Pre-Budget Submission 2022-2023

Social Recovery beyond COVID-19: A National Strategy to Alleviate Loneliness and Social Isolation

Ending Loneliness Together

In partnership with R U OK?, The Australian Psychological Society, and Infoxchange

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future, for they hold the dreams of Indigenous Australia.

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Ending Loneliness Together

Ending Loneliness Together (ELT) is a national Australian initiative that aims to raise awareness, and reduce the negative effects, of loneliness and social isolation in our community through evidence-based interventions and advocacy.

Inspired by the work of the UK *Campaign to End Loneliness* and the growing research evidence of the role of loneliness in the prevention of poor health and wellbeing. Ending Loneliness Together has drawn together knowledge from Australian and international universities along with service delivery expertise from community groups, professional organisations, government agencies and skilled volunteers, in order to address loneliness in Australia.

R U OK?

R U OK? is a national harm prevention charity that empowers people to have regular, meaningful conversations with those in their world and lend support when they are struggling with life.

R U OK? is the only national activity with a dedicated focus on the help-giver, working to build upon informal community care networks to increase the capacity of individuals to have positive and well-informed conversations. This is an important element in the integrated approach to harm and suicide prevention in Australia.

Since it's inception in 2009 R U OK? has grown and developed extensively in Australia and is now seeing international adoption of its messages and principles. Currently, R U OK? is viewed by the Australian population amongst the three most recognisable organisations contributing to suicide prevention. The broad support for R U OK? across rural, remote, regional and metropolitan communities in Australia provides a vital awareness raising and community engagement presence to underpin other efforts for suicide prevention – with a related benefit to improvements in the mental wellbeing of people.

The Australian Psychological Society

The Australian Psychological Society (APS) is the peak professional organisation for psychologists, with more than 25,000 members across Australia. It seeks to help people achieve positive change so they can confidently contribute to the community.

Psychologists represent the largest mental health workforce in Australia. Through their extensive training they are skilled to provide the most recent and leading evidence-based assessments and interventions for individuals and groups experiencing mental health difficulties, and for those seeking to optimise their wellbeing and functioning in the community.

Mental health continues to be one of the leading causes of disability in Australia, with the burden of disease grouped in the top three with cancer and cardiovascular disease. Mental health not only has a substantial impact on personal and social factors but is also an economic burden to the Australian Government. Reducing the burden of disease of mental health in Australia by fully utilising the expertise of the largest mental health workforce will reduce expenditure and provide significant benefits to the Australian community.

Infoxchange

Infoxchange is a not-for-profit social enterprise that has been delivering technology for social justice for over 30 years. With 180 staff across Australia and New Zealand, we tackle the biggest social challenges through the smart and creative use of technology, ultimately working to ensure no-one is left behind in today's digital world. We work with community, government and corporate partners to solve issues around homelessness, family violence, mental health and disability, as well as supporting Indigenous communities, women, youth and families. Through our work in digital inclusion and social innovation we use technology to empower people experiencing disadvantage, driving social inclusion and creating stronger communities.

Ask Izzy (www.askizzy.org.au) is a website that connects people in need with housing, a meal, wellbeing services, family violence support, counselling and much more. Powered by Infoxchange, it is free and anonymous, with over 400,000 services listed across Australia. Regarded as a trusted tool that has been designed by community for community, Ask Izzy receives over 250,000 searches for support per month. It is updated by a team of 20+ database updates who connect with service providers daily to ensure their listing is accurate, up to date and easy for people to understand. This database updating team is funded by agreements with state and territory governments and not-for-profits such as Lifeline who use the directory to support their own operations.

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Introduction

The Productivity Commission 2020 Mental Health report[1] highlighted the importance of loneliness and social isolation for mental illness and suicide. Loneliness and social isolation can affect anyone, at any age. Internationally, loneliness and social isolation are clearly recognised as significant threats to public health, important community-based targets for prevention of mental and physical ill-health, and major contributors to health system costs. Notably, in 2018, the UK Government announced its first major contribution to addressing loneliness with the introduction of a national strategy tackling loneliness[2], and in 2019 the US government took steps to tackle these issues via legislation to address the negative mental and physical health effects of social isolation and loneliness among aging Americans. As of of January 2021, the UK Government has outlined further plans to prioritise loneliness in response to COVID-19, with £31.3 million for charities tackling loneliness[3].

We commend the Morrison Government in as $2.3 billion investment in the National Mental Health and Suicide Prevention Plan – the largest Commonwealth mental health investment in Australia's history. While we welcome this significant investment in mental health, loneliness and social isolation, known antecedents of poor health remained overlooked. We therefore encourage the Australian Federal Government to develop an evidence-based coordinated plan to tackle loneliness and social isolation across all states and territories.

Loneliness has a detrimental impact on health and wellbeing, productivity, and functioning in daily life. **One in four Australians** aged 12 to 89 experience problematic levels of loneliness[4,5]. At any given time, the estimated prevalence of problematic levels of loneliness[6] is around **5 million Australians**. While the financial burden on Australia's health service has not been quantified, equivalent costs to Medicare in the USA have been estimated at $6.7 billion annually[7]. Given the high prevalence rates of loneliness and the exacerbation of this issue as a result of the COVID-19 pandemic, we urge the Federal Government to consider addressing two additional major gaps to deliver a more sustainable, effective and efficient response to address loneliness and social isolation, in order to promote our social recovery.

We propose four specific solutions which can be implemented to cover the two identified gaps: 1) a lack of community awareness and skills on how to manage loneliness and social isolation; 2) targeting loneliness and social isolation for better health outcomes. Addressing the two gaps can be delivered within a wider National Strategy to reduce loneliness and social isolation.

The benefits of a **National Strategy to Address Loneliness and Social Isolation** for the future of all Australians are multiple, and include:

1. Reducing excess costs to healthcare by improving prevention and early intervention so that people can manage their own loneliness as much as possible;
2. Reducing demand on general health, youth services, aged and community services and mental health specialist services by redirecting socially vulnerable people to appropriate, effective, low intensity community support;

[1] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[2] H.M Government, *A Connected Society: A Strategy for Tackling Loneliness.* 2018. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf
[3] https://www.gov.uk/government/publications/loneliness-annual-report-the-second-year/loneliness-annual-report-january-2021
[4] Lim MH, Eres R, Peck C. The Young Australian Loneliness Survey: understanding loneliness in adolescents and young adults. Swinburne University of Technology VicHealth 2019. Available from: https://www.vichealth.vic.gov.au/loneliness-survey.
[5] Lim M, Australian Psychological Society. Australian loneliness report: a survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. 2018. Available from: https://psychweek.org.au/2018-archive/loneliness-study/.
[6] 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. p. 1-20.
[7] AARP Public Policy Institute, *Medicare Spends More on Socially Isolated Older Adults.* November 27, 2017. Available from: https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf

3. Fostering prevention and reducing the prevalence of loneliness in the Australian population by increasing effective and appropriate avenues of recovery for individuals experiencing or at risk of loneliness;
4. Increasing community awareness of loneliness and social isolation as well as equipping Australians with the skills and confidence to manage their distress and support others struggling with loneliness and social isolation;
5. Improved transparency over outcomes achieved by services and providers, both within and beyond the healthcare system tackling loneliness and social isolation.

The road to recovery from the COVID-19 pandemic will be long and arduous – with significant costs to the Australian economy. Our organisations will leverage a skilled and capable team of centrally positioned industry partners and scientific experts in loneliness, social isolation, and mental health. We call for the Federal Government to consider significant investments to advance this work to ensure an effective and extensive impact on combatting the next public health issue facing Australians.

Global efforts to address loneliness and social isolation have commenced

Loneliness is now widely recognised as a public health priority across the world. In recognition of this issue, the World Health Organisation (WHO) recently released an Advocacy Brief on Social Isolation and Loneliness in Older People[8]. The importance of addressing loneliness and social isolation is further reflected in two commissioned reports, both of which will be completed in 2022. The first piece of work synthesises solutions that target loneliness and social isolation in older Australians using digital programs and the second in solutions delivered within face-to-face programs. Similarly, the European Commission has released a report, Loneliness in the EU: insights from surveys and online media data, led by the Joint Research Centre[9], outlining the need for concerted action.

The Global Initiative on Loneliness and Connection (GILC) is a non-profit organisation established by Ending Loneliness Together and the Coalition to End Social Isolation and Loneliness (USA) to drive international change. GILC is based in Washington DC and now has 10 member countries working on evidence-based frameworks and policies to tackle social disconnection, alongside an emerging partnership with the WHO.

