/iverson-health/Loneliness-in-COVID-19-15-07-20_final.pdf.
8. Nicolaisen M, Thorsen K. What Are Friends for? Friendships and Loneliness Over the Lifespan—From 18 to 79 Years. Int J Aging Hum Dev [Internet]. 2016 [cited 2020 Nov 16]26;84(2):126–58. Available from: http://dx.doi.org/10.1177/0091415016655166
9. Diehl K, Jansen C, Ishchanova K, Hilger-Kolb J. Loneliness at universities: determinants of emotional and social loneliness among students. Int J Environ Res Public Health [Internet]. 2018 [cited 2020 Nov 16]29;15(9):1865. Available from: http://dx.doi.org/10.3390/.
10. Victor C, Grenade L, Boldy D. Measuring loneliness in later life: a comparison of differing measures. Rev Clin Gerontol [Internet]. 2005 [cited 2020 Nov 16];15(1):63–70. Available from: http://dx.doi.org/10.1017/s0959259805001723
11. Mental Health Foundation. The lonely society? [Internet]. 2010 [cited 2020 Nov 16]. Available from: https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf.
12. Campaign to end loneliness: connection in older age [cited 2020 Nov 16]. Available from: https://www.campaigntoendloneliness.org/
13. Uotila H, Lumme-Sandt K, Saarenheimo M. Lonely older people as a problem in society – construction in Finnish media. Int J Ageing Later Life [Internet]. 2011 [cited 2020 Nov 16]26;5(2):103–30. Available from: http://dx.doi.org/10.3384/ijal.1652-8670.1052103
14. Manchester Institute of Education. The BBC loneliness experiment [Internet]. 2018 [cited 2020 Nov 16]. Avaiable from: https://www.seed.manchester.ac.uk/education/research/bbc-loneliness-experiment/
15. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality. Perspect Psychol Sci [Internet]. 2015 [cited 2020 Nov 16];10(2):227–37. Available from: http://dx.doi.org/10.1177/1745691614568352
16. Deckx L, van den Akker M, Buntinx F. Risk factors for loneliness in patients with cancer: a systematic literature review and meta-analysis. Eur J Oncol Nurs [Internet]. 2014 [cited 2020 Nov 16];18(5):466–77. Available from: http://dx.doi.org/10.1016/j.ejon.2014.05.002
17. Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. Heart [Internet]. 2016 [cited 2020 Nov 16]18;102(13):1009–16. Available from: http://dx.doi.org/10.1136/heartjnl-2015-308790
18. Cacioppo JT, Hawkley LC, Crawford LE, Ernst JM, Burleson MH, Kowalewski RB, et al. Loneliness and health: potential mechanisms. Psychosomatic Medicine [Internet]. 2002 [cited 2020 Nov 16];64(3):407–17. Available from: http://dx.doi.org/10.1097/00006842-200205000-00005
19. Lim MH, Rodebaugh TL, Zyphur MJ, Gleeson JFM. Loneliness over time: the crucial role of social anxiety. J Abnorm Psychol [Internet]. 2016 [cited 2020 Nov 16];125(5):620–30. Available from: http://dx.doi.org/10.1037/abn0000162
20. Meltzer H, Bebbington P, Dennis MS, Jenkins R, McManus S, Brugha TS. Feelings of loneliness among adults with mental disorder. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2012 [cited 2020 Nov 16];9;48(1):5–13. Available from: http://dx.doi.org/10.1007/s00127-012-0515-8
21. Stravynski A, Boyer R. Loneliness in relation to suicide ideation and parasuicide: a population-wide study. Suicide Life Threat Behav [Internet]. 2001 [cited 2020 Nov 16];31(1):32–40. Available from: http://dx.doi.org/10.1521/suli.31.1.32.21312
22. Stickley A, Koyanagi A. Loneliness, common mental disorders and suicidal behavior: findings from a general population survey. J Affect Disord [Internet]. 2016 [cited 2020 Nov 16];197:81–7. Available from: http://dx.doi.org/10.1016/j.jad.2016.02.054
23. Badcock JC, Shah S, Mackinnon A, Stain HJ, Galletly C, Jablensky A, et al. Loneliness in psychotic disorders and its association with cognitive function and symptom profile. Schizophr Res [Internet]. 2015 [cited 2020 Nov 16];169(1-3):268–73. Available from: http://dx.doi.org/10.1016/j.schres.2015.10.027
24. Lim MH, Gleeson JFM, Alvarez-Jimenez M, Penn DL. Loneliness in psychosis: a systematic review. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2018 [cited 2020 Nov 16];53(3):221–38. Available from: http://dx.doi.org/10.1007/s00127-018-1482-5
25. Badcock JC, Adery LH, Park S. Loneliness in psychosis: a practical review and critique for clinicians. Clin Psychol (New York) [Internet]. 2020 [cited 2020 Nov 16]; Available from: http://dx.doi.org/10.1111/cpsp.12345
