Parliamentary Committees

Inquiry into social isolation and loneliness in Queensland

Report No. 14, 57th Parliament
Community Support and Services Committee
December 2021

Community Support and Services Committee

Chair	Ms Corrine McMillan MP, Member for Mansfield
Deputy Chair	Mr Stephen Bennett MP, Member for Burnett
Members	Mr Michael Berkman MP, Member for Maiwar
	Mr Jon Krause MP, Member for Scenic Rim
	Ms Cynthia Lui MP, Member for Cook
	Mr Robert Skelton MP, Member for Nicklin

All web address references are current at the time of publishing.

Contents

Abbreviations

AASW	Australian Association of Social Workers
ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ACSA	Aged and Community Services Australia
ADF	Australian Defence Force
AHPA	Australian Health Promotion Agency (Queensland Branch)
AIHW	Australian Institute of Health and Welfare
ANA	A New Approach
ANU	Australian National University
APS	Australian Psychological Society
BCC	Brisbane City Council
BYS	Brisbane Youth Service
CALD	Culturally and linguistically diverse
CEO	Chief Executive Officer
CLAWs	Centres for Learning and Wellbeing
committee	Community Support and Services Committee
COTA	Council on the Ageing
CVS	Community Visitors Scheme
DCHDE	Department of Communities, Housing and Digital Economy
DCYJMA	Department of Children, Youth Justice and Multicultural Affairs
DESBT	Department of Employment, Small Business and Training
Dingle, Sharman and Hayes	Associate Professor Genevieve Dingle, Dr Leah Sharman and Mr Shaun Hayes, School of Psychology, UQ
DSDSATSIP	Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
DTIS	Department of Tourism, Innovation and Sport

FNTS	First Nations Training Strategy
GP	General Practitioner
GSS	General Social Survey
HILDA	Household Income and Labour Dynamics in Australia Survey
Inquiry	Inquiry into social isolation and loneliness in Queensland
IUIH	Institute for Urban Indigenous Health
LECNA	Logan East Community Neighbourhood Association
LSE	London School of Economics
MGCC	Mount Gravatt Community Centre
MUK	Mind UK
NCCs	Neighbourhood community centres
NHF	National Heart Foundation of Australia
NHS	National Health Service
NSW	New South Wales
NZ	New Zealand
PBNC	Palm Beach Neighbourhood Centre
PC	Productivity Commission
PDAs	Priority Development Areas
PHN	Primary Health Network
PIA	Planning Institute of Australia
Planning Act	*Planning Act 2016* (Qld)
QAMH	Queensland Alliance for Mental Health
QCA	Queensland Community Alliance
QCOSS	Queensland Council of Social Service
QCS	Queensland Corrective Services
QDN	Queenslanders with Disability Network

QFCA	Queensland Families and Communities Association
QMSA	Queensland Men's Shed Association
QNMU	Queensland Nurses and Midwives' Union
QPHN	Queensland Primary Health Network
QSS	Queensland Social Survey
QUT	Queensland University of Technology
ROI	Return on investment
SCAQ	Strata Community Association Queensland
SDS	Skills Disability Support
SGQ	Support Groups Queensland Inc.
SMI	Scanlon-Monash Index
SPA	Suicide Prevention Australia
SQW	Skilling Queenslanders for Work
The Framework	Student Learning and Wellbeing Framework
TSS	Taxi Subsidy Scheme
U3A	University of the Third Age
UCLA	University of California Los Angeles
UK	United Kingdom
UK Loneliness Strategy	*A connected society: A strategy for tackling loneliness – laying the foundations for change*
UQ	University of Queensland

Chair's foreword

It was late 2017, when I was delivering meals to those in need in my community on behalf of my local Meals on Wheels organisation. Towards the end of my delivery run, I knocked on the door of a woman whom I found to be distressed and very sad. She shared with me that her only sister had passed away early that morning. Until she shared this information with me, she had not had the opportunity to share her sad news with anyone else, and further, she told me that I was likely to be the only person that she would share this news with and that I would be the only person that she would talk to that day. I offered her a hug in comfort and put the kettle on to share a cup of tea with her and spend some time listening to her.

This story stayed with me for many days after. I was left feeling hollow and helpless and for the first time questioned whether I truly knew my community, a community that many perceive to be an inner-city community of relative privilege and opportunity. As the days passed, I wondered about the extent of this issue in my community and considered the role of a good Government, asking myself what would a strong, caring and considered Government do to address this issue?

In the following months, I encountered many others with similar stories of a solo existence in need of love, warmth, friendship and connection.

It was this experience that was the catalyst that began my conversations in 2018 with the University of Queensland, the Queensland Community Alliance and the Mount Gravatt Community Centre to investigate social isolation and loneliness in the local community.

Our research and pilot project, the Ways to Wellness Program sparked Government curiosity, attracted a resource allocation and interstate and global interest.

On 27 May 2021, the Legislative Assembly agreed to a motion by the Honourable Leeanne Enoch, Minister for Communities and Housing, Minister for Digital Economy and Minister for the Arts that the Community Support and Services Committee inquire into and report on social isolation and loneliness in Queensland.

This report presents a summary of the committee's Inquiry into social isolation and loneliness in Queensland.

The committee's task was to inquire into and report on the nature and extent of the impact of social isolation and loneliness experienced in Queensland, to identify the causes and drivers, and the protective factors available in society that might mitigate the problem. The terms of reference also required the committee to inquire into and report on the potential benefits of addressing social isolation and loneliness, which I note are significant, both to the individual and to the Queensland community.

The committee learned that social isolation and loneliness is not clearly or universally defined, or easily identified. One person may be socially isolated but never feel lonely, while another may have strong links to community through their work or their family but for various reasons, feel isolated or lonely. The committee also learned that there is no singular action or treatment to end social isolation and loneliness. Rather, the committee heard compelling evidence for systemic change to the delivery and interaction of social and community services and infrastructure to best deliver a more place-based and person-centred approach to address the problem.

During the course of the inquiry, the committee received evidence from world experts in this field. I am deeply appreciative of the information and research generously shared with the committee by academics here in Queensland as well as across the world. Their work forms the foundations of this report upon which the committee has built its recommendations.

On behalf of the committee, I thank those individuals and organisations who provided submissions to the inquiry, both written and in video format. I am especially thankful for the people throughout Queensland who took the time to speak to the committee at one of the committee's public hearings, often setting aside their essential work within their community to share their stories. It is the contribution of these Queenslanders that has guided the committee towards a set of recommendations that shape a vision for a state-wide strategy to address social isolation and loneliness in Queensland.

I thank the Deputy Chair, Mr Stephen Bennett MP, the Member for Burnett and all fellow committee members for recognising the difference that they will make through their genuine care for and commitment to this important issue. I also thank the Member for Everton and the Member for Traeger for their assistance and participation during the regional hearings in North Queensland.

I thank the Parliamentary Service staff for their patience, time and endurance compiling the extensive State, National and global research evidence, personal stories and the experience of organisations across Queensland that supported the clarity with which our committee detailed the recommendations of this report. Finally, I thank the 16 Queensland Government departments and public servants who work tirelessly every day to support Queenslanders to better their lives and who have contributed to the committee's inquiry.

I commend this report to the House.

Corrine McMillan MP

Chair

… connections are important.

One piece of string cannot hold the same weight an entire net can.

Ben White, public hearing transcript, Mount Gravatt, 28 September 2021.

Recommendations

Recommendation 1 **3**

The committee recommends the Legislative Assembly note the report.

Recommendation 2 **8**

The committee recommends that the Queensland Government clearly define social isolation and loneliness to create a common discourse and ensure consistent language to enhance understanding of these issues across Queensland and to support appropriate policy responses.

Recommendation 3 **52**

The committee supports the establishment of a network of frontline professionals involved in preventing and responding to social isolation and loneliness, with a view to building sector capacity through opportunities such as online professional development, supervision and structured mentoring opportunities.

Recommendation 4 **52**

The committee recommends that the Queensland Government explore opportunities to place social work students in Neighbourhood and Community Centres across Queensland, to nurture university partnerships, build capacity of workers, attract staff and support programs responding to social isolation and loneliness.

Recommendation 5 **54**

The committee recommends that the Queensland Government review the funding model for Neighbourhood and Community Centres across Queensland including consideration of measures to help stabilise the workforce, retain corporate knowledge and help ensure centres are best positioned to meet the emerging needs of their communities in preventing and responding to social isolation and loneliness.

Recommendation 6 **73**

The committee encourages the Queensland Government to reflect on the work and the research in other jurisdictions to identify best practice in addressing social isolation and loneliness.

Recommendation 7 **85**

The committee recommends that the Queensland Government consider partnering with other levels of government to implement a state-wide trial of the social prescription model similar to that occurring through the Mount Gravatt Community Centre.

The committee also recommends that the Queensland Government seek the support of the University of Queensland to monitor and evaluate the effectiveness of the model, with a view to government reviewing the findings of such evaluation.

Recommendation 8 **87**

The committee recommends that the Queensland Government identify the most suitable tool to measure social isolation and loneliness, in order to gather longitudinal data for the Queensland context, which will assist in the allocation of resources in the future.

Recommendation 9 **96**

The committee recommends that the Queensland Government advocate to the Commonwealth Government the work of federally-funded primary health network nurses and other Commonwealth-funded positions in addressing social isolation and loneliness, including for primary health network nurses to be allocated to major medical centres where needed.

Recommendation 10   102

The committee encourages the Queensland Government to advocate to city councils of major centres to ensure adequate provision of green space, parks, toilet access, infrastructure and planning, access to transport and meeting places such as libraries, and social infrastructure, to promote mitigating factors that alleviate social isolation and loneliness.

Recommendation 11   109

The committee recommends that the Queensland Government consider the development of online induction and training opportunities for volunteers who contribute to programs aimed at preventing and responding to social isolation and loneliness.

Recommendation 12   112

The committee recommends that the Queensland Government investigates the opportunities to co-locate State and Commonwealth Government funded, and non-government organisations where possible, to support efficiency and client access across communities.

Recommendation 13   115

The committee recommends that the Queensland Government consider a consistent approach among neighbourhood and community centres, mapping services and programs available locally, to support place-based responses to social isolation and loneliness.

Recommendation 14   121

The committee recommends that the government develop a 10-year state-wide strategy to address social isolation and loneliness which should:

   a) Identify the social determinants and preventative factors of social isolation and loneliness

   b) Detail examples of successful strategies through published case studies to help guide best practice

   c) Encourage communities to access, publish on and utilise *My Community Directory* or similar resources to raise awareness of the organisations who provide local support for individuals who experience social isolation and loneliness

   d) Identify opportunities for improved digital access and inclusion in preventing and responding to social isolation and loneliness, including in regional, remote, and very remote communities

   e) Explore the role of infrastructure that supports strong social outcomes, including Neighbourhood and Community Centres, in implementing place-based approaches to preventing and responding to social isolation and loneliness

   f) Investigate and analyse the research related to the effectiveness of a social prescribing model of addressing social isolation and loneliness in Queensland through the use of link workers, including social workers

   g) Further investigate the socio-cultural factors causing social isolation and loneliness in remote First Nations communities, including access to housing.

1 Introduction

1.1 Role of the committee

The Community Support and Services Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 26 November 2020 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The committee's areas of portfolio responsibility are:

- Communities, Housing, Digital Economy and the Arts
- Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
- Children, Youth Justice and Multicultural Affairs.

1.2 Inquiry referral and terms of reference

On 27 May 2021, the Legislative Assembly agreed to a motion that the committee inquire into and report on social isolation and loneliness in Queensland (the Inquiry). The committee is required to report to the Legislative Assembly by Monday 6 December 2021.

The terms of reference for the Inquiry are that the committee inquire into and report on:

1) the nature and extent of the impact of social isolation and loneliness in Queensland, including but not limited to:

   a) identification of and consultation with vulnerable and disadvantaged individuals or groups at significant risk across the life course

   b) the interplay of COVID-19 with this issue

2) the causes and drivers of social isolation and loneliness, including those unique to Queensland

3) the protective factors known to mitigate social isolation and loneliness

4) the benefits of addressing social isolation and loneliness, examples of successful initiatives undertaken nationally and internationally and how to measure social isolation and loneliness in Queensland to determine if implemented strategies are effective

5) how current investment by the Queensland Government, other levels of government, the non-government, corporate and other sectors may be leveraged to prevent, mitigate and address the drivers and impacts of social isolation and loneliness across Queensland, including:

   a) services and programs such as health and mental health, transport, housing, education, employment and training, sport and recreation, community services and facilities, digital inclusion, volunteering, the arts and culture, community development, and planning for accessible, inclusive and connected communities

   b) targeted support to vulnerable and disadvantaged groups and those most at risk

6) the role, scope and priorities of a state-wide strategy to address social isolation and loneliness, considering interactions with existing Queensland and national strategies.