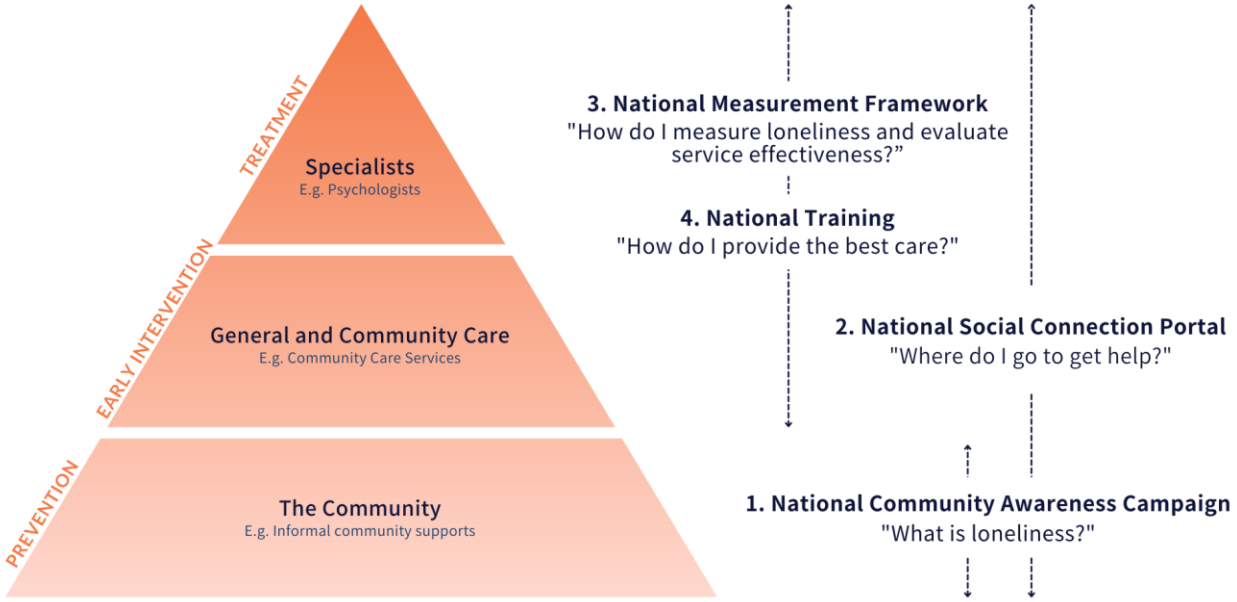
The partnership will focus on the development of living guidelines and recommended approaches for reducing social isolation and loneliness, and building social connection.

Japan and the UK have appointed Ministers to address loneliness in their respective countries. Mr Nigel Huddleston, Member of Parliament in the UK, a member of the Conservative party, was appointed as the new minister in charge of loneliness in October 2021. To address loneliness in the UK, the British government has distributed over £20 million since May 2002 to many initiatives to reduce loneliness - including charities and community-based programs dedicated to combatting loneliness in all age-groups. Ms Seiko Noda from the Liberal Democratic Party of Japan, was appointed as Minister of Loneliness in 2021. Japan's focus has been on combatting loneliness in an attempt to slow accelerating rates of suicide.

[8] World Health Organisation WH (2021) Social isolation and loneliness among older people: advocacy brief. Geneva. doi:Licence: CC BY-NC-SA 3.0 IGO
[9] Baarck, J., Balahur-Dobrescu, A., Cassio, L.G., D`hombres, B., Pasztor, Z. and Tintori, G., Loneliness in the EU. Insights from surveys and online media data, EUR 30765 EN, Publications Office of the European Union, Luxembourg, 2021, ISBN 978-92-76-40247-3, doi:10.2760/46553, JRC125873

2022-2023 Budget Proposal

A National Strategy to Address Loneliness and Social Isolation



We invite the Australian Federal Government to work in partnership with Ending Loneliness Together (ELT), R U OK?, The Australian Psychological Society (APS), and Infoxchange, to respond to the growing issue of loneliness and poor mental health in Australia by equipping, implementing and mobilising all sectors to deploy Australia's first *National Loneliness and Social Isolation Response Strategy*.

1.	Deliver a **national community awareness campaign** to address loneliness as a whole of population target for preventing mental illness and equip individuals with the information, tools and resources to facilitate positive mental health improvements.	$3.9 million - $4.9 million over 3 years
2.	Deliver the **National Social Connection Portal**, an online, digital tool to help consumers and healthcare professionals find local, evidence-based **programs and services targeting loneliness and social isolation** that best suit their needs or those of their patients.	$2.8 million - $3.5 million over 3 years
3.	Develop a national **standardised measurement** and evaluation **framework, practice guidelines, and training for frontline workers** to equip frontline practitioners and workers with evidence-based approaches, resources and solutions to systematically identify, monitor and assist people experiencing loneliness.	$1.9 million - $2.4 million over 3 years

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The estimated budget provided is subject to discussion as the scope of the work can be readily extended to a range of other providers, such as first responders and different health practitioners. All training programs developed will be launched online and offered to frontline practitioners and workers for free. As a first step, we will develop these for mental health professionals, specifically psychologists. Our resources will cater to practising psychologists, as well as student members or newly graduated psychologists. As a second step, we will develop programs for the community sector. We will include community-sector specific materials, including tailored resources for aged care and disability support services.

The Issue: Loneliness and Social Isolation is a Signature Concern of COVID-19

Addressing loneliness in Australia is a preventative strategy to improve mental health, economic and social participation and productivity.

The COVID-19 crisis has brought loneliness and social isolation to the centre of our attention and serves as a powerful reminder of just how important meaningful social relationships are to our sense of self and purpose in life.

The spread of the virus has resulted in ongoing measures aimed at reducing social interactions in order to curb infection, including social distancing, quarantine, and self-isolation. While these restrictions are proving effective for 'flattening the curve' of infections, emerging outbreaks have highlighted the difficulty in controlling the virus spread and emphasised significant and growing concerns about the impact on loneliness, social isolation, mental health and community wellbeing[10]. In particular, the disproportionate impact of the social restrictions on vulnerable groups, such as older adults, youth, people with mental ill health, and those who live alone[11].

Mental Health Impact

The detrimental impact of the current pandemic on mental health outcomes is consistent with the impact of quarantine reported in previous infectious diseases outbreaks (e.g., Severe Acute Respiratory Syndrome)[12]. Social restrictions invariably exacerbate mental health symptoms associated with depression, anxiety, stress, anger, and post-traumatic stress disorder[13].

One in two Australians reported feeling lonelier since the onset of the COVID-19 pandemic. For Australian residents aged 18-81 years surveyed during March-April 2020, loneliness increased the likelihood of a developing a clinical depressive disorder by eight times and a clinical social anxiety disorder by five times. Unfortunately, based on previous infectious diseases research, it is likely that poor mental health triggered by COVID-19 will be persistent even after the immediate public health crisis ends.

More Australians are expected to report emerging mental ill health as the pandemic progresses. Those who did not have prior mental health disorders are expected to report more loneliness, financial and work-related stress, and problematic mental health symptoms. First-time help-seekers struggling with loneliness may be reluctant to access services through specialist mental health service providers and may have difficulties identifying relevant community solutions or service providers.

Currently, mental health providers do not offer low intensity or short-term support for loneliness and have a focus on reducing distress and addressing safety, as opposed to adopting a preventative approach to addressing loneliness. These providers were overly burdened and under resourced even before the pandemic. In a similar vein, community organisations who offer programs to address loneliness are not equipped to reliably measure loneliness or evaluate the effectiveness of their services and are under-resourced to implement these programs more widely in order to make an impact. Thus, a new and more

[10] O'Sullivan R, Burns A, Leavey G, Leroi I, Burholt V, Lubben J, Holt-Lunstad J, Victor C, Lawlor B, Vilar-Compte M, Perissinotto CM, Tully MA, Sullivan MP, Rosato M, Power JM, Tiilikainen E, Prohaska TR. Impact of the COVID-19 Pandemic on Loneliness and Social Isolation: A Multi-Country Study. *International Journal of Environmental Research and Public Health*. 2021; 18(19):9982. https://doi.org/10.3390/ijerph18199982

[11] Lim MH (2020). InPsych-Australian Psychological Society. Accessed 11 July 2020, https://psychology.org.au/for-members/publications/inpsych/2020/June-July-Issue-3/Loneliness-in-the-time-of-COVID-19

[12] Wu KK et al. (2005). Emerg Infect Dis 11:1297-1300.

[13] Brooks SK et al. (2020). Lancet 395: 912-920.

integrated community-based approach to addressing loneliness and its effects on mental health is needed.

Workplace Social Impact

We need to focus on accelerating our social recovery from the public health crisis including mitigating the long-term impacts on mental health and social changes within our workplaces.

The COVID-19 pandemic has also significantly disrupted the way we work. In a recent Australian COVID-19 work survey, 76% of participants reported experiencing moderate or severe psychological distress as a result of reduced work hours or losing their job[14]. Unemployed Australians reported experiencing four times more severe psychological distress (31% of participants) than those who were employed (8% of participants, 18 to 65 years old)[14].

Remote working has increased exponentially since the onset of COVID-19, from 20% to 45% in Victoria and from 20% to 39% in New South Wales, adding new challenges and barriers to our ability to connect and maintain social relationships. Crucial to understanding these effects is recognising that those working from home and unemployed workers can suffer significant stress arising from changes to their social identity, reduced social support, networks, and loneliness.

Research evidence shows that tackling loneliness has many benefits for the workplace. Social connection improves productivity, creativity and collaboration in the office. It also reduces staff burnout, sick leave and staff turnover – thereby significantly enhancing workplace outcomes[15] [16].

[14] Collie A et al. (2020). MedRxiv. doi.org/10.1101/2020.05.06.20093773
[15] 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
[16] Bloom N. How working from home works out. Policy Brief. Stanford Institute for Economic Policy Research (SIEPR) [Internet]. 2020 [cited2020 Nov 16]. Available from: https://siepr.stanford.edu/research/publications/how-working-home-works-out

The Cost: The Economic Burden of Loneliness

Health Service Utilisation Costs

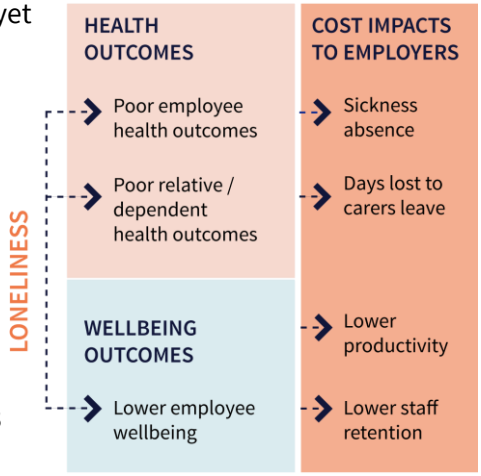
According to the Mental Health Inquiry Report[17], mental ill-health and suicide cost the Australian economy between $43 billion to $70 billion in 2018-19, including the direct cost of healthcare expenditure and other services and supports ($16 billion), the cost of lost productivity due to lower employment, absenteeism and presenteeism (ranging from $12 billion to $39 billion), and the informal care provided by family and friends ($15 billion).

There is an additional economic burden of mental health service use associated with loneliness. A systematic review on the economic costs associated with loneliness highlights that loneliness is associated with excess healthcare costs[18]. Loneliness is associated with an increased number of general practitioner visits and frequent use of hospital services in older adults and people with psychotic disorders in particular, independently of other sociodemographic factors and health needs[19]. Tackling loneliness could therefore assist with reducing waiting time and improving access to health services.

Fortunately, investment in loneliness initiatives provides clear value for money. In 2019, economic modelling conducted by the National Mental Health Commission shows that for every $1 invested in programs that address loneliness, the return on investment is between $2.14 to $2.87 respectively[20,21]

Work Productivity Costs

Implementing initiatives to counteract loneliness will alleviate the burden and cost to health services and enable economic participation, productivity and economic growth.



While extensive economic modelling of loneliness in Australia has yet to be comprehensively quantified, the costs are expected to be significant enough to warrant our immediate attention, especially as it relates to workforce productivity. The New Economics Foundation Report[22] estimated the cost impact to employers from poor health and wellbeing associated with loneliness (see Figure). In the UK, loneliness cost non-private employers £2.53 billion and private employers £2.10 billion per year. This includes the cost of working days lost due to poor health associated with loneliness (non-private: £20 million; private: £16.5 million), cost of caring responsibilities due to poor health associated with loneliness (non-private: £200 million; private: £183 million), loneliness due to lower job satisfaction and productivity (non-private: £665 million; private: £549 million), and volunteer staff turnover (non-private: £1.62 billion; private: £1.32 billion).

[17] Productivity Commission 2020, Mental Health, Report no. 95, Canberra
[18] Mihalopoulos C…Lim MH, & Engel L (2020). Soc Psychiatry Psychiatr Epidemiol 55:823-836
[19] Badcock JC et al. (2020). Schizo Res. doi.org/10.1016/j.schres.2020.05.059
[20] National Mental Health Commission. (2019). Educational interventions to reduce older persons' loneliness. Online Report.
[21] National Mental health Commission. (2019). e-Health interventions to reduce older persons' loneliness. Online Report.
[22] New Economics Foundation. (2017). The cost of loneliness to UK employers. Online Report

Investments in loneliness initiatives will lead to clear economic benefit to Australia and be critical to Australia's recovery. However, specific capacity to deal with growing rates of loneliness has not yet been systematically designed, created, or widely implemented.

A National Strategy to Address Loneliness and Social Isolation

Identified Gap 1: Increasing Community Awareness and Skills

Understanding and reducing the stigma surrounding loneliness

While 1 in 4 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. There are countless Australians living with persistent loneliness who do not access the appropriate help 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.

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[23]. 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 or socially isolated adds to the burden of loneliness.

One line of evidence suggests that people who experience loneliness fear how they will be judged by their community – reflecting the social stigma that surrounds the issue. Evidence reported by the UK Campaign to End Loneliness suggests that people who feel lonely are likely to be judged negatively by the general public[24]. When asked '*What do you think people imagine about those who are lonely?*' common responses include '*there is something wrong with them*', '*they are unfriendly*' and '*it is their fault they are lonely*'.

Society's attitudes to loneliness are reflected in depiction of loneliness 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[25]. Lonely individuals also self-stigmatise and commonly report feeling shame. Women in particular report more shame about feeling lonely than men. Moreover, feelings of shame about loneliness are higher in younger than older adults[26]. People who self-stigmatise loneliness may also experience a loss of self-esteem in an 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 and challenging public misconceptions about loneliness, while normalising loneliness as a signal to connect, maintain, or rebuild social bonds. As a subsequent step, we need to empower lonely individuals to manage distressing feelings of loneliness.

Leveraging the R U OK? framework to develop a national campaign on loneliness that works

The benefits of community health promotion and awareness campaigns are evidenced in long-term outcomes. For example, every R U OK? campaign is based on the R U OK? *Social Impact Framework* which notes four key behaviour changes for long-term outcomes (those being: people understand mental health and their role in suicide prevention, people are meaningfully connecting, people can support anyone

[23] Mental Health Foundation. The Lonely Society? 2010. Available from: https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf.
[24] https://www.campaigntoendloneliness.org/
[25] Uotila H, Lumme-Sandt K, Saarenheimo M. Lonely older people as a problem in society–construction in Finnish media. International Journal of Ageing and Later Life. 2010;5(2):103-30.
[26] https://www.seed.manchester.ac.uk/education/research/bbc-loneliness-experiment/

struggling with life, and people are seeking help and feeling supported) to achieve its long-term outcome of people feeling more connected and protected from suicide.

Campaigns like R U OK? contribute to building community capacity, including strengthened leadership, participation, resource mobilisation, interpersonal connections, collaborations and partnerships. Community awareness campaigns drive social capital by building trust amongst community members, and empowering individuals' to act upon ideas.

Every campaign works with a set of objectives co-created with experts in the relevant setting via advisory group membership and if possible, mental health sector collaboration. Priorities identified as critical to achieving such objectives include ensuring resources:

- Are free, culturally relevant and publicly available
- Capitalise on and complement existing programs in an effort to avoid duplication and/or wasted resources
- Take a holistic approach that is relevant to a diverse range of help-givers, and
- Are simple, practical and effective, and remain flexible as the campaign evolves amongst its target audience.

The goal of Ending Loneliness Together is to halve the prevalence of loneliness in Australia by 2030. To that end, a national campaign to improve public understanding of loneliness is sorely needed, so that every Australian can gain the health, social and economic benefits. We need to increase community awareness of the causes and consequences of loneliness and help people who are feeling lonely to manage their experiences more effectively. Further to this, we need to empower those individuals and groups surrounding lonely individuals to encourage a sense of connection, as lower belongingness is a risk factor for mental ill health and suicide[27]

[27] Van Orden, Kimberly A et al. "The interpersonal theory of suicide." *Psychological review* vol. 117,2 (2010): 575-600. doi:10.1037/a0018697

Solution 1: National Community Awareness Campaign

We call on the Government to fund an evidence-based national community awareness campaign to improve understanding of loneliness, challenge public misconceptions and stigma of loneliness, upskill Australians to better manage their loneliness, and empower others to assist.

Loneliness is poorly understood within our community. While related to social isolation, the ways to manage loneliness are less straightforward than merely reducing social isolation (e.g., through social prescribing). We need to increase awareness of loneliness, reduce the stigma attached to the issue, and empower people to take appropriate action. 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.

A national community health promotion and awareness campaign will raise awareness of loneliness, address the social stigma that surrounds the issue, and reduce the demand on more costly health and specialist mental health services by strengthening effective community responses to loneliness.

Guided by related international frameworks from the World Health Organisation and local frameworks such as the VicHealth Health Promotion Framework, we will focus on the development and delivery of a national health promotion and awareness campaign, resources and tools to promote community awareness of loneliness across three key priority issues:

1. The distinction between objective and subjective social isolation (i.e., loneliness)
2. The stigma of loneliness as a barrier to help-seeking
3. The consequences of loneliness for poor mental health and wellbeing

An overarching campaign call to action will be defined through a co-design approach across a cohort of 'lonelier' people and 'less lonely' people. This overarching call to action will form the umbrella message, with iterations of the campaign developed for various audience interactions, including 16–25-year old's, senior Australians, CALD communities and those with sensory loss.

Key to the success of the national campaign will be well-defined outputs and outcomes to foster help-seeking and build social resilience. Outputs will include the demand, uptake, relevance and credibility of a suite of TV, radio, print and digital assets to improve community understanding about loneliness and its impact on mental health during pandemics and disasters.

To assist driving knowledge, attitudes, intentions and behaviour change, toolkits will also be developed in order to upskill Australians to better manage their loneliness or to assist others who are socially vulnerable, referencing help seeking pathways for both 'lonelier' and 'less lonely' individuals and groups. These pathways will be identified amongst the existing mental health sector – at national and local levels – where possible. These toolkits will too be developed for several socially-vulnerable communities including those living in aged care, young people, culturally and linguistically diverse groups, carers, and people with a disability. To ensure accessibility, campaign assets and resources will be developed in a range of formats for people with a disability, including people with communication difficulties (including Braille and Auslan) and made available in top community languages to ensure inclusion of multicultural communities.

The campaign evolution will be underpinned by three phases from: 1) research and development; 2) launch and 3) amplification (details will be made available if requested). As the campaign evolves, corporate sponsorship will be considered for this national initiative and it is expected to be a sought-after opportunity given the scale and trend.

Solution 2: National Social Connection Portal

We call on the Government to fund the development of a National Social Connection Portal which includes the development of an online database of all health and community sector programs and services tackling loneliness and social isolation across the country to redirect at-risk individuals to the appropriate local solutions.

Ending Loneliness Together, together with Infoxchange, will develop a national service portal that provides a searchable database of local community programs and services (i.e., from neighbourhood houses to not-for-profit led community groups) tackling loneliness and social isolation within a stepped-care framework. The National Social Connection Portal will leverage off the Infoxchange's Ask Izzy service directory, which lists over 370,000 services nationally.

The portal will also function as an online directory to refer individuals at risk of, or experiencing, loneliness to programs within the community offering low intensity solutions, and specialist services for those with more complex needs. This community service seeker is needed because many people who are lonely and or socially isolated do not have mental ill-health or do not readily identify as having mental ill health. Consequently, existing digital mental health platforms (e.g., Head to Health) may not reach the necessary target group. Furthermore, a national social connection portal can redirect people who are lonely, and or socially isolated, who also experience mental ill health, back to established government platforms, in order to increase accessibility to health care.

The *Social Connection Portal* will collate programs and services targeting loneliness and social isolation by postcode, program name, host organisation, disaster responsiveness (e.g., alignment with COVID-19 safety protocols), target group (e.g., demographic) and level of evaluative rigor (i.e., program evaluation and effectiveness).

The portal will empower people who feel lonely to choose the solution that best suits them. It will also equip service providers, including community services, aged-care providers, community-link workers, GPs, and psychologists, with evidence-based approaches, resources and solutions tailored to the needs of their clients/patients.

Mapping of programs and services will be completed systematically across sectors, including by local government area; aged-care; workplaces; schools/universities; and by vulnerable population group (e.g., culturally and linguistically diverse groups; regional and remote communities).

Identified Gap 2: Targeting Loneliness and Social Isolation for Better Mental Health

Before the pandemic, loneliness was identified as a growing public health problem with a robust body of evidence testifying to the deleterious impacts on both mental and physical health[28], including poor cardiometabolic health, physical inactivity, obesity, impaired sleep, cognitive decline and increased risk for dementia[29]. In fact, people who are lonelier not only have increased morbidities, but they also experience higher mortality rates compared with their less lonely counterparts[30]. Loneliness is associated with a 26% greater risk of premature mortality equivalent to rates of living alone or being socially isolated[31].

Critically, **loneliness is a significant predictor of a range of mental health symptoms and disorders**. One in four Australians aged 12 to 89 report problematic levels of loneliness, with lonelier individuals reporting more severe depression, social anxiety and poorer psychological wellbeing, physical health outcomes, and worse quality of life[32,33]. Importantly, loneliness predicts more severe social anxiety, paranoia, and depression over a six-month time period in community residents aged 18 to 89[34].

Loneliness increases the likelihood of having a clinically diagnosed mental disorder, especially those with phobias, depression and obsessive-compulsive disorder[35]. **Loneliness also predicts increased suicidality**[36,37]. Alarmingly, those with severe loneliness were 17 times more likely to make a suicide attempt in the past 12 months[38]. In addition, loneliness increases the risk of rapid cognitive decline and onset of dementia, and therefore represents a modifiable factor that can be a target of intervention before the development of severe cognitive decline[39].

Australians with a psychotic disorder identified loneliness as one of three top challenges in daily life, yet loneliness is rarely a focus within mental health care[40] - highlighting a major gap in translating research into clinical practice. While models of loneliness and evidence-based solutions have been developed for those with high prevalence mental health disorders[41], psychotic disorders[42], and the community[43], none are routinely implemented within mental health services or community services.

Instead, loneliness continues to be treated as a by-product of mental health problems which will end once symptoms resolve, as opposed to an independent driver of poor mental health outcomes[44]. 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 targeted training to identify, monitor or target loneliness as a main outcome of therapeutic treatment or support.

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Solution 3: National Standard for the Assessment and Evaluation of Loneliness

We call on the Government to develop evidence-based frameworks to guide program and service providers to identify, assess, monitor and refer individuals experiencing or at risk of loneliness to existing services and other informal pathways.

Despite the robust evidence, loneliness is not widely recognised or routinely assessed as an indicator of importance in the health sector (or beyond). There are no clear recommendations to guide either primary health practitioners (e.g., General Practitioners) or specialist mental health professionals (e.g., Psychologists) on when or how to assess, refer, or monitor people experiencing or at risk of loneliness. Such guidance is also lacking for other sectors beyond health, such as community organisations offering programs to reduce loneliness, which impedes pathways to care. While Ending Loneliness Together has begun to develop and disseminate tools for evaluating the effectiveness of loneliness services for adults, attention on assessment tools appropriate for younger people under the age of 18 has not kept pace. Ending Loneliness Together has the capacity to develop and test an age-appropriate Loneliness Outcomes Measurement Framework for children, adolescents, and young people.

Given the significance to health and wellbeing, valid and reliable measures of loneliness and social isolation also need to be incorporated as a standard component of electronic health records. Similarly, guidance on measuring loneliness is needed for community organisations. National guidelines and recommendations will be developed for screening and measuring loneliness in adults and children, appropriate to a variety of health or community settings.

Assessment alone, however, provides insufficient evidence about what works to reduce loneliness, for whom and when. Tools and resources will also be developed to facilitate evaluation and reporting of the effectiveness and efficiency of programs and services designed to reduce loneliness. These assets will increase the level of transparency and accountability over outcomes achieved by programs and services tackling loneliness, consistent with the recommendations of the Productivity Commission (2020).

Solution 4: National Training for Health Practitioners and Community Workers

We call on the Government to develop a set of national competencies and training modules to facilitate best practice approaches to assist people who are socially vulnerable, including those with mental ill health.

Acquisition of the competencies required to support people with problematic loneliness is essential to providing a high quality of care. Currently, many lonely people use primary health services (i.e., GPs, emergency departments, and ambulance services) to cater to their social needs, yet frontline workers such as GPs are not adequately equipped or resourced accordingly. Many patients with existing mental illness also report that their problems with loneliness and social isolation are often downplayed or ignored by their treatment team, which hampers recovery and diminishes their quality of life. On the other hand, community organisations often struggle to know how best to help lonely service-users.

Guidelines and training can reduce this burden, by equipping health professionals and community providers with the information and tools they require, including how to assess, monitor, treat, and redirect socially vulnerable individuals to the right solutions for their social needs.

Based on the latest research evidence and using scientist-practitioner frameworks, we will train frontline health practitioners and community workers to better manage socially vulnerable individuals with or without mental ill health. We are particularly well-placed to develop and implement training in the management of loneliness and social isolation, since competency development is a central feature of our alliance.

We will undertake robust stakeholder consultations to establish the core set of competencies required in different workplace settings (community, health, and mental health sectors) to assess and manage loneliness and social isolation, alongside developing a suite of online training modules to enhance the knowledge, skills and attitudes of the health and community sector who assist people who are lonely or socially isolated.

All training programs developed will be launched online and offered to frontline practitioners and workers for free. As a first step, we will develop these for mental health professionals, specifically psychologists. Our resources will cater to practising psychologists, as well as student members or newly graduated psychologists. As a second step, we will develop programs for the community sector. We will include community-sector specific materials, including tailored resources for aged care and disability support services.

Conclusion

Loneliness and social isolation have been highlighted as major signature concerns for public health and while there has been investment in this area, there are also identified gaps. Significant investment in Australia is needed to deal with this critical issue which has been readily identified as the next public health crisis in other parts of the world.

Australia requires a coordinated national strategy to address loneliness and social isolation. These scope and extent of this strategy is open to discussion and we look forward to codesigning and implementing an effective response with the Federal Government.

Allocating sector support funding will ensure that Ending Loneliness Together, in partnership with the R U OK?, Infoxchange, and the Australian Psychological Society, has the resources to work effectively with the Federal Government to deliver the reforms outlined in the Productivity Commissions' Mental Health Inquiry Report and generate greater efficiency and effectiveness for the Australian Government.