26. Stratford AC, Halpin M, Phillips K, Skerritt F, Beales A, Cheng V, et al. The growth of peer support: an international charter. J Ment Health [Internet]. 2017 [cited 2020 Nov 16];28(6):627–32. Available from: http://dx.doi.org/10.1080/09638237.2017.1340593
27. Byrne L, Wykes T. A role for lived experience mental health leadership in the age of Covid-19. J Ment Health [Internet]. 2020 [cited 2020 Nov 16];29(3):243–6. Available from: http://dx.doi.org/10.1080/09638237.2020.1766002
28. Schinka KC, VanDulmen MHM, Bossarte R, Swahn M. Association between loneliness and suicidality during middle childhood and adolescence: longitudinal effects and the role of demographic characteristics. J Psychol [Internet]. 2012 [cited 2020 Nov 16];146(1-2):105–18. Available from: http://dx.doi.org/10.1080/00223980.2011.584084
29. Stickley A, Koyanagi A, Koposov R, Schwab-Stone M, Ruchkin V. Loneliness and health risk behaviours among Russian and U.S. adolescents: a cross-sectional study. BMC Public Health [Internet]. 2014 [cited 2020 Nov 16];14(1). Available from: http://dx.doi.org/10.1186/1471-2458-14-366
30. Loades ME, Chatburn E, Higson-Sweeney N, Reynolds S, Shafran R, Brigden A, et al. Rapid systematic review: the impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. J Am Acad Child Psychiatry [Internet]. 2020 [cited 2020 Nov 16];59(11):1218–1239.e3. Available from: http://dx.doi.org/10.1016/j.jaac.2020.05.009
31. Victor CR, Scambler SJ, Bowling A, Bond J.The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. Aging Soc [Internet]. 2005 [cited 2020 Nov 16];25(6):357–75. Available from: http://dx.doi.org/10.1017/s0144686x04003332
32. Relationships Australia. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey [Internet]. 2018 [cited 2020 Nov 16]. Available from: https://www.relationships.org.au/what-we-do/research/an-epidemic-of-loneliness-2001-2017
33. Grenade L, Boldy D. Social isolation and loneliness among older people: issues and future challenges in community and residential settings. Aust Health Rev [Internet]. 2008 [cited 2020 Nov 16];32(3):468. Available from: http://dx.doi.org/10.1071/ah080468
34. Stanley IH, Conwell Y, Bowen C, Van Orden KA. Pet ownership may attenuate loneliness among older adult primary care patients who live alone. Aging Ment Health [Internet]. 2013 [cited 2020 Nov 16];18(3):394–9. Available from: http://dx.doi.org/10.1080/13607863.2013.837147
35. Kuiper JS, Zuidersma M, Oude Voshaar RC, Zuidema SU, van den Heuvel ER, Stolk RP, et al. Social relationships and risk of dementia: a systematic review and meta-analysis of longitudinal cohort studies. Aging Res Rev [Internet]. 2015 [cited 2020 Nov 16];22:39–57. Available from: http://dx.doi.org/10.1016/j.arr.2015.04.006
36. Hanratty B, Stow D, Collingridge Moore D, Valtorta NK, Matthews F. Loneliness as a risk factor for care home admission in the English Longitudinal Study of Ageing. Age Ageing [Internet]. 2018 [cited 2020 Nov 16];47(6):896–900. Available from: http://dx.doi.org/10.1093/ageing/afy095
37. Victor CR. Loneliness in care homes: a neglected area of research? Aging health [Internet]. 2012 [cited 2020 Nov 16];8(6):637–46. Available from: http://dx.doi.org/10.2217/ahe.12.65
38. Gardiner C, Geldenhuys G, Gott M. Interventions to reduce social isolation and loneliness among older people: an integrative review. Health Soc Care Community [Internet]. 2016 [cited 2020 Nov 16];26(2):147–57. Available from: http://dx.doi.org/10.1111/hsc.12367
39. Havens B, Hall M, Sylvestre G, Jivan T. Social isolation and loneliness: differences between older rural and urban Manitobans. Can J Aging / La Revue canadienne du vieillissement [Internet]. 2004 [cited 2020 Nov 16];23(2):129–40. Available from: http://dx.doi.org/10.1353/cja.2004.0022
40. Kearns A, Whitley E, Tannahill C, Ellaway A. Loneliness, social relations and health and well-being in deprived communities. Psychol Health Med [Internet]. 2014 [cited 2020 Nov 16];24;20(3):332–44. Available from: http://dx.doi.org/10.1080/13548506.2014.940354
41. Windle K, Francis J, C C. Preventing loneliness and social isolation: interventions and outcomes. London: Social Care Institute for Excellence. 2011 [cited 2020 Nov 16].
42. Brandling J, House W. Social prescribing in general practice: adding meaning to medicine. Br J Gen Pract [Internet]. 2009 [cited 2020 Nov 16];59(563):454–6. Available from: http://dx.doi.org/10.3399/bjgp09x421085
43. Reventure Ltd. Workplace loneliness: solutions for the growing epidemic [Internet]. 2019 [cited 2020 Nov 16]. Available from: https://static1.squarespace.com/static/573aa5fe4d088e8be7903561/t/5d-22c6d98c74c30001e2eeaa/1562560228299/AFTW_LonelinessReport_Online.pdf?utm_source=sniply&utm_campaign=sniply&utm_medium=sniply
44. R U OK?, iCare. The Australian workplace psychological safety survey [Internet]. 2017 [cited 2020 Nov 16]. Avaible from: https://www.icare.nsw.gov.au/news-and-stories/icare-and-r-u-ok-launch-world-first-study#gref
45. Zumaeta J. Lonely at the Top: how do senior leaders navigate the need to belong? J Leadersh Organ Stud [Internet]. 2018 [cited 2020 Nov 16];26(1):111–35. Available from: http://dx.doi.org/10.1177/1548051818774548
46. Ozcelik H, Barsade SG. No employee an island: workplace loneliness and job performance. Acad Manage J [Internet]. 2018 [cited 2020 Nov 16];61(6):2343–66. Available from: http://dx.doi.org/10.5465/amj.2015.1066
47. Bloom N. How working from home works out. Policy Brief. Stanford Institute for Economic Policy Research (SIEPR) [Internet]. 2020 [cited 2020 Nov 16]. Available from: https://siepr.stanford.edu/research/publications/how-working-home-works-out
48. Fulton L, Jupp B. Investing to tackle loneliness - a discussion paper. Social Finance: London, UK[Internet]. 2015 [cited 2020 Nov 16]. Available from: https://www.socialfinance.org.uk/sites/default/files/publications/investing_to_tackle_loneliness.pdf
49. McDaid D, Park AL, Fernandez J-L. Reconnections evaluation interim report. Personal Social Services Research Unit (PSSRU). London School of Economics and Political Science: London, UK [Internet]. 2016 [cited 2020 Nov 16]. Avaiable from: https://s3.eu-west-2.amazonaws.com/golab.prod/documents/McDaid_et_al._2016.pdf
50. Gerst-Emerson K, Jayawardhana J. Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults. Am J Public Health R [Internet]. 2015 [cited 2020 Nov 16];105(5):1013–9. Available from: http://dx.doi.org/10.2105/ajph.2014.302427
51. Newall N, McArthur J, Menec VH. A longitudinal examination of social participation, loneliness, and use of physician and hospital services. J Aging Health [Internet]. 2014 [cited 2020 Nov 16];27(3):500–18. Available from: http://dx.doi.org/10.1177/0898264314552420
52. Zhang J, Xu L, Li J, Sun L, Ding G, Qin W, et al. Loneliness and health service utilization among the rural elderly in Shandong, China: a cross-sectional study. Int J Environ Res Public Health [Internet]. 2018 [cited 2020 Nov 16];15(7):1468. Available from: http://dx.doi.org/10.3390/ijerph15071468.
53. Ellaway A, Wood S, Macintyre S. Someone to talk to? The role of loneliness as a factor in the frequency of GP consultations. Br J Gen Pract[Internet]. 1999 [cited 2020 Nov 16];49(442):363-7. Avaiable from" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1313421/pdf/10736886.pdf
54. Mental Health Australia, KPMG. Investing to save: the economic benefits for Australia of investment in mental health reform [Internet]. 2018 [cited 2020 Nov 16]. Available from: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf.
55. National Mental Health Commission. The economic case for investing in mental health prevention: Summary[Internet]. [cited 2020 Nov 16]. Available from: https://www.mentalhealthcommission.gov.au/getmedia/ffbf9cc5-f815-4034-b931-dfc0c1ecb849/The-economic-case-for-investing-in-mental-health-prevention.
56. Mihalopoulos C, Le LK-D, Chatterton ML, Bucholc J, Holt-Lunstad J, Lim MH, et al. The economic costs of loneliness: a review of cost-of-illness and economic evaluation studies. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2019 [cited 2020 Nov 16];55(7):823–36. Available from: http://dx.doi.org/10.1007/s00127-019-01733-7
57. Lim MH, Eres R, Vasan S. Understanding loneliness in the twenty-first century: an update on correlates, risk factors, and potential solutions. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2020 [cited 2020 Nov 16];55(7):793–810. Available from: http://dx.doi.org/10.1007/s00127-020-01889-7

Contributors

Dr Michelle H Lim, Prof Johanna Badcock, Prof Benjamin Smith, Dr Lidia Engel, Prof Lisa Brophy, Kerry McGrath, Tess Newton-Palmer, Nick Tebbey, Sue Karzis, Fay Mound, Prof Cathy Mihalopoulos, Prof Julianne Holt-Lunstad, Elizabeth Priestley, Karn Nelson, Anna Minson.

Acknowledgements

We would like to acknowledge Prof Gavin Lambert, Mr Jonathon Gurry, Dr Fiona Martin MP, Co-Chair Parliamentary Friends of Ending Loneliness, UK Campaign to End Loneliness, Australian Psychological Society, VicHealth, R U OK? and Medibank Private. Thanks must also go to the champions, allies, donors, and multiple partner organisations that have provided advice, support, and actively participated in the loneliness agenda since 2017.

Special thanks to Ms Lesley Brookes for inspiring and empowering the formation of this organisation and for giving a voice to lonely people.

How to cite this article

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

About Ending Loneliness Together

Ending Loneliness Together is a national network of organisations who have come together to address the emerging problem of loneliness in people living in Australia. We are guided by these following principles:

- People with lived experience must be included in developing solutions for managing loneliness
- A coordinated and collaborative approach to tackling loneliness is most effective
- Evidence-based approaches are the most effective way of reducing chronic loneliness
- Capacity and capability to create connectedness needs to be built in the community.

www.endingloneliness.com.au

ENDING LONELINESS TOGETHER

Join the fight to end loneliness in Australia

Ending Loneliness Together

C/ Way Ahead NSW
Level 2, Building C/33 Saunders St
Pyrmont NSW 2009

Call us (61 2) 9339 6001
Email info@endingloneliness.com.au