---

[1]   *Parliament of Queensland Act 2001*, s 88 and Standing Order 194.

1.3 Inquiry process

On 9 June 2021, the committee invited stakeholders and subscribers to make written submissions to the inquiry. One hundred and ninety-six submissions were received, including one video submission.[2]

The committee received written advice from the below departments in response to the terms of reference of the inquiry:

- Department of Children, Youth Justice and Multicultural Affairs (DCYJMA)
- Department of Communities, Housing and Digital Economy (DCHDE)
- Department of Education
- Department of Employment, Small Business and Training (DESBT)
- Department of Environment and Science
- Department of Justice and Attorney-General
- Department of Regional Development, Manufacturing and Water
- Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP)
- Department of State Development, Infrastructure, Local Government and Planning
- Department of the Premier and Cabinet
- Department of Tourism, Innovation and Sport (DTIS)
- Department of Transport and Main Roads
- Queensland Corrective Services (QCS)
- Queensland Health
- Queensland Police Service
- Queensland Treasury.

On 30 August 2021, the committee received public briefings about the inquiry from the following departments:

- DCHDE
- Queensland Health
- DCYJMA
- DSDSATSIP
- Department of Transport and Main Roads
- Department of Education
- DTIS.

A transcript is published on the committee's web page; see Appendix B for a list of officials.

---

[2]   Two submissions were confidential.

The committee held public hearings on the following dates and in the below listed locations:

- Brisbane, 13 September 2021
- Mount Gravatt, 28 September 2021
- Toowoomba, 29 September 2021
- Nambour, 30 September 2021
- Brisbane, 11 October 2021
- Mount Isa, 18 October 2021
- Townsville, 19 October 2021
- Cairns, 20 October 2021
- Thursday Island, 21 October 2021.

Please see Appendix C for a list of witnesses.

The submissions, correspondence from departments and transcripts of the briefings and hearings are available on the committee's webpage.

1.4 Report structure

This report considers the evidence provided to the committee across the categories included in the terms of reference. The committee's conclusions and recommendations are provided throughout the report.

The committee's first recommendation is that the Legislative Assembly note the contents of the committee's report.

Recommendation 1

The committee recommends the Legislative Assembly note the report.

---

2 Nature and extent of the impact of social isolation and loneliness in Queensland

2.1 What is social isolation and loneliness?

Social isolation and loneliness, while related, are not the same. Loneliness has been defined as an 'aversive and subjective feeling of social isolation', which occurs when a person perceives that the quality or quantity of social relationships that they have is less than what they desire.[3] Research has found that lonely people feel that their relationships are not meaningful and they are not understood by others.[4]

According to Relationships Australia, social isolation, social connection and loneliness are often used interchangeably, although it is widely understood that they capture highly related but distinct concepts.[5] One of the challenges in reporting on social isolation and loneliness is the absence of universally agreed upon definitions of the terms.

There are many respected definitions of the terms social isolation and loneliness. The DCHDE informed the committee that acknowledging and understanding the differences between social isolation and loneliness is important.[6]

2.1.1 Loneliness

Peplau and Perlman define loneliness as a subjective state of negative feelings about having a lower level of social contact than desired.[7] Some academics define loneliness as a form of social isolation,[8] while others believe that loneliness is an emotional reaction to social isolation.[9]

---

[3]   Letitia Anne Peplau and Daniel Perlman, *Perspectives on loneliness.* In Letitia Peplau and Daniel Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therap*y, New York: John Wiley and Sons, pp 1-20.

Julianne Holt-Lunstad, Timothy Smith, Mark Baker, Tyler Harris and David Stephenson, 'Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review', *Perspectives on Psychological Science* Issue 10, 2015, pp 227–37.

Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

[4]   Michelle H Lim, Thomas L Rodebaugh, Michael J Zyphur and John FM Gleeson, 'Loneliness over time: The crucial role of social anxiety', *Journal of Abnormal Psychology*, Issue 125(5) 2015, p 620.

Consumers Health Forum of Australia, *Loneliness Thought Leadership Roundtable Report – Roadmap for addressing loneliness in Australia*, Report, January 2021, p 5.

[5]   Relationships Australia, *Is Australia experiencing an epidemic of loneliness?* Working paper, September 2018, p 2.

[6]   DCHDE, correspondence, 25 June 2021, p 2.

[7]   Letitia Anne Peplau and Daniel Perlman, *Perspectives on loneliness.* In Letitia Peplau and Daniel Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therap*y, New York: John Wiley and Sons, pp 1-20.

[8]   Graeme Hawthorne, 'Measuring social isolation in older adults: development and initial validation of the friendship scale', *Social Indicators Research,* 2006, 77:521–48.

[9]   Liesl Heinrich and Eleonora Gullone, 'The clinical significance of loneliness: A literature review', *Clinical Psychology Review,* Issue 26, 2006, pp 695–718.

Peplau and Perlman identified three important points of agreement in the way scholars view loneliness:

> First, loneliness results from deficiencies in a person's social relationships. Second, loneliness is a subjective experience; it is not synonymous with objective social isolation. People can be alone without being lonely, or lonely in a crowd. Third, the experience of loneliness is unpleasant and distressing.[10]

The Jo Cox Foundation defined loneliness as:

> … a subjective, unwelcome feeling of lack or loss of companionship, which happens when we have a mismatch between the quality and quantity of social relationships that we have, and those that we want. It is often associated with social isolation, but people can and do feel lonely, even when in a relationship or when surrounded by others.[11]

The Australian Loneliness Report has defined loneliness as a feeling of distress people experience when their social relations are not the way they would like. The report also noted that loneliness is related more to the quality than the quantity of relationships.[12]

Although many people will experience loneliness from time to time,[13] at what point does loneliness become a problem? Ending Loneliness Together has stated that loneliness itself is not a pathological condition, but should be seen as a natural signal to build or regain connections with others.[14]

Further, even when people feel lonely, it can be felt differently by different people. According to Aged and Community Services Australia (ACSA), feelings of loneliness come in many different forms.[15] The ACSA also noted that 'loneliness can be felt with differing levels of intensity and severity', and stated:

> Passing feelings of loneliness are common and do not necessarily reflect a significant underlying problem. It has been argued that loneliness becomes a serious issue, however, when it is persistent and leads to a cycle of self-reinforcing negative thoughts.[16]

2.1.2   Social isolation

Social isolation is considered an objective state, measured by the number of friends, family and other social connections that a person has and the frequency of contact with these social connections.[17]

---

[10]   Letitia Anne Peplau and Daniel Perlman, *Perspectives on loneliness.* In Letitia Peplau and Daniel Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therapy*, New York: John Wiley and Sons, pp 1-20; Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

[11]   Jo Cox Commission on Loneliness, *Combatting loneliness one conversation at a time: A call to action*, 2017, p 8.

[12]   APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 3.

[13]   Relationships Australia, *Is Australia experiencing an epidemic of loneliness?* Working paper, September 2018, p 2.

[14]   Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 12.

[15]   Aged and Community Services Australia, *Social isolation and loneliness among older Australians*, Issues Paper No 1, October 2015, p 6.

[16]   Aged and Community Services Australia, *Social isolation and loneliness among older Australians*, Issues Paper No 1, October 2015, p 6.

[17]   Jenny De Jong Gierveld and Betty Havens, 'Cross-national comparisons of social isolation and loneliness: introduction and overview', *Canadian Journal of Aging,* Summer 2004, cited 2020 Nov 16; 23(2):109–13.
        Erin York Cornwell and Linda J Waite, 'Social disconnectedness, perceived isolation, and health among older adults', *Journal of Health and Social Behaviour*, March 2009; 50(1):31–48.

Peplau and Perlman define social isolation as the state of having minimal contact with others.[18]

Relationships Australia stated that people who have poor or limited social contact can often be considered at risk of social isolation, however, an individual may have a small social network and experience no loneliness or have a large social network and still feel lonely.[19]

As noted by Ending Loneliness Together, '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'.[20]

2.1.3 Other concepts

In addition to social isolation and loneliness, there are a number of other related concepts and terms used across the literature, such as social participation, social inclusion and social exclusion.

2.1.3.1 *Social participation*

Social participation can be taken to refer to a person's involvement in activities that allow interaction with others in society or the community or in society.[21]

The Productivity Commission (PC) stated:

> 'Social participation' can also refer to an individual's access to 'social capital' — the 'features of social organisation, such as civic participation, norms of reciprocity and trust in others that facilitate cooperation for mutual benefit' (Kawachi et al. 1997, p. 1491). Social capital can protect individuals from isolation, provide social safety, improve schooling, education, community life and work outcomes. However, strong social capital can have negative effects — the same strong ties that enable people to act and work together in an inclusive and supportive way can exclude 'non-members' (Portes 1998).[22]

2.1.3.2 *Social inclusion*

In relation to the term social inclusion, the PC concluded:

> 'Social inclusion' can be considered a more *subjective* concept that relates to an individual's feeling of belonging to and being valued and respected by a social network. Feelings of inclusion are likely to be affected by a range of individual factors, as well as the behaviour and attitudes of people in the community. Whether or not they have mental illness, people's ability to participate socially is likely to affect their feelings of social inclusion.[23]

The PC noted that related to this term is the concept of social exclusion, defining it as:

> … the processes whereby people are excluded from the social, political, economic and cultural systems that integrate a person into a community (Cappo 2002). Social exclusion is a multidimensional and complex idea; it includes traditional ideas of disadvantage (such as income) but also extends to a wider range of life domains, with a focus on social connection and participation (McLachlan, Gilfillan and Gordon 2013).
>
> The causes of social exclusion span different areas of people's lives, including access to material resources, employment, education and skills, health and disability, social connection, community and

---

18 Letitia Anne Peplau and Daniel Perlman, *Perspectives on loneliness.* In Letitia Peplau and Daniel Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therap*y, New York: John Wiley and Sons, pp 1-20.

19 Relationships Australia, *Is Australia experiencing an epidemic of loneliness?* Working paper, September 2018, p 3.

20 Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

21 Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 356.

Melanie Levasseur *et al*, 'Inventory and analysis of definitions of social participation found in the aging literature: proposed taxonomy or social activities', *Social Science and Medicine,* December 2010, 71(12):2141-9.

22 Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 356.

23 Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 356.

personal safety. Social exclusion is closely linked between these different areas, with exclusion in one area predisposing people to exclusion in other domains.[24]

2.1.4   Stakeholder views

Public hearing held on Thursday Island, 21 October 2021.

Some submissions emphasised to the committee that there are no universally agreed upon definitions of social isolation and loneliness.[25] Several stakeholders highlighted Peplau and Perlman's definitions of loneliness and social isolation and used it to shape their submission to the inquiry.[26]

Some stakeholders noted that the definitions of social isolation and loneliness differ across the literature.[27] Others informed the committee that the terms social isolation and loneliness are not well defined.[28]

Several stakeholders stressed that the 2 concepts of social isolation and loneliness do not necessarily coexist.[29] However some stakeholders noted that social isolation and loneliness are distinct concepts, despite being used interchangeably.[30]

At one of the committee's public hearings, Professor Jo Badcock, Ending Loneliness Together, provided the committee with a practical example of the difference between social isolation and loneliness:

> For example, when we are talking to aged-care service providers they will often say things like, 'How on earth can our aged-care residents be lonely? They have people come in the morning, then they come in again mid-morning and then they come in to assist with changing or to provide food and so on. How can

---

[24]   Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 356.

[25]   Submissions 58, 88, 121, 125, 162.

[26]   Submissions 4, 8, 30, 58, 74, 93, 111 and 134.

[27]   Professor John Allan, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health, public briefing transcript, 30 August 2021, p 6; Ms Catrin Noone, Early Career Loneliness Research Network, public hearing transcript, 11 October 2021, p 8; submissions 8, 58, 69 and 152.

[28]   Dr Michelle Lim, Ending Loneliness Together, public hearing transcript, Brisbane, 11 October 2021, p 2.

[29]   For example, submissions 8, 58, 69, 88, 111, 114 and 162.

[30]   For example, submissions 79, 88, 114 and 123.

---

they possibly be lonely?' In their minds they are confusing the difference between feeling lonely and being alone or being socially isolated. This is where this key concept difference is relevant.[31]

Professor Badcock stressed the importance of finding a national coordinated definition or distinction between social isolation and loneliness.[32]

2.1.5 Committee comment

The committee notes that the concepts of social isolation and loneliness are not universally defined, which can make social isolation and loneliness more difficult to recognise and address. The committee acknowledges the wealth of academic research in this area, the differing ideas in the literature and the difficulties in defining the concepts. However, the Queensland Government may wish to give further consideration to finding widely accepted definitions of social isolation and loneliness so that the issues can be better addressed.

Recommendation 2

The committee recommends that the Queensland Government clearly define social isolation and loneliness to create a common discourse and ensure consistent language to enhance understanding of these issues across Queensland and to support appropriate policy responses.

2.2 Impacts of social isolation and loneliness

There are many impacts of social isolation. Age UK has reported that through research, it is now known that:

- the effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity

- lonely individuals are at higher risk of the onset of disability

- loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64% increased chance of developing clinical dementia.[33]

The Australian Psychological Society (APS), in collaboration with Swinburne University, produced the Australian Loneliness Report in 2018, based on a national survey of adults in Australia. The Report concluded that there is strong evidence that loneliness has a negative impact on health and wellbeing, educational attainment and economic outcomes.[34] It also noted that loneliness has a substantial impact on the likelihood of being depressed and anxious about social interactions.[35]

Ending Loneliness Together acknowledged 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.[36] Additionally, Ending Loneliness Together noted that the prevalence of loneliness in Australian workplaces creates a flow-on impact on workplace safety, absenteeism, employee retention and business productivity.[37]

---

[31] Public hearing transcript, Brisbane, 11 October 2021, p 4.

[32] Public hearing transcript, Brisbane, 11 October 2021, p 3.

[33] Age UK, *Promising approaches to reducing loneliness and isolation in later life*, January 2015, p 6.

[34] APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 5.

[35] APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 12.

[36] Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 17.

[37] Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 23.

The Australian Loneliness Report stated that compared to non-lonely people, lonely people:

- are more anxious about social interactions
- express more symptoms of depression
- have less social interaction with family, friends and neighbours
- have poorer physical health
- have more negative emotions
- have fewer positive emotions
- have poorer overall quality of life
- are more likely to suppress their emotions
- are less likely to be able to change the way they think about a difficult situation
- have poorer physical health.[38]

There is evidence to suggest that the impacts of social isolation and loneliness vary with age and gender.[39] These impacts can be experienced differently by different people. Logan East Community Neighbourhood Association (LECNA) submitted anecdotal evidence reported by its staff and volunteers showing while the impact of social isolation and loneliness on some people is highly apparent, with some people reporting high levels of depression, anxiety and other health issues that sometimes pose an immediate threat to their lives, others experience impacts at a lesser level which although not as severe can still diminish the quality of their lives considerably.[40]

2.2.1 Stakeholder views

Several stakeholders noted that social isolation and loneliness can have a significant impact.[41]

Suicide Prevention Australia (SPA) submitted that international evidence demonstrates clear associations between loneliness, social isolation and suicidality and self-harm.[42]

Queensland Men's Sheds Association (QMSA) stated that maintaining strong social connections is vital for good mental health, and that social isolation and loneliness are serious problems.[43]

Many submitters acknowledged the links between loneliness and depression and early death.[44] In particular, Relationships Australia recognised that loneliness has been found to be a risk factor for all causes of early death and feeling lonely increases the likelihood of an early death by 26%.[45]

Other submitters noted the links between social isolation and loneliness and other serious health conditions. For example, Friends for Good submitted that some of the biological impacts of social isolation and loneliness have been related to increased blood pressure, heart disease, immune

---

[38] APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 11.

[39] APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 13.

[40] Submission 85, p 2.

[41] For example, submissions 65, 68, 72, 74, 81, 82, 83, 84, 85, 108, 111, 119, 125, 126 and 129.

[42] Submission 65, pp 5-6.

[43] Submission 7, p 1.

[44] For example, submissions 19, 20, 35, 53, 58, 65, 83, 94, 114, 126, 134, 138, 150, 157, 162, 180, 181, 185, 190 and 191.

[45] Submission 83, p 1.

dysregulation and Alzheimer's disease.[46] Similarly, the Queensland Family and Child Commission stated that social isolation, loneliness and associated issues have been linked to poor physical and mental health for individuals, and negative impacts for the community as a whole.[47]

2.2.1.1 Committee comment

The committee notes the evidence from stakeholders that social isolation and loneliness are distinct experiences and may have significant negative impacts upon both physical and mental health.

2.3   The prevalence of social isolation and loneliness

There have been a number of Australia-wide studies conducted on the prevalence of social isolation and loneliness. However, Ending Loneliness Together has noted that loneliness can be difficult to accurately assess, due to its subjective nature, stigma, sampling issues and measurement error.[48]

The Australian Institute of Health and Welfare (AIHW) has identified that most Australians will experience loneliness at some point in their lives. The AIHW noted that data from the Household Income and Labour Dynamics in Australia (HILDA) Survey indicated one in 3 Australians reported an episode of loneliness between 2001 and 2009, with 40% of these people experiencing more than one episode.[49]

The Australian Broadcasting Corporation (ABC)'s Australia Talks Survey collected representative data from over 36,000 Australians in 2019 and 9,000 in 2021, approximately 20% of whom were Queenslanders. The data from the survey showed that 12-15% of Australians frequently or always experienced loneliness. Researchers from the University of Queensland (UQ) and Australian National University (ANU) stressed that these figures have not changed over time, indicating that there has been no improvement (or decline) in social isolation and loneliness within the last 2 years.[50]

The Australian Loneliness Report highlights suggested that loneliness is prevalent in Australia, including:

- one in 4 Australian adults are lonely

- one in 2 Australians feel lonely for at least one day in a week, while one in 4 feel lonely for 3 or more days

- nearly 55% of the population feel they lack companionship at least sometimes

- one in 4 Australians experience high levels of social interaction anxiety

- Australians who are married are the least lonely, compared to those who are single, separated or divorced. Australians in a de facto relationship are also less lonely than those who are single or divorced

- lonely Australians have significantly worse health status (both physical and mental) than connected Australians

- lonely Australians are 15.2% more likely to be depressed and 13.1% more likely to be anxious about social interactions than those not lonely

---

[46]   Submission 119, p 1.

[47]   Submission 62, p 4.

[48]   Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

[49]   The HILDA survey is a broad social and economic survey established to support research in: household and family dynamics; income and welfare dynamics; and labour market dynamics; Australian Government, AIHW, 'Social isolation and loneliness', www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness.

[50]   Submission 43, p 1.

- Australians over 65 years are least lonely; other age groups experience similar levels of loneliness

- Australians over 65 also report better physical and mental health, lower levels of social interaction anxiety, fewer depression symptoms and greater social interaction than younger Australians

- younger adults report significantly more social interaction anxiety than older Australians

- higher levels of loneliness are associated with higher levels of social interaction anxiety, less social interaction, poorer psychological wellbeing and poorer quality of life.[51]

Ending Loneliness Together noted that the estimated prevalence of problematic levels of loneliness is around 5 million Australians at any one time.[52]

The Australia Institute conducted polling on social isolation and loneliness, surveying a nationally representative sample of 1,000 Australians in May 2021. Some questions were previously asked in 2011 and in April 2020.[53]

The Australia Institute noted that the results Queensland were not significantly different to the Australia-wide results from the same poll, and are summarised below.

2.3.1 Social isolation and loneliness in Queensland

Data collected on social isolation and loneliness is generally representative of Australia as a whole, however there is some data available specific to Queensland.

In 2021, the Australia Institute reported the following:

- 79% of Queenslanders agreed that they enjoyed spending time with people important to them

- 75% of Queenslanders agreed that talking with people makes them feel better if something is on their mind

- 66% of Queenslanders agreed that they can usually find someone when they need help

- 59% of Queenslanders agreed that there is always someone who can cheer them up when they are down.[54]

However, the Australia Institute also reported:

- 53% of all Queenslanders agreed that they are not visited as often as they would like to be

- Queenslanders were split evenly on whether they have a lot of friends or not

- 42% of all Queenslanders often needed help from other people but could not get it

- 43% of all Queenslanders often felt very lonely

- 41% of all Queenslanders do not have anyone they can confide in

- 39% of Queenslanders agreed that they have no-one to lean on in times of trouble.[55]

---

[51]   APS, *Australian Loneliness Report*, November 2018, p 5.

[52]   Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

[53]   Submission 96, p 3.

[54]   Submission 96, p 5.

[55]   Submission 96, p 5.

The Australia Institute noted that the results listed above show few differences between Queenslanders and Australians more broadly when it comes to responses to social and mental wellbeing questions.[56]

Professor Catherine Haslam from UQ stated that research conducted last year shows that about 15% of Queenslanders reported frequently or always feeling lonely.[57]

Specific to Queensland, the Australia Institute reported that connectedness has improved since 2020, with 27% of Queenslanders feeling much more connected to friends and family and 35% feeling somewhat more connected. Twenty three per cent of Queenslanders felt less connected to friends and family, of which 7% felt much less connected.[58]

2.3.2 Stakeholder views

Many submitters noted the high prevalence of loneliness within Australia.[59] Queensland Alliance for Mental Health (QAMH) acknowledged that the prevalence and distribution of social isolation and loneliness is unknown within Queensland, indicating the need for state-wide monitoring using validated measures.[60]

In its submission to the inquiry, the QMSA stated that Australia is in the midst of a loneliness crisis, with many experiencing a deficit of social connection.[61]

This view was echoed by other submitters.[62] In particular, Queensland Community Alliance (QCA) argued:

> A consistent and trusted data source for measuring the true state of social isolation and loneliness in Queensland would capture any trends or changes. This needs to provide a state-wide picture, as well as detailed local data, broken down by regional, remote and very remote areas. Survey design that can explore the impact of lock-downs on self-report loneliness by LGA would also provide policymakers with crucial information about areas of priority. We submit that the Queensland Government should introduce a regular (i.e. annual or biennial) research survey to provide this data.[63]

Indicating the prevalence of loneliness in Queensland, at many of the public hearings, the committee heard personal stories from people who described themselves as lonely.[64] Representatives from many neighbourhood community centres (NCCs) also told the committee about the prevalence of loneliness in their communities.

Louise Judge, Manager, Chinchilla Community Centre, stated:

> We see lots of people who are lonely and who are rather socially isolated and at times we become a substitute family, which is rather tragic.[65]

---

[56]   Submission 96, p 9.

[57]   Public hearing transcript, Brisbane, 11 October 2021, p 24.

[58]   Submission 96, p 4.

[59]   For example, submissions 30, 65, 68, 69, 70, 74, 77, 121, 126, 129, 133, 134, 185, 185 and 192.

[60]   Submission 74, p 4.

[61]   Submission 7, p 1.

[62]   For example, submission 185.

[63]   Submission 185, p 9.

[64]   Thelma Cawley, public hearing transcript, Mount Gravatt, 28 September 2021, p 12.

[65]   Public hearing transcript, Toowoomba, 29 September 2021, p 3.

Julia Geljon, Queensland Council for LGBTI Health, spoke to the committee about how social isolation and loneliness affected one of her clients on the Community Visitors Scheme:

> An 82-year-old gay man was assigned to me, as a volunteer visitor, in 2013. At that time he was living in a caravan park with his much younger partner, who had morphed into his carer. He was not in good health physically and suffered from depression. His carer felt unable to continue to provide the level of care needed and he agreed to go into an aged-care facility. This seemed to be a good move as he was now receiving suitable health care, medication and food. Consequently his mental state improved and he was able to enjoy his considerable musical abilities and pursue his many interests. He was an amazing pianist.
>
> I enjoyed his company, his wit, intelligent conversation on many subjects and visits to cafes, museums, libraries and shopping centres. He was given a tablet by a virtual visiting scheme run by the Nundah Community Centre in 2016. He was supplied with data so that he could communicate with his coordinator and also other participants. This gave him the ability to reconnect with a brother in the UK and a cousin in Norway. It also allowed him to go online to pursue his varied interests.
>
> Despite dealing with his health issues, his life was pretty good and he enjoyed his freedom. Apart from me, his ex-partner was the only other visitor he ever had. This changed during the frequent COVID lockdowns in aged-care homes. Initially he did not mind much, but the lack of freedom, visitors and stimulation eventually took its toll and he felt lonely and miserable. It was difficult to keep in touch via phone calls, numerous texts and the occasional visit when allowed, but it became very hard to enthuse him over time, as he just had to sit in his room. His sense of isolation was exacerbated when he was ordered to relinquish his tablet because a new provider did not have a suitable—read LGBTIQ—volunteer to maintain virtual contact. This sudden rule change devastated him as it effectively cut him off from his overseas family and intellectual stimulation.
>
> Just before Christmas we went out and he bought a new tablet but found it difficult to set up because the home's Wi-Fi did not function in his room and he had no-one to help him with it. They said they would provide a booster, which eventually arrived about four months later. In the meantime he had lost interest and his phone had stopped working as well. Because of no visiting rules, it was difficult for his ex-partner to get a new phone to him. The home could not manage it somehow.
>
> My only contact through the home's landline was very hard. Every time I phoned he was unavailable and requested call-backs did not happen. I became concerned when told, 'He's not feeling well at the moment but he's fine.' When I asked for further information they told me they could not give me any because I was not a relative.
>
> In the end I wrote an email to the parent organisation, which was Alzheimer's Australia, to complain about their lack of understanding that some LGBTIQ elders do not have relatives apart from their family of choice. The home then got in touch with me and said they would give me more information. I also expressed my concerns to his ex-partner, who was also his EPA. He was unaware how sick he actually was until the Logan Hospital called as he was not expected to last the night due to a severe bladder infection. He spent two weeks in hospital, but once imminent death had passed again we were not allowed to visit. This episode did so much damage to his mind and body that he never properly recovered and became disoriented. A few weeks later he had a fall and broke his hip, which proved to be inoperable. He died in the PA on 7 June. A lot of that was due to the fact that he really did not have anyone to advocate for him.[66]

2.3.3 Site visits

The committee also conducted many site visits over the course of the inquiry. These site visits were extremely useful in helping the committee understand the seriousness and prevalence of social isolation and loneliness within Queensland, and highlighted the importance of the committee's inquiry. The committee acknowledges that many issues intersect with the issue of social isolation and loneliness.

Some of these site visits, and the committee's learnings from them, are outlined below.

---

[66]   Public hearing transcript, Brisbane, 13 September 2021, pp 26-27.

Mount Gravatt Community Centre

The committee undertook a site visit to Mount Gravatt Community Centre (MGCC). The centre offers a range of groups and activities facilitated by staff and volunteers, including a senior's social group, card making group, Afternoon Friends (a weekly social group specifically for women), a music group, a ukulele group, computer groups, craft groups and a crochet group. The centre also has a large community pantry to provide emergency food parcels, and showers and washing machines for those in need.

MGCC also operates the Ways to Wellness program, a model of social prescribing, which is described in detail in section 6.4 of the report.

Some of the committee members participating in Afternoon Friends, at MGCC on 28 September 2021.

Committee members in the community pantry at MGCC on 28 September 2021.

Momentum Mental Health

One particular visit took the committee to Momentum Mental Health in Toowoomba. Momentum Mental Health was established in 1996 under the name of Toowoomba Clubhouse. The service is now leading the way in contemporary mental health and wellbeing programs, and supports many clients who are socially isolated or lonely. The service is accessible by anyone in the community, provided they have a goal, and are committed to working on that goal. Importantly, a referral is not needed to access the services provided.

Momentum Mental Health support their clients using strength-based approaches to help them build capacity and confidence and aim to get them back in the driver's seat of their own wellbeing and recovery.[67]

During the site visit, the committee met with staff and clients of Momentum Mental Health, and learned about the different programs offered to clients. The committee learned first-hand from this site visit that social isolation and loneliness are closely connected to a decline in mental health issues, and that these issues can affect anyone.

The centre also provides a community lunch, where members of the job club are encouraged to gain valuable work experience and social connection by participating in cooking and eating lunch together several times a week. The committee notes that this provides valuable experience and social connection for many members of the community.

Community lunch at Momentum Mental Health, Toowoomba on 29 September 2021.

---

[67] Momentum Mental Health, 'About us', www.momentummentalhealth.com.au/about-us.

East Creek Community Centre

The committee visited East Creek Community Centre in Toowoomba. Here the committee learned that East Creek Community Centre addresses social isolation and loneliness within the Toowoomba community by providing emergency relief in association with OzHarvest, craft groups, art groups, walking groups, a community literacy program, gardening, a blanket making group, computer lessons and a stroke and brain injury support group. The centre also provide advice and referrals to other support services. Sally Fischer, Manager of East Creek Community Centre noted that feedback from the community has shown that many lonely and socially isolated people come to the centre to join an activity group or to volunteer, which makes it an easier, less pressured way to meet new people, develop a social network and find a meaningful activity to participate in.[68]

Some of the committee members at East Creek Community Centre on 29 September 2021.

---

[68]   Submission 60, p 2.

Picabeen Community Centre

The committee visited Picabeen Community Centre in Mitchelton. Picabeen Community Centre aims to provide a respectful, compassionate and holistic approach to everyone who accesses its services. Each week the centre welcomes over 120 people for social groups, youth support, play groups, activity mornings and volunteering. It provides emergency food parcels to approximately 30 people per week, and 20-25 hot meals through a community barbecue. It also hires out its spaces to facilitate workshops, information sessions, employment opportunities and counselling. It provides around 100 food hampers to families in need each Christmas. Picabeen Community Centre is only able to operate through the assistance of 60 volunteers and 4 social work students completing placements.[69]

Picabeen Community Centre also holds a weekly safe space for young people who identify with the LGBTQIA+ community, or for curious allies of that community. Picabeen Community Centre volunteers told the committee that this group has had a significant impact in connecting young people and building friendships by providing a space of curiosity, safety and acceptance. Representatives from Picabeen Community Centre advised the committee that funding for these groups has not been renewed but Picabeen continues to provide the service in a reduced capacity because it is a significant need of the community.[70]

The committee notes the value of student social workers and the relationship with local universities as an asset to NCCs, and to build workforce capacity.

During the site visit, the committee learned about the prevalence of social isolation and loneliness within the Mitchelton Community, and spoke to student social workers about how they are helping to reduce social isolation and loneliness within the community.

Members of the committee with student Social Workers of Picabeen Community Centre on 30 September 2021.

---

[69]   Submission 84, p 10.

[70]   Submission 84, p 10.

Mount Isa Family Support Service and Neighbourhood Centre

The committee also conducted a site visit to the Mount Isa Family Support Service and Neighbourhood Centre. Leeanne Harris, Centre Manager, told the committee that they have the connection and capacity to notice when people are absent and take steps to reconnect them with their community.[71]

At the Mount Isa Family Support Service and Neighbourhood Centre, the committee learned that the centre addresses social isolation and loneliness by facilitating emergency relief funding, supporting those in domestic violence situations, providing food vouchers, small loans programs, after school activities and help with numeracy and literacy.

Members of the committee with staff of the Mount Isa Family Support Service and Neighbourhood Centre on 18 October 2021.

2.3.3.1 *Stigma*

A number of stakeholders noted the stigma surrounding social isolation and loneliness, and how this can affect measures of how prevalent it is within Queensland.[72] Professor Badcock, from Ending Loneliness Together, told the committee that loneliness can be difficult to measure because of the stigma surrounding the word 'lonely':

> One of the problems that has been identified when you use the word 'lonely' in … questionnaires is that there is a fair deal of stigma associated with loneliness and that tends to inhibit people in speaking up.[73]

Phoebe McKenna-Plumley and Catrin Noone from the Early Career Loneliness Research Network, noted that the stigma surrounding social isolation and loneliness is a big issue in the United Kingdom (UK).[74]

---

[71]   Public hearing transcript, Mount Isa, 18 October 2021, p 2.

[72]   For example Mr David Harmer, Senior Director, Social Policy and Legislation Branch, Queensland Health, public briefing transcript, Brisbane, 30 August 2021, p 6.

[73]   Public hearing transcript, Brisbane, 11 October 2021, pp 4-5.

[74]   Public hearing transcript, Brisbane, 11 October 2021, p 8.

QCA advised the committee of a survey they conducted in Inala, interviewing 50 people:

> Of the 50 people interviewed in listening that QCA conducted in Inala, 42 people revealed a story of isolation relating to themselves or someone they knew. Only two people, however, used the word 'lonely' to describe their own circumstances. More often, when asked a direct question about loneliness, people would tense up, change the subject, or speak about how busy they were performing mundane tasks around the home. While loneliness was seldom explicitly disclosed, once relationships were built and people felt safe sharing their story, it would emerge people had in fact experienced social isolation and loneliness in the past year. When a relational approach was taken, language signalling loneliness - such as "feeling forgotten", "irrelevant", "invisible", or "anxious about social events" - surfaced and there was greater receptivity to referrals to a social group formed during the project.[75]

2.3.4   Committee comment

Based on the evidence submitted the committee notes the high prevalence of social isolation and loneliness within Queensland.

The committee acknowledges that stigma surrounding social isolation and loneliness may make it difficult for lonely or socially isolated community members to access necessary help but is highly supportive of the work of all of the NCCs around the state.

---

[75]   Submission 185, p 10.

3   Causes and protective factors of social isolation and loneliness

3.1   Causes and drivers of social isolation and loneliness

Throughout the inquiry, the committee considered many sources of information and evidence on the causes and drivers of social isolation and loneliness.

Peplau and Perlman identified two distinct classes of causes:

- events or changes that precipitate the onset of loneliness, including:
  - changes in the person's *actual social relations,* eg the ending of a close relationship through death, divorce or separation and physical separation from loved ones, such as children leaving home or a family moving to a new community
  - changes in the person's social needs or desires – life-cycle changes in a person's capacities or desires for social relations may precipitate loneliness if they are not accompanied by changes in actual relations

- factors that predispose individuals to become lonely or to persist in remaining lonely over time, for example:
  - personal characteristics: being shy, introverted, low self-esteem and self-deprecation and inadequate social skills
  - cultural and situational factors: societal values of individualism, competition and independence and unrealistic expectations about relationships
  - a person's immediate social situation – housing and working conditions.[76]

Researchers from UQ and ANU analysed the results of the Australia Talks Survey and noted that a key factor identified as contributing to loneliness is the decline in civic engagement and membership of organisations, clubs and societies, highlighting that the proportion of Australians who are not a member of any organisations rose from 28% in 2019 to 36% in 2021.[77]

At one point, it was thought that loneliness was caused by social isolation, according to Aged and Community Services Australia:

> While previous definitions of loneliness have viewed it as a direct consequence of social isolation, more recent studies have highlighted that loneliness is associated more with the quality of social bonds than the number of connections that a person has. Social isolation may lead to feelings of loneliness but at the same time, it may not; people who have very few social connections may not feel lonely at all. On the other hand, a person with many social connections and interactions can still experience loneliness.[78]

The Australian Loneliness Report stated that loneliness is thought to arise because an innate need to belong to a group is unmet, and therefore loneliness signals a need to form a meaningful connection with others.[79]

---

[76] Letitia Anne Peplau and Daniel Perlman, *Perspectives on loneliness.* In Letitia Peplau and Daniel Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research and Therap*y, New York: John Wiley and Sons, pp 1-20.

Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 11.

[77] Submission 43, p 5.

[78] Aged and Community Services Australia, *Social isolation and loneliness among older Australians*, Issues Paper No 1, October 2015, p 5.

[79] APS, *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing,* November 2018, p 3.

Mind UK (MUK) reported that loneliness has many different causes, which can vary from person to person. MUK suggested that for some people, certain life transitions or events may cause loneliness, whereas for others, loneliness is felt at certain times of year, such as around Christmas. MUK also reported that some research suggests that people who live in certain circumstances, or belong to particular demographics are more vulnerable to loneliness.[80]

Therefore, the causes of social isolation and loneliness can be varied and complex. Ending Loneliness Together stated that what causes loneliness in one person will differ from another.[81]

Loneliness NZ highlighted that social isolation is caused by circumstances, how a person is treated by others, and how a person reacts to situations and people, stating that social isolation may be driven by:

- a person actively withdrawing from others, due to feeling shame, embarrassment, humiliation, fear, bitterness or any other negative emotion affecting a person's ability to interact with others

- other people withdrawing from a person as they fear being in their company, for example, if a person tends to become violent or if they are seen as stigmatised, for example if they have HIV or another illness

- others being socially inept and having anxiety with interaction, if they do not know how to engage with a person, for example, following a bereavement, or cultural differences

- life circumstances, such as living rurally, or a person being physically dependent on others to leave their home

- a person having social anxiety, depression or any other health problem which prevents them from socialising easily.[82]

The AIHW reported that living alone and not being in a relationship are substantial risk factors for both social isolation and loneliness. Similarly, the AIHW reported that many people reported that they were experiencing more social isolation as lockdown restrictions came into effect from March 2020.[83]

The Queensland Government suggested that people experience social isolation for a variety of reasons, such as discrimination, lack of employment, being homeless or generally being in situations where they feel like their ideas and opinions are not valued.[84]

The UK National Health Service (NHS) stated that older people may become socially isolated for a variety of reasons, such as getting older or weaker, no longer being the hub of their family, leaving the workplace, the deaths of spouses and friends, or through disability or illness.[85]

---

[80]   MUK, 'About loneliness', www.mind.org.uk/information-support/tips-for-everyday-living/loneliness/about-loneliness.

[81]   Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 32.

[82]   Conquering Loneliness in NZ, 'Meaning of social isolation', loneliness.org.nz/loneliness/terms/social-isolation/.

[83]   AIHW, 'Social isolation and loneliness'; www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness-covid-pandemic.

[84]   Queensland Government, 'Avoiding social isolation', www.qld.gov.au/community/getting-support-health-social-issue/avoiding-social-isolation.

[85]   UK Government, NHS, 'Loneliness in older people', www.nhs.uk/mental-health/feelings-symptoms-behaviours/feelings-and-symptoms/loneliness-in-older-people/.

3.1.1.1 Structural drivers and risk factors

Some submissions noted the structural risk factors that drive social isolation and loneliness.

Anglicare Southern Queensland identified structural risk factors associated with social isolation and loneliness, including 'socioeconomic disadvantage', 'living alone', 'loss of relationships', disability, illness, lack of transport and housing.[86]

Feros Care advised that structural risk factors impacting social isolation and loneliness include: town planning, poor digital services, physical and mental safety, the stigma of loneliness, loss of social capital, limited community facilities, discrimination, social media, pandemic-enforced isolation, lack of access to transport, housing design and neighbourhood infrastructure.[87]

3.1.1.2 Societal drivers and risk factors

Some submitters outlined that social isolation and loneliness can also be a societal problem.[88] The Council on the Ageing (COTA) outlined that societal factors include government policies around housing, infrastructure, planning, development, transport, changes and reform in relation to welfare and social services, the wider economic and political climate, demographic and familial change, changes in pension and income and media influences.[89]

3.1.1.3 Individual drivers and risk factors

The COTA stated that examples of individual risk factors include physical health, mental health, environmental health, social health, lifestyle, life events and diversity.[90]

The QMHC also noted that the interplay between individual, structural and societal factors is complex and each person will experience social isolation and loneliness differently depending on their own risk and protective factors.[91]

3.1.2 Stakeholder views

Submissions and evidence to the inquiry identified a diverse range of different causes and drivers of social isolation and loneliness.[92] Some stakeholders, such as Neami, further argued that there is diversity in how the drivers and impacts of social isolation and loneliness are felt by different people.[93]

Ending Loneliness Together reported that loneliness is the consequence of multiple risk factors and can differ depending on a person's vulnerability and social environment.[94]

Queensland Network of Alcohol and Other Drug Agencies stated that people who identify as LGBTIQ+, from culturally and linguistically diverse (CALD) communities, asylum seeker and refugee backgrounds, older adults, young people and those with disability are also more likely to experience multiple forms of stigma, discrimination and prejudice which exacerbate social isolation and loneliness.[95]

---

[86] Submission 82, pp 3, 8 & 13.

[87] Submission 150, p 9.

[88] Submission 90, p 2.

[89] Submission 126, p 12.

[90] Submission 126, pp 28 – 29.

[91] Submission 114, p 3.

[92] For example, submissions 29, 65, 66, 69, 82, 92, 94 and 114.

[93] Submission 68, p 6.

[94] Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 12.

[95] Submission 115, p 4.

Some stakeholders advised the committee that those who identify as LGBTIQ+ are particularly vulnerable to social isolation and loneliness.[96] Rainbow Families Queensland submitted that there is still much stigma for LGBTIQ+ families, which directly causes social isolation and loneliness.[97]

The Australian Health Promotion Agency (AHPA) submitted that there are certain groups who may be more prone to experiencing social isolation and loneliness, such as people in prison, low socio-economic groups, Aboriginal and Torres Strait Islander people, CALD people, people with a disability, gender and sexually diverse people, and young people.[98]

AHPA further noted the importance of identifying particular vulnerable and disadvantaged groups so that they can be actively engaged with, to determine the scope of their lived experiences and to tailor services, initiatives and programs to their needs.[99]

Logan City Council noted that the drivers and impacts of social isolation and loneliness go far beyond specific themes and are linked to broader mental health challenges, which in turn can be the driver for other impacts such as homelessness, criminal behaviour, domestic and family violence and addiction.[100]

A selection of the more vulnerable demographics impacted by social isolation and loneliness is set out below.

3.1.3 Young people

A number of stakeholders identified young people as a particularly vulnerable group impacted by social isolation and loneliness.[101]

David Hadley noted that in the school age population, social disconnectedness results in loneliness which increases depression, anxiety, eating disorders, suicide ideation and self-harm.[102] QAMH reported that studies have shown that in young adults, loneliness often occurs simultaneously with anxiety, depression and self-harm.[103] Brisbane Youth Service (BYS) submitted:

> Social isolation and loneliness have a significant impact on overall health and wellbeing for young people. Adolescence marks a developmental phase of navigating complex tasks and transitions that are supported through social engagements across different contexts. Key milestones include the development of self-worth and life skills, as well as connection and relationships with others. The lack of access to social opportunities by young people who may be experiencing issues such as homelessness, mental illness, domestic and family violence and poverty, can lead to interrupted development and social isolation. This can also lead to ongoing ramifications into adulthood for young people for physical and emotional wellbeing, feeding into continuous cycles of isolation and loneliness and poor life outcomes.[104]

Worryingly, the impacts of social isolation and loneliness may also have a lasting effect on young people. Orygen stated that a rapid systematic review identified that children and adolescents who experienced loneliness and social isolation had an increased risk of mental ill-health for up to 9 years

---

[96] For example, submissions 133, 152, 154, 159, 161, 165, 182,

[97] Submission 42, p 2.

[98] Submission 69, p 5.

[99] Submission 69, p 5.

[100] Submission 92, p 2.

[101] For example, submissions 3, 9, 29, 43, 74, 82, 90, 93, 94 and 161.

[102] Submission 180, p 2.

[103] Submission 74, p 4.

[104] Submission 161, p 8.

after loneliness was measured, which was more strongly related to the duration of loneliness than its severity.[105]

Within this demographic, there are also a number of vulnerable sub-groups. The DCYJMA noted the significant risks of social isolation and loneliness faced by children leaving statutory care or transitioning out of the youth justice system, and in particular for those who have experienced very traumatic family experiences or have limited support networks and connections with their communities and to their culture.[106] Jessica Vidafar, General Manager, Access Community Housing, spoke to the committee about the challenges faced by young people leaving out-of-home care:

> We have a lot of young people who exit state care and they, on a day-to-day basis, are becoming homeless as well. They are feeling socially excluded from a lot of services as well and do not have access to housing and a lot of mainstream services.[107]

3.1.4   Older people

A number of stakeholders identified that older Queenslanders are at particular risk of suffering from social isolation and loneliness.[108] National Seniors Australia submitted that older adults are at increased risk of loneliness and social isolation because they are more likely to face factors such as living alone, the loss of family or friends, chronic illness and hearing loss.[109] The PC stated that people living in aged care facilities are at increased risk of social isolation, particularly during the COVID-19 pandemic, due to visitor restrictions and potential limited access to technologies that may offset isolation.[110]

Music Broadcasting Society of Queensland stated that the aged are very vulnerable to the negative impacts of social isolation.[111]

Anglicare Southern Queensland noted that while ageing in itself is not a risk factor, isolation among older people tends to increase because they have greater exposure to structural risk factors outlined above, such as socioeconomic disadvantage, restriction of social activities, living alone, loss of relationships and disability and other chronic health issues.[112]

Queensland Men's Shed Association stated that older people who remain connected with others and have strong relationships are likely to report better quality of life and satisfaction with their life, have delayed progression of dementia and mental decline and need less domestic support and enjoy greater independence.[113]

Ending Loneliness Together submitted that loneliness is associated with an increased number of general practitioner (GP) visits and frequent use of hospital services among older adults,[114] resulting in significant cost to the health system.

---

[105]   Submission 3, p 2.

[106]   Public briefing transcript, Brisbane, 30 August 2021, p 10.

[107]   Public hearing transcript, Cairns, 20 October 2021, p 12.

[108]   For example, submissions 3, 7, 19, 20, 30, 33, 69, 82, 168 and 193.

[109]   Submission 168, p 3.

[110]   Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 383.

[111]   Submission 51, p 1.

[112]   Submission 82, p 3.

[113]   Submission 7, p 2.

[114]   Submission 30, p 6.

Some submitters also noted that social isolation and loneliness is prevalent among those who live within aged care accommodation,[115] or those who receive aged care packages in their own home.[116]

In addition, the committee received evidence to highlight links between social isolation and loneliness in older people and elder abuse.[117]

3.1.5 Families

Tracey Johnson, Chief Executive Officer (CEO), Inala Primary Care, advised the committee that young families with many responsibilities are often lonely or socially isolated:

> … if we look demographically at what has happened in all western countries over the past 30 years, is when women entered the workforce—and I am not saying we should not have had women enter the workforce in the numbers they have. Women historically played a lot of that social glue role and were actively involved in facilitating access to all sorts of community activity. Now we have women and men actively involved in putting their children in day care and working very long hours with long transportation times, particularly in metropolitan locations, to and from work. The data is increasingly showing that those young families are some of the most disengaged, particularly before their kids start sporting activities, from any form of social activity outside of their immediate household and immediate family. That is a big risk as families break down and things like that, which inevitably happens. Again, we need new strategies. We all have busy lives and busy roles. How do we engage the people who are perhaps most busy and most busy because of their caring responsibilities?[118]

Jill Warren, Centre Manager, Picabeen Community Centre also noted that mothers of young children are vulnerable to the effects of social isolation.[119] This view was echoed by Jeril Thomas, Multicultural Australia.[120]

The Queensland Nurses and Midwives' Union (QNMU) stated that new parents are at risk of social isolation and loneliness due to new and additional caring responsibilities, and new parents having decided to take time off work or study, or put aside usual activities to raise their children.[121]

Other submitters suggested that women may be more vulnerable to the risks of social isolation and loneliness.[122] The FARE stated that particularly recently, women have experienced both a lack of adequate childcare while working from home and increasing levels of domestic and family violence during COVID-19, with intensified living arrangements and nowhere to escape to.[123]

The issue of domestic and family violence as a cause and driver of social isolation and loneliness was indicated by several submitters. BYS submitted that most of the young people they engage with have experienced traumatic histories, often whilst in the care of parents and families. BYS noted that with a lack of social supports, women and young people can become easily isolated from important networks and are particularly vulnerable to falling into intimate partner relationships that are characterised by domestic violence and coercive control.[124]

---

[115] Submission 158, p 2.

[116] Submission 194, p 1.

[117] For example, submissions 62, 79, 83 and 125.

[118] Public hearing transcript, Brisbane, 11 October 2021, p 11.

[119] Public hearing transcript, Brisbane, 13 September 2021, p 13.

[120] Public hearing transcript, Mount Gravatt, 28 September 2021, p 21.

[121] Submission 71, p 5.

[122] For example, submission 157.

[123] Submission 154, p 4.

[124] Submission 161, p 7.

The BYS also highlighted that disconnection from family due to family breakdown or conflict is a major driver for social isolation and loneliness.[125]

In addition, the committee noted one submission highlighting the loneliness felt by adoptees.[126]

3.1.6   Life transitions

Christopher Mundy, from the Queensland Families and Communities Association (QFCA) suggested that life transitions can be a key cause of social isolation and loneliness:

> For example, women who are leaving domestic violence situations may have built relationships in the context of that, but leaving a domestic violence relationship may mean leaving all of the social relationships that the romantic relationship was a part of. Also, I am hearing that middle-age men and those who are separated from their children or partner can be really affected by social isolation.[127]

The AHPA also stated that typical transitions can increase a person's vulnerability to social isolation and loneliness, such as moving away from home, starting university, retirement, changes in living environment, bereavement, financial pressures and declining physical health.[128]

The UQ Institute for Social Science Research and Life Course Centre identified that the 2 key life transitions that elevate the risk of loneliness are adolescence and retirement.[129]

Similarly, MGCC submitted that the Ways to Wellness project often sees referrals for people experiencing loneliness at points of transition or life changing events such as leaving school, loss of employment, separation of a loved one, becoming a parent or carer and relocation.[130]

3.1.7   Defence forces

The impact of social isolation and loneliness upon defence personnel and veterans were also acknowledged by stakeholders.

RSL Queensland advised that Queensland contains the greatest proportion of veterans, in comparison to other states, at 32% of the overall veteran population.[131] RSL Queensland highlighted that social isolation and loneliness is commonly experienced by Australian Defence Force (ADF) families, stating:

> By the nature of ADF postings, a family relocating into a new area, starts off already socially isolated and vulnerable They face the challenge of not only physically settling into the community and accessing normal services, but also being accepted, welcomed to be a valued part of that community – and all the time knowing that they will be moved on, yet again. This added factor of vulnerability and consequent risk to all members of the family increases the risk of isolation for these families.[132]

This view was echoed by the Defence Force Welfare Association.[133] Australian War Widows Queensland and Legacy Brisbane also highlighted the social isolation and loneliness felt by widows, and in particular, war widows.[134]

---

[125]   Submission 161, p 6.

[126]   Submission 6, p 1.

[127]   Public hearing transcript, Brisbane, 13 September 2021, p 9.

[128]   Submission 69, p 6.

[129]   Submission 72, p 5.

[130]   Submission 94, p 2.

[131]   Submission 121, p 11.

[132]   Submission 121, p 12.

[133]   Submission 148, p 3.

[134]   Submissions 13 and 61.

3.1.8   Mental health

A number of submissions noted the link between social isolation and loneliness and mental health.[135]

The PC reported:

> Loneliness and mental ill-health are mutually reinforcing — loneliness may increase an individual's likelihood of developing mental illness, but people with severe mental illness are particularly likely to be lonely. Part of the relationship between mental illness and the propensity to feeling lonely may be explained by social factors — people living in areas with low incomes, high unemployment, and poor access to transport and healthcare are likely to have higher levels of loneliness and are more likely to experience mental ill-health.[136]

Jennifer Black, QAMH, agreed with this view and told the committee that a consequence of mental illness can be loneliness and isolation.[137]

Social Work Professional Leaders, Metro North Mental Health, advised the committee about the needs of mental health and substance dependent clients of Metro North Mental Health who are further marginalised and impacted by the issues of social isolation and loneliness.[138] Carissa Uzabeaga, Social Work Professional Lead, Metro North Mental Health stated that mental health and alcohol and drug clients have additional challenges in relation to social connections due to stigma, poverty, homelessness, trauma, family and support network breakdowns, transportation, digital exclusion and social and communication skills, along with other associated health comorbidities.[139]

Dementia Australia noted that people living with dementia can be especially socially isolated due to factors such as unconscious bias, poor education, ignorance, having a comorbid disability, living alone, limited finances, impaired mobility, lack of close family, never having married, transportation challenges and being divorced, separated or widowed.[140]

Selectability Townsville witnesses at a public hearing held in Aitkenvale on 19 October 2021.

---

[135]   For example, submissions 9, 11, 13, 14, 17, 19, 20, 21, 22, 23, 24, 25, 28, 30, 33, 34, 35, 39, 41, 42, 46, 49, 52, 53, 58, 59, 60, 61, 62, 65, 66, 68, 71, 72, 73, 74, 81, 82, 83, 84, 88, 90, 91, 99 and 101.

[136]   Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 380.

[137]   Public hearing transcript, Toowoomba, 29 September 2021, p 8.

[138]   Carissa Uzabeaga, Social Work Professional Lead, Metro North Mental Health, Metro North Hospital and Health Service, public hearing transcript, Brisbane, 11 October 2021, p 18.

[139]   Public hearing transcript, Brisbane, 11 October 2021, p 19.

[140]   Submission 34, pp 6-7.

3.1.9 Physical health

Many stakeholders noted the links between social isolation and loneliness and physical health. Paul Martin, Executive Manager, Queensland Primary Health Network (QPHN) advised the committee:

> We absolutely recognise the impact that loneliness and isolation has on people's mental health and physical health but also the other way around: physical health and mental health can impact on people's ability to make connections and keep those connections.[141]

Queenslanders with Disability Network (QDN) submitted that the experiences of social isolation and loneliness for people with disability are well documented in research, data, and individual stories and experiences. QDN stated that despite progress made following the shift from institutional models of care to a social model of disability, social isolation, lack of inclusion and loneliness for people with disability remains an ongoing issue for many.[142]

The committee also received evidence from a number of specialist interest groups relating to the links between physical disability and social isolation and loneliness. For example, the Save Our Sons Duchenne Foundation provided extensive information about the effects of social isolation and loneliness on those with serious physical disabilities, such as Duchenne or Becker Muscular Dystrophy:

> Loneliness and Isolation are major factors for the Duchenne and Becker community. Duchenne muscular dystrophy is a rare disease and therefore it is challenging to find members of the local community who you can relate to and feel amongst your own. It is also incredibly difficult and isolating when there are very few activities and resources that a person living with DMD can use and you are forced to not attend and take part in various community activities that are easily accessible and catered to for able body people or people not in a wheelchair.[143]

Diabetes Queensland advised the committee that their survey suggests that when people encounter more difficulties with their diabetes, their immediate and dominant response is to withdraw.[144]

Aged and Disability Australia stated that individual and systemic discrimination and unconscious bias against people with disability is common, which can drive social isolation and loneliness.[145]

Palliative Care Queensland highlighted the issues faced by those in palliative care, noting that social interaction for people experiencing a serious illness, dying, death or grief is critical to providing care and support and reduces loneliness and social isolation.[146]

Mark Counter, President, Queensland Positive People told the committee:

> Whilst isolation and loneliness might be an emerging feature of the COVID epidemic, for people living with HIV it has been a constant in most of our lives for very much longer. For long-term survivors like Chris and myself, who have lived with HIV for over 35 years, we have watched as stigma and discrimination associated with HIV have led our colleagues, clients and friends to experience self-imposed isolation and loneliness, severing of family ties and friendships, accelerated HIV related comorbidities linked to ageing and heightened mental health and alcohol and drug problems.[147]

In support of this submission, Associate Professor Lisa Fitzgerald and Associate Professor Allyson Mutch, School of Public Health, UQ, reported that social isolation experienced by people living with

---

[141]   Public hearing transcript, Brisbane, 11 October 2021, p 30.

[142]   Submission 181, p 5.

[143]   Submission 24, p 3.

[144]   Submission 45, p 1.

[145]   Submission 158, p 2.

[146]   Submission 192, p 3.

[147]   Public hearing transcript, Brisbane, 13 September 2021, p 22.

HIV have complex links with HIV-related stigma, discriminations and broader determinants of health, such as employment, housing and social disadvantage.[148]

3.1.10 Culturally and linguistically diverse communities

Inala Primary Care commented that one driver of social isolation and loneliness is the lack of culturally-appropriate events and activities, noting that a high proportion of migrants have unique social needs which are poorly understood by the cultural majority and generally, not met.[149]

The Australian Red Cross highlighted its concern that CALD communities and migrants in transition (refugees, people seeking asylum, people in immigration detention and others who are vulnerable as a result of migration) may be disproportionately affected by social isolation and loneliness.[150]

Tania Miljevic, Multicultural Australia, described the effects of social isolation and loneliness on those from CALD backgrounds:

> The majority of our clients, as Kelly mentioned, have gone through unthinkable trauma and have had to leave their country and settle in a new one. This is not an easy task. From my own lived experience, I know how hard that is. It takes a toll on your mental health. Despite all of the support you receive from service providers, you can still experience social isolation and loneliness. A new country means trying to learn a new system—from Centrelink to the job market to the housing market. It means adjusting to the Australian accent and slang. It means learning English in general.
>
> During COVID lockdowns our clients had to home school their children and receive support services online. This was extremely hard for them, and they often felt lonely and isolated. I specifically work with women from CALD communities. Almost every single woman I have spoken to has reported that they do not have good basic skills. This includes language, literacy, numeracy and digital skills as well. They also report that they do not have Australian friends and they often stay at home. Clients have also reported that it is hard to compete in the Australian job market due to the language barrier, and employers unfortunately often say that it is too hard to recruit someone who comes from a multicultural background. We know this is not true. Our clients, if given the chance, would be the best possible workers. As we all know, work gives people purpose and can break the cycle of loneliness and social isolation.[151]

3.1.11 Geographical isolation

A number of stakeholders agreed that remote, rural or regional living is a significant cause of social isolation and loneliness.[152]

The UK Commission for Rural Communities noted that rural and remote areas have a distinctive set of circumstances that can aggravate the social isolation of older residents in particular, leading to poor health, loss of independence and lower quality of life.[153]

Every Life Matters stated that one in 5 Australians will experience some form of chronic or episodic mental illness each year, with this number expected to rise significantly due to COVID-19. In particular, Every Life Matters noted that this is highly prevalent in regional and rural Queensland, where the resulting impact on the loved ones of individuals and their families, peers and community is immense.[154]

---

[148] Submission 155, p 1.

[149] Submission 66, p 3.

[150] Submission 81, p 2.

[151] Public hearing transcript, Toowoomba, 29 September 2021, pp 14-15.

[152] For example, submissions 22, 24, 25, 35, 50, 58, 61, 71 and 193.

[153] Commission for Rural Communities, *Social isolation experienced by older people in rural communities,* Final report, September 2012, pp 66-70.

[154] Submission 137, p 2.

Gympie Community Place noted that those who live in regional areas can be especially socially isolated, due to a lack of public transport. In addition, the high cost of maintaining a private vehicle can be a significant barrier for social connection, especially if the opportunity to connect requires time, means and money.[155]

Somerset Regional Council echoed these issues and further noted that the Somerset region has been drought declared since March 2017. The regular pattern of drought, combined with floods, bushfires and the COVID-19 pandemic has forced farmers to purchase supplementary fodder and take time to hand feed animals, limiting their capacity to participate in social and other activities, which in turn, increases social isolation and loneliness.[156]

Scenic Rim Regional Council also submitted the following causes and drivers of social isolation and loneliness in Scenic Rim:

> Lack of public transport especially for those who find themselves not having a Drivers Licence (that has allowed them to feel included/involved in community/life) due to age, impairment, or traffic penalty which often leads to the person losing their job therefore dramatically increasing the chance of them becoming socially isolated. Lack of regular local activities that encourage social participation in the smaller townships in Scenic Rim. Individuals who have raised their families locally but now find themselves without any family close due to their teenage/adult children having to move for work, suitable rental accommodation, public transport.[157]

Outback Futures highlighted the need to address social isolation and loneliness in remote and regional areas.[158] At the public hearing in Mount Isa, Selena Gomersall noted that Western Queensland has the worst suicide statistics in the country.[159]

The QNMU stated that in addition to the issues raised above, those in rural and remote communities may not have the same opportunities for social interaction due to limited telecommunications infrastructure.[160] Several other submitters also raised concerns about a lack of broadband connectivity in rural and remote locations, and how this can increase social isolation and loneliness in these areas.[161]

Witnesses at the public hearing held in Mount Isa on 18 October 2021.

---

[155] Submission 50, p 2.

[156] Submission 35, p 4.

[157] Submission 58, p 3.

[158] Submission 22, p 7.

[159] Public hearing transcript, Mount Isa, 18 October 2021, p 12.

[160] Submission 71, p 5.

[161] For example, submissions 69 and 73.

End Loneliness Inc. submitted that the Fly In Fly Out industry in the Central Queensland mining sector has been associated with adverse outcomes for workers, including extreme loneliness.[162]

3.1.12 Housing

Some stakeholders told the committee about how housing can affect social isolation and loneliness.[163] Anglicare Queensland noted that housing may be a structural and systemic barrier to social connectedness in some areas.[164]

The National Association for Prevention of Child Abuse and Neglect advised the committee that a lack of stable social housing can be a driver of social isolation and loneliness, particularly for families.[165] At the public hearing on Thursday Island, Dalessa Yorkstone and Gabrielle Walsh from Torres Shire Council, explained the impacts of social isolation and loneliness on the Torres Strait communities, with particular regard to housing. This is detailed in section 3.2.1, below.

The Institute for Urban Indigenous Health (IUIH) reported that Indigenous Queenslanders living in urban areas experience disadvantages in terms of housing affordability and are more likely to live in areas on the urban fringe, resulting in poor mobility and access to services and transport.[166]

Access Community Housing stated:

> We are experiencing a very competitive private housing market as rental prices continue to rise forcing people on lower incomes to seek financial support to maintain their homes. We are also seeing an increasing demand on social housing as the private rental market is no longer a viable and affordable housing option for many low-income households. More and more people are finding themselves in difficult situations where their tenure is not sustainable and are at risk of homelessness or experiencing homelessness for the first time; for others this is a situation that they can cycle in and out of over their life journey.
>
> There are also concerns that the size of a person's living space and proximity to other people can be a factor that impacts loneliness. Depending on a person's situation and life circumstances they may find it difficult living in alone in a 1-bedroom property. Some people would prefer to be living in shared accommodation where they can communicate and have regular contact with others. Our current focus in the social housing has been to build one bedroom properties to accommodate the need of people on the register of need. It would be helpful for us to also be mindful that not everyone likes to live alone, and consideration should be given to different and alternative models of shared accommodation and housing designs that support connection.[167]

3.1.13 Technology

The Queensland Family and Child Commission submitted that during the COVID-19 pandemic, social media has allowed people of all ages to remain connected to their friends and peers while adhering to social distancing and lockdown restrictions but that habitual or excessive online activity has been associated with depression, anxiety and loneliness.[168]

Brisbane City Council (BCC) stated that digital exclusion, which is where people do not have access to data, devices or the knowledge to use them, can increase a person's experience of isolation.[169]

---

[162]   Submission 143, p 4.

[163]   For example, submissions 31, 77 and 83.

[164]   Submission 83, p 13.

[165]   Submission 141, p 6.

[166]   Submission 144, p 8.

[167]   Submission 31, p 1.

[168]   Submission 62, p 8.

[169]   Submission 12, p 1.

BCC noted that the 2016 Census identified that 38,000 households in Brisbane do not have access to the internet.[170]

A number of submitters recommended that the Australian Government enhance digital infrastructure to connect isolated individuals.[171]

Central Queensland, Wide Bay and Sunshine Coast Primary Health Network (PHN) stated:

> While digital solutions have been successful in some circumstances, it is not a panacea, particularly for groups where digital literacy and confidence is low (such as in elderly people or those who are illiterate or visually impaired), in geographical areas where internet connection is limited, or for those where affordability is a barrier. Thus, for vulnerable groups, these solutions are not entirely viable and further impair accessibility to much needed services.[172]

Some submitters commented that older people are less likely to have access to social media, which may result in a lack of social connection.[173] The University of the Third Age (U3A) noted it teaches its members how to get the best use from their media devices, how to engage in social media and be active with computers.[174]

CEOs of QPHN submitted information about the 'digital divide', stating:

> Social media provides a growing opportunity for people to connect with others like them, family and friends, and to find new interests and connections. However access to knowledge, skills and devices is unequal across the community, with cost being a major barrier. The 'digital divide' needs to be addressed to ensure that all people have equitable access to social media and new technologies. Social media can also create or reinforce loneliness and isolation, by creating unrealistic expectations, a focus on physical appearance and online bullying. People need to be equipped with the skills and understanding to manage social media and their online activities.[175]

Site visit to Picabeen Community Centre on 30 September 2021.

---

[170]   Submission 12, p 5.

[171]   For example submissions 36, 37, 38, 40, 44, 47, 48, 54, 55, 56, 57 and 60.

[172]   Submission 39, p 2.

[173]   Submission 65, p 7.

[174]   Submission 49, p 5.

[175]   Submission 52, p 6.

3.1.14 COVID-19 Pandemic

AHPA stated that physical distancing regulations instituted to control COVID-19 have had a significant psychological consequence for young people and older adults. The AHPA stated that both age groups are marked by developmental or transitional life changes that can increase the risk of, or act as a trigger, for loneliness.[176]

Many stakeholders noted that the COVID-19 pandemic has significantly exacerbated loneliness within Australia and worldwide.[177] Northside Alliance of Neighbourhood Centres stated:

> For many people, traversing the COVID-19 pandemic has been defined as living a personal trauma. For almost two years COVID-19 has become almost the only news, and it is news that is inevitably almost exclusively bad. Such an alarming atmosphere has had adverse effects on peoples' mental health and well-being. The pandemic has caused economic impact in the way of income loss and job losses and/or the emotional impact of domestic violence, acute isolation, and loneliness.

> Social relations have been curtailed by lockdown confinement measures and physical or social distancing. Rituals that are inherent to being human: handshakes; hugs; kisses; and many others, have been suppressed, so loneliness and isolation have thus resulted. For now, no person knows whether nor when they might return completely to their old way of life. The inability to make plans or engage in specific activities that used to be intrinsic parts of peoples' normal life and vital sources of pleasure (like visiting family and friends abroad) has left people confused and demoralized. In reality, people are inherently social beings and companionship, and social interactions are a vital component of living. The state of being, now, has left everyone confused with life as it is.[178]

Dan Nipperess, General Manager, Clubs Queensland, advised the committee that the impacts of the COVID-19 pandemic have been a catalyst in recognising the impact of social isolation and loneliness for many Queenslanders.[179]

Several stakeholders submitted that the COVID-19 pandemic has changed the loneliness risk profile within some demographics.[180]

Ending Loneliness Together reported that one in 2 Australians reported feeling lonelier since the onset of the COVID-19 pandemic.[181]

Orygen reported that international data suggests that young people were 5.3 times more likely to experience loneliness than people aged over 65 during the pandemic.[182]

However, other submitters believed that the COVID-19 pandemic increased loneliness and social isolation for older adults as the most vulnerable demographic.[183] SPA suggested that the COVID-19 pandemic is likely to have exacerbated loneliness among older Australians due to physical distancing measures, difficulties in adapting to technology resulting in social isolation, fear and anxiety of contracting COVID-19 due to higher level risk of fatality from the disease and avoiding accessing necessary healthcare due to online models of service delivery.[184]

---

[176] Submission 69, pp 5-6.

[177] For example submissions 3, 7, 8, 10, 12, 14, 15, 19, 20, 21, 23, 24, 25, 27, 28, 30, 31, 33, 34, 35, 39, 41, 42, 43, 45, 46, 53, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 72, 74, 79, 81, 82, 83, 84, 85, 86, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 106, 108, 111, 112, 113, 114, 115, 125 and 128.

[178] Submission 84, pp 1-2.

[179] Public hearing transcript, Brisbane, 11 October 2021, p 2.

[180] For example, submissions 3, 132 and 185.

[181] Submission 30, p 6.

[182] Submission 3, p 2.

[183] For example submissions 19, 33 and 65.

[184] Submission 65, p 18.

Social Work Professional Leaders at Metro North Mental Health noted:

> Mental health and alcohol and drug consumers are a vulnerable group in our society, frequently suffering the health impacts associated with social isolation and loneliness. The COVID-19 pandemic has exacerbated the vulnerability of this cohort due to the impact of lockdowns and physical distancing. Furthermore, the extended nature of the pandemic has seen more mental health and substance use disorder presentations in hospital and health services increasing the number of people within this cohort.[185]

Recovered Futures submitted that the COVID-19 pandemic has had a lesser impact in North Queensland as there have been fewer restrictions imposed.[186]

The QFCA noted that COVID-19 had flow-on effects on the work of NCCs, particularly because NCCs are reliant on volunteers to operate. Em James, General Manager, QFCA stated that people in the over-70 age group were vulnerable because of the health concerns of contracting COVID-19 and so often stayed at home.[187] Some submitters noted that this demographic were less digitally connected than other groups, which can severely restrict their social connection.[188]

The Community Services Industry Alliance submitted that the evidence shows that Australia has seen a sharp rise in mental health issues during the pandemic and many experts suggest that this will have long term ramifications, including increasing social isolation and loneliness.[189]

In its submission to the inquiry, Orygen noted:

> The pandemic has exacerbated loneliness for young people, with Kids Helpline reporting that social isolation was the second most frequent concern reported by children and young people in relation to COVID-19. Headspace National reported that the proportion of young people in Australia feeling isolated from others increased from 39 per cent in 2018 to 43 per cent in 2020. International data suggest that young people were 5.3 times more likely to experience loneliness than people aged over 65 years old during the pandemic. There is therefore a need to focus and respond to the pandemic's impact on loneliness in young people.[190]

Apunipima Cape York Health Council stated that staff working with Aboriginal and Torres Strait Islander peoples reported that their observations were that COVID-19 added to the layers of stress already being experienced by clients and community members, such as fear of the unknown, social isolation from family, restrictions in carrying out cultural responsibilities, further impact on food security and lack of schooling for children sent home from boarding schools.[191]

Metro North Mental Health and Metro North Hospital and Health Service submitted:

> The current impacts of COVID-19 are replicating those experiences that are typically associated with older age such as unemployment, the passing of loved ones and close friends, and a restricting of social networks. This in effect is increasing the risk of social isolation and loneliness felt by the wider population, more specifically, mental health consumers who in comparison to the general public already have a higher risk of social isolation and loneliness.[192]

---

[185]   Submission 19, p 1.

[186]   Submission 29, p 2.

[187]   Public hearing transcript, Brisbane, 13 September 2021, p 7.

[188]   Submission 65, p 7.

[189]   Submission 111, p 10.

[190]   Submission 3, p 2.

[191]   Submission 8, p 3.

[192]   Submission 19, p 1.

Metro North Mental Health and Metro North Hospital and Health Service further submitted:

> Statistical data demonstrates the impact that social isolation, lockdowns, and physical distancing associated with COVID-19, has had on service demand for mental health and alcohol and other drug help seeking in both emergency departments and community health settings.

> The ADIS 24/7 Alcohol and Drug Support (Queensland Health) service recorded a 41% increase in help seeking callers from across Queensland since the start of the COVID-19 pandemic in March 2020, with this increase sustained since.

> Mental health presentations to Emergency Departments … (including alcohol and drug concerns) have contributed to 11% of the total health expenditure in Metro North Health and are one of the largest determinants of morbidity and mortality. Presentations to ED at The Prince Charles Hospital were 42% higher in the period between April-June 2021 than the same period in 2020, with a sizeable proportion being alcohol and drug related presentations. The Metro North Health – Working Together to Connect Care Program at the Royal Brisbane and Women's Hospital identified that of frequent ED users approximately 28% were re-presenting predominantly due to alcohol and 13% predominately due to drug related concerns.[193]

A number of stakeholders also informed the committee that the COVID-19 pandemic resulted in increased social isolation and loneliness, as targeted support services were forced to close their services temporarily.[194]

Jennifer Black, QAMH, stated that the enforced isolation and loneliness as a result of the pandemic, has had an impact on mental health and rates of anxiety and depression. Ms Black noted that this is particularly prevalent amongst young people.[195]

SPA stated:

> Links exist between social isolation and the experience of psychological harm. For example, post-traumatic stress symptoms are heightened by extended periods of isolation, financial distress, and worry of contracting infection. Heightened anxieties due to pandemic fears can intensify existing mental health problems.[196]

3.2 Factors unique to Queensland

The National Heart Foundation of Australia (NHF) submitted:

> Queensland faces particular challenges because it has one of the most regionalised populations in Australia; with 38% living in regional and remote parts of the state. There are ongoing disparities in the health of people in regional and remote areas compared to urban dwellers. An ageing population is one of the key issues for regions.[197]

However, the most prevalent factors unique to Queensland included effects on Aboriginal and Torres Strait Islander peoples and geographic isolation.

3.2.1 Aboriginal and Torres Strait Islander people

The DCYJMA advised the committee:

> For Aboriginal and Torres Strait Islander peoples and communities, the separation and isolation of children, families and communities was and remains a traumatic experience that correlates with an

---

[193] Submission 19, p 2.

[194] For example, submissions 42, 70, 71, 74 and 81.

[195] Public hearing transcript, Toowoomba, 29 September 2021, p 10.

[196] Submission 65, p 7.

[197] Submission 25, p 2.

increased likelihood of adverse health, cultural and socio-economic outcomes, including social isolation and loneliness when people are not connected to kin, community and culture.[198]

The NHF submitted:

First Nations people face more and unique social, cultural, and financial barriers to engaging in physical activity. Some environmental factors include geographical location (urban, regional, remote) and environmental factors such as feeling unsafe and unwelcome to walk in neighbourhoods.[199]

The Apunipima Cape York Health Council noted the following causes and drivers of social isolation observed by their staff working with Aboriginal and Torres Strait Islander people:

- lack of access to technology, or lack of familiarity with technology

- language and communication difficulties, especially for those whom English is not their first language, which may present difficulty in communicating issues and needs

- institutional racism and discrimination

- poverty.[200]

At the public hearing on Thursday Island, Dalessa Yorkstone and Gabrielle Walsh from Torres Shire Council, explained the impacts of social isolation and loneliness on the Torres Strait communities.

Ms Walsh described the experience of some women in Torres Strait communities:

One of the things that was really interesting in Doomadgee was that it was found that women did not have their own bank accounts. They did not know how to have their own bank accounts. All of their money was through their male partners. The first thing that has been done at Doomadgee is learning how to open a bank account as part of the community safety strategy. That was sent down to the bureaucrats to Brisbane and they said, 'Where's your alcohol management plan?' What? There is such a disconnect, isn't there? Imagine that being the response! Here we are talking about the real drivers and the response back from Brisbane is, 'Where's your alcohol management plan?'

The CEO is so right and she is so passionate about this. Until we change those things, until it stops being $362 to buy food when it is $120 if I catch a ferry, a plane, and get into Cairns, until that stops, and until it stops being $900 a week to rent an enclosed carport—that is more expensive than the Gold Coast, Sunshine Coast and parts of Brisbane. How can someone who earns $5.60 more than the Queensland minimum wage every fortnight possibly hope? So the only way to do it is to get lots and lots and lots of people to put their money in the family and they are living in a two-bedroom enclosed carport for $900 a week. It is an utter disgrace. I feel very passionate about this because these are the real drivers that create the situations that break down communities, break down families, create violence, create disturbance, create abuse. We know it; we have known it for decades. If those real drivers are not addressed, no amount of excellent legislation is going to mean a dot of beans. Do you know what I mean? It is not going to materially change it. It is critical. I am not trying to diminish that, but unless those really important economic drivers are actually addressed it is just a waste. Well, it is just frustrating going around in circles.[201]

Ms Yorkstone stated:

It is all of the dependencies. You just cannot look at the issue through one angle with one lens. The Torres Shire Council covered that in our 10-point plan to the state and our 10-point plan to the federal government. It is all of those issues. We need housing. We need to fix up telecommunications. Telstra needs to deliver on the Universal Service Guarantee. We are not Third World; we are Australians. Where are our options? Why do we not have all of the other service providers like down south? When is the

---

[198]   Public briefing transcript, Brisbane, 30 August 2021, p 10.

[199]   Submission 25, p 2.

[200]   Submission 8, p 4.

[201]   Public hearing transcript, Thursday Island, 21 October 2021, p 12.

conduit from Cairns to Cape York that has the optic fibre ever going to be expanded? There are lots of towers. Everybody has mobile phones. If that bandwidth does not expand, you are wasting time.

Can you imagine if there is a lady at home and she needs to ring the police, or if there is a child at home who is being abused and they need to call someone? Where do they go? This is what we mean. We never start from the same level playing field as South-East Queensland or mainland Australia. We are always steps behind. It is should not be like that. We are all taxpayers. We all get burdened with the same tax bills but, boy, try getting some food down the road! It is hard work. Once you have four or five mouths to feed you are in trouble. Five days out from pay, you have nothing left.[202]

Public hearing held on Thursday Island, 21 October 2021.

Ms Walsh added:

You are trying to study. Children here are trying to get an education during COVID, and so with it all going online—brilliant, but the download and upload speeds are so appalling. What is required for a minimum for an educational institution is one. What they will get at different times of the day on different days of the week at best is 0.75, normally 0.45. The worst case scenario that you need is one and the desirable is two. What do they get here? They get 0.45 to 0.75. What did that mean? That meant that teachers had to go out with hard copies of the material and deliver it, completely destroying the reason for it in terms of COVID. This is madness. As the CEO said, the Torres Shire Council has raised all of these things ad nauseam, year in and year out. We have quantified it. We have tried to talk about it. Nothing seems to be happening.[203]

IUIH submitted that in relation to Aboriginal and Torres Strait Islander people, existing schemes can be leveraged to mitigate social isolation:

To protect vulnerable Elders that had become socially isolated from family and community supports as a result of COVID-19, IUIH has led a national COVID-19 Elder's response in every capital city of Australia, including throughout South East Queensland to provide critical welfare checking, meals and other supports. Through leveraging the existing and trusted client relationships with the Community Controlled Health Sector {CCHS) and a fully integrated aged care, health and disability model of care, this successful measure has highlighted the strength and capability of the CCHS sector for identifying and addressing the needs of most vulnerable Elders.[204]

---

202   Public hearing transcript, Thursday Island, 21 October 2021, p 13.

203   Public hearing transcript, Thursday Island, 21 October 2021, p 13.

204   Submission 144, p 5.

3.2.1.1 *Committee comment*

The committee notes the difficulties faced by First Nations Queenslanders relating to social isolation and loneliness, and acknowledges that there are a range of inter-related factors to be addressed. The committee also notes the importance of access to housing and other housing issues faced by First Nations Queenslanders.

3.2.2 Regional and remote communities

At one of the public hearings, Louise Judge, Manager, Chinchilla Community Centre told the committee about some of the challenges of rural community centres in addressing social isolation and loneliness:

> What contributes to being lonely and isolated in our community? We are no different from any other community, so the issues are the same as everywhere else. However, we have also had prolonged drought, and drought alone is extremely isolating and devastating. There are also changing work and work patterns. If you work on the solar farm, you work for six days a week and you have Sunday off, when everything is shut in small rural communities and there are no social activities to go to, so you stay home alone. You might be a drive-in drive-out worker, so you live in the camp and then you go home to wherever you came from. You actually do not participate in any of those communities because you are not reliable. One in four—'Gee, you're not going to be good on a team.' You cannot be depended upon to be a part of anything, so you choose not to be and you become increasingly socially isolated. Unfortunately, we have high incidents of suicide in those lifestyles.

> Rural communities experience poor internet connections and often no telephone signal for miles. You may need to drive 20 minutes down the road to receive a text message. In an environment where online is viewed as being the answer to staying connected, to participating in health services and education, doing your Centrelink, doing your banking and even doing your groceries in the COVID era, it is not satisfactory to not have access to that technology.

> The tyranny of distance is significant in rural areas. Public transport rarely exists and far too many people have unreliable vehicles and drive without the correct licence. Complex vulnerabilities and being different to others in the community in any way contributes significantly to social isolation, and that is about community attitudes. Shame is a significant contributor to loneliness and isolation, particularly amongst our Aboriginal and Torres Strait Islander communities. Whether it is real or perceived is irrelevant. Interestingly, whether or not you are a local also fits in there because it is a generational barrier. Again, it is a perceived barrier, but it is real and it is experienced.[205]

Helen Davis from Selectability Mount Isa, described the causes of social isolation and loneliness upon residents of Mount Isa:

> I have been to that many meetings about the fact we do not have any bus service in Mount Isa. It has been going on for 25 years. If you happen to have no wheels, which happens as you get older, Mount Isa is a small town but you still cannot get around town. It is too hot to walk. For most of that age group that fall into that category—a lot of women in their 70s and 80s who never learned to drive, for example— there is no bus service. There is absolutely no way. They can get the Irish club/Buffs club courtesy bus, but that is not really the best-case scenario. They have tried this before and it has not worked. That is a major cause of isolation.

> We have a lot of people who do not speak English as a second language. They do not understand. You mentioned the newspaper. I wholeheartedly believe what Leeanne says: people do not read the newspapers anymore. They have gone away from it. The older age group might have done, but if they cannot get down to the newsagent you might as well forget that. I do not even know if they deliver it anymore. I have a house on Maggie island. There is a bus service there. It is the same population as Cloncurry. Your supermarket will deliver over there. Over here you cannot get your groceries delivered. It is click and pick up. If you are an old person or a disabled person and you ring up for your groceries, you have to get someone to pick them up because there is no system in Mount Isa. You have a population of whatever it is now—it has dropped, I know. You have a population of 18,000 or whatever it is and they

---

[205]   Public hearing transcript, Toowoomba, 29 September 2021, p 3.

do not deliver groceries? It is just madness. You can see why people leave Mount Isa and go down to the coast to live. There are a lot of reasons, but that would be one of them. You just cannot function, so what do you do? It is very depressing, very isolating and very lonely for them.[206]

Christopher Mundy, Sector Development Officer, QFCA stated:

Some of the neighbourhood centres that we work closely with are particularly out in the SWAN network, the South West Area Network—that is, Chinchilla, Tara, Charleville, Roma and those sorts of areas. They are dealing particularly with people who have been affected by drought. What we see in different pockets of neighbourhood centres is that they are often responding to natural disasters as well as the day-to-day issues. Particularly in the South West Area Network, they are responding to people in their communities who are affected by drought. That is not only affecting the farmers; there are the flow-on effects to local communities as well, the economic effects to those local centres. They are also dealing with a lot of housing issues out there at the moment as there is a lot of housing being taken up by workers from the city who are coming in to work on various projects there. There is not a lot of housing in those small towns. When people lack housing in those small towns they have to up and relocate to an entirely different town or a different area.[207]

Father Mick Lowcock, Parish Priest of Mount Isa Catholic Church, described his view on the issues that social isolation presents for remote communities such as Mount Isa:

Other examples of social isolation, for example, come about due to drought and remoteness. For example, Boulia is in the Longreach health district, but if you are sick you come to Mount Isa. The flying doctor visits here one week and the next week visits Longreach or Winton. In terms of health issues, at times there is a disconnect with what people have and what they are offered. This Friday we have a funeral in Dajarra, which is 150 kilometres south, halfway to Boulia. I will take the body down in the car. That saves people $500 to $700. Social isolation causes lots of issues that people cannot really fund for themselves, and most of the community are on some sort of pension or disability benefit.

People have raised the issue of blue cards and also the bus service. The issue for me is that, since COVID came, there is no longer a bus service to the Northern Territory. Greyhound used to do that. One of the disabilities associated with Greyhound was that they could not pick up anyone between Townsville and Mount Isa because that is run by Sunbus and subsidised by the government. They would come here and then go to the territory, so people who come here were stranded. We are in the process of hiring a bus to take 20 or 30 people. In the last two weeks we have sent 20 people back to Mornington Island. The department of housing gave us a special dispensation to use some of the money we have to fund that service through Rex Airlines, who have a special arrangement to do that. That is with the police and with our own Riverbed Action Group Outreach and Support Service.

…

The other issue I want to mention is pokies and alcohol. Pokies are open till 4 am now, as you probably know. That is a form of social isolation. People are able to come here and they are offered Tim Tams and free coffee after midnight. People's pension comes in between two and three in the morning, so by four o'clock there is nothing left in the account. All these things which provide some entertainment for people have a side effect which to me is devastating. In the old days, when their pension came in the kids would get the card, go uptown in the morning and get some groceries before they went to the pokies and spent the money. If you have any influence at all, can you bring the closing time for pokies back to midnight at least?

…

If I can mention one more, there is the issue of new people coming to town such as, as people referred to earlier, teachers or mining people. For example, more than three-quarters of teachers in our Catholic schools—we have two primaries and a secondary school here—are in their first, second or third year. That means that a young person comes here from university with no money because they have lived at home. They have bought their car to get out here and then they have to set up house. Some of them

---

[206]   Public hearing transcript, Mount Isa, 18 October 2021, p 8.

[207]   Public hearing transcript, Brisbane, 13 September 2021, p 8.

have never cooked before in their lives. With all the things that young people go through, they feel really isolated. There are extreme cases, and one of the extreme cases was in Cloncurry where someone was coming to the school and he got as far as Barcaldine with his father and he cried so much that he went back to Brisbane.

There is the whole sense of distance. What we could afford to offer is really difficult in terms of young people who come out here as professionals. As an example, Education Queensland offer about $75 a fortnight in terms of education with free electricity. The best we can offer is $175 so we cannot compete, but I think there is a sense in which social isolation for these young people ends up being at the grog, at the shop. As I said, the young engineer comes home sitting in his unit and the young teacher comes home sitting on the front. By mid-Easter or April sometimes, there is only one unit needed, because it is social isolation. There are a lot of issues in the community that could be developed.[208]

Witnesses at the public hearing held in Mount Gravatt on 28 September 2021.

3.3   Protective factors to mitigate social isolation and loneliness

A report by the PC noted that although loneliness is regularly cited as a mental health concern, there is limited evidence about how it should be addressed. The report also noted that there is little evidence about effective interventions to reduce loneliness in cohorts other than the elderly, particularly in relation to people with severe mental illness.[209]

Despite this, there are a number of known protective factors to mitigate social isolation and loneliness. QAMH stated that there are a range of protective factors known to alleviate social isolation and loneliness including social relationships, caring for others, having paid work, engaging in volunteer work and actively participating in community and sporting organisations, although these safeguards alone do not reduce loneliness.[210]

The PC cited research from Age UK,[211] categorising loneliness interventions in the UK into three broad types: foundation services, direct interventions and gateway services:

Foundation services identify people who may be lonely or at risk of loneliness and their individual needs, and provide support when reconnecting with the wider world. This may involve the provision of individual and group cognitive therapies (Cacioppo et al. 2015), or for people with more serious mental illness, social skills training may be required (Webber and Fendt-Newlin 2017). Without access to these foundation

---

[208]   Public hearings transcript, Mount Isa, 18 October 2021, pp 18-19.

[209]   Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 383.

[210]   Submission 74, p 5.

[211]   Age UK, *Promising approaches to reducing loneliness and isolation in later life*, January 2015, pp 12-43.

services to identify people in need of support, and the types of support they need, other interventions are likely to be less effective at reducing loneliness in the general population …

Direct interventions provide people with opportunities for social engagement, either by supporting them in reconnecting or maintaining existing relationships or by providing opportunities for new social connections. Group-based interventions are likely to be most effective when they offer something in addition to opportunities for socialising, in that they are focused on a shared interest or have an educational focus and group members are involved in the running of the group (Cattan et al. 2005). Volunteering is a type of direct intervention that not only reduces the loneliness of those involved, but provides others with opportunities for social engagement. