Loneliness & Social Isolation

Suicide Prevention Australia

POLICY POSITION

February 2022

POSITION

1. Commonwealth Government to develop a national strategy to address loneliness and social isolation which acknowledges and includes lived experience expertise and allocate responsibility for implementation to a senior minister.
2. Commonwealth Government to plan and deliver a national survey on loneliness and social isolation to provide a national dataset to enable targeted prevention and intervention.
3. Commonwealth, State and Territory Governments invest in suicide prevention training that has a nationally consistent approach for all frontline workers (including educators) and community gatekeepers who interact with individuals that may be socially isolated or lonely.
4. Commonwealth, State and Territory Governments support alternative measures (such as social prescribing and community-based programs and interventions in community spaces) as part of primary healthcare and preventative health strategies, including funding to support the 'link worker' and peer workforce.

CONTEXT AND COMMENTARY

Loneliness is defined as "an adversive and subjective feeling of social isolation that arises when an individual perceives that the quality or quantity of social relationships they have is less than what they desire."[1] Social isolation is defined as "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]

Social isolation and loneliness can have significant impacts and pose harms to both mental and physical health of Australians.[3] Research has shown social isolation to pose more significant health risk than 'smoking, poor diet and lack of exercise[4], and loneliness has been found to increase the risk of premature death by approximately 30%.[5]

The Australian Psychological Society reports approximately one in four Australians are experiencing an episode of loneliness, and 1 in 2 report they feel lonely for at least 1 day each week.[6] Loneliness is highlighted as a modifiable risk factor for suicide by the Royal Australian & New Zealand College of Psychiatrists.[7]

The estimated prevalence of problematic levels of loneliness among Australians is around 5 million.[8] Loneliness has also been attributed to increasing the risk of health problems such as myocardial infarction and stroke[9], and increases the likelihood of experiencing depression by 15.2%[10], and links exist between social isolation and the experience of psychological harm.[11]

Stigma and discrimination are harmful to mental health and can occur against people with mental illness, and high rates of people with mental ill health withdraw themselves from public spaces due to stigma and discrimination.[12,13] Mental illness is further associated with lower involvement in the labour force and greater discrimination, both of which are risk factors for suicide.[14,15] It is crucial that active efforts should be made to reduce the stigma surrounding mental ill health and loneliness.

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One in 10 Australians aged 15 and over report lacking social support.[16,17] Among older Australians, rates of emotional loneliness are estimated to be 19% among those aged 75 and over.[18] During COVID-19 lockdown, staying connected to others was reported most difficult for Aboriginal and Torres Strait Islander Victorians (51%) and young Victorians aged 18-24 (39%).[19] Response measures to the COVID-19 pandemic to protect community health have subsequently heightened risk factors for suicide such as social isolation, financial distress, and unemployment.

International evidence demonstrates clear associations between loneliness, social isolation, and suicidality. For example, a UK longitudinal study of the link between loneliness and suicide found for men living alone and living with non-partners were associated with death by suicide.[20] For both men and women, loneliness was associated with hospital admissions for self-harm.[21] The study determined overall loneliness is an important risk factor for self-harm.[22]

While we don't know the economic impact loneliness has on the Australian economy, in the US it is estimated that a lack of social connection among older adults can cost the government approximately $6.7 billion per year.[23,24]

WHOLE OF GOVERNMENT APPROACH TO LONELINESS AND SOCIAL ISOLATION

Suicide and suicidal behaviours exact an economic toll in addition to their immense emotional and social impacts. Suicide is also, however, a complicated and multi-factorial human behaviour and should be understood as more than an expression of mental ill health. A whole-of-government approach to suicide prevention acknowledges this and seeks better cross-portfolio coordination to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention.

Whole of government approaches to loneliness and social isolation have been witnessed internationally. In 2018 the UK appointed Tracey Crouch, the world's first Minister for Loneliness supported by launching a cross-government strategy to address loneliness to respond to evidence that up to a fifth of UK adults feel lonely most or all of the time.[25] The Strategy includes reforms aimed to equip all GPs in England to refer patients experiencing loneliness to community activities and voluntary services by 2023, and the Government has invested £1.8m to increase and transform community spaces (e.g. new cafes, art spaces or gardens).[26] The Minister oversees implementation of this strategy as well as awareness raising activities and a Local Connections Fund.

Recently, Japan has followed suite appointing its first Minister for Loneliness in 2021. Strong international evidence shows that a whole-of-government approach is essential to driving reform, coordinated action and a reduction in the suicide rate.[27]

Australia has a number of existing programs and interventions aimed at reducing loneliness and social isolation of Australians that have yielded positive results. For example, Groups 4 Health (GH4), an evidence-based intervention targeting psychological distress resulting from loneliness and social isolation reports 60-69% of participants demonstrating improvement in depression, social anxiety, and loneliness post program completion.[28] Program participation has further been associated with reducing visits to General Practitioners[29] – which evidence has suggested social isolation and loneliness can be contributing factors to increased visits to GPs.[30] The program is now run annually in Australia and internationally (UK, Germany and Switzerland)[31] and as a result is reducing health expenditure.

The Commonwealth Government should lead the development of a national strategy to address loneliness and social isolation and allocate responsibility for implementation to a senior minister to coordinate similar proposed efforts in states such as Victoria and Queensland. A national strategy should acknowledge and include lived experience expertise, recognise stigma and discrimination experienced by loneliness and mental ill-health, and the associated barriers to social inclusion and connection.

MORE RESEARCH INTO LONELINESS AND SOCIAL ISOLATION IS NEEDED

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development, and implementation. This includes accurately recording suicide and suicidal behaviour; and linking data on agreed risk factors for suicidal behaviour, including social isolation and loneliness.

It is estimated that for every death by suicide, there are 20 suicide attempts.[32] Access to consistent and accurate data enables Government and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions. We know that loneliness is linked to risk of suicide, yet we have limited Australian data on loneliness and social isolation.

We need quality, robust data on loneliness and social isolation to better understand who is at risk and how best to support more connected communities. A national survey on loneliness and social isolation that captures key demographics and geographics on populations already at risk of suicide (Aboriginal and Torres Strait Islander peoples, LGBTQI communities, culturally and linguistically diverse communities, veterans, young people, older people) will enable targeted prevention and intervention.

STRENGTHENING COMMUNITIES TO PREVENT LONELINESS AND SOCIAL ISOLATION

Community-based programs and interventions should be co-designed with priority populations, be appropriately targeted to age demographics given protective factors can differ among age groups and be integrated into communities and existing programs. Lived experience expertise should be included in all levels of community-based programs (i.e. design, delivery, and evaluation).

Alternative and innovative approaches to addressing loneliness are emerging overseas. For example, 'social prescribing', which involves the process of healthcare providers referring people in the community to existing community-based non-clinical supports. These supports may include social support services, volunteering opportunities, arts activities, community gardens, and community groups. Research estimates that there is approximately 20% of people who consult their GP for social issues.[34]

International evidence of social prescribing reports 74% of physicians in Germany and 65% in the UK reported connecting patients with social services or other community-based supports.[35] In Australia, the first pilot program for social prescribing targeting individuals living with mental illness was delivered over 2016/2017. Evaluation found participants experienced improved self-perceived quality of life, loneliness, social participation and economic participation among others.[36]

The Victorian Royal Commission into mental health recommended in the final report (Rec. 15) to implement a social prescribing trial in each region in Victoria by the end of 2022.[37]

Museums have been utilised in the UK as places to address community health and wellbeing.[38] The Bristol Museum and Art Gallery 'Art Shed' started in 2016 and involves prescribed art courses that take place in community wellbeing centres and surgeries. Course participants have a diagnosed mental health issue, most commonly depression or anxiety.[39] A case study of course participants reported improved confidence and sense of self-worth, with many appreciating the safe welcoming space provided by the activity.[40]

Many neighbourhood and community centres are often first responders to distress in the community and provide critical place-based infrastructure. The Royal Commission into Victoria's Mental Health System reported evidence that the declining role of community-based organisations and supports can increase feelings of social isolation.[41] Community gatekeepers are community members who have received training to be able to identify and respond

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to people experiencing suicidality and encourage people in distress to connect to supports.[42] Approximately half of people who die by suicide have not had contact with a health service in the previous 12 months.[43] Training key touchpoints in the community who may interact with at-risk people presenting with suicidality can help connect people with support and build upon community capacity to respond to distress.

We need more community-based programs and interventions in community spaces to address loneliness and social isolation (such as arts, community gardens, social cafes, community groups, phoneline services, sports, community gatekeepers, and mentoring). Community-based peer-led organisations, including those who utilise peer workers are well placed to target hard-to-reach at risk populations.

COMMUNITY-WIDE APPROACH TO REDUCING LONELINESS AND SOCIAL ISOLATION

The negative impact of COVID-19 on isolating individuals within their own communities, while suicide rates have remained stable in the near-term as a result of additional protective and financial supports, crisis service access has increased[44] and there's evidence from disasters in Queensland (Cyclone Yasi)[45] and other countries[46] that the long-term impact of disasters may not be felt for several years. This means we must put in place systems and supports in the community now to intervene early.

The 2021 State of the Nation in Suicide Prevention surveyed the sector on emerging issues and challenges, including suicide risks. Social isolation and loneliness was the highest rated risk when respondents were asked what will pose the most significant risk to suicide rates over the next 12 months.[47] YouGov polling conducted over the same period saw 58% of surveyed individuals of the public identified social isolation and loneliness as the highest risk to suicide rates over the next 12 months.[48]

Due to COVID-19, people providing face-to-face services are facing clients and customers in crisis. To adapt to the continually changing COVID-19 response measures all workers both in and outside of health need to be equipped with the knowledge and skills to identify people at risk and refer them onto appropriate support services. By equipping key touchpoints and gatekeepers in the community with the capacity to identify risk factors for suicide and to guide individuals towards appropriate supports, we can reduce suicide.

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There are crisis services available 24/7 if you or someone you know is in distress

Lifeline: 13 11 14
www.lifeline.org.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

Imagine a world without suicide

Acknowledgements Statement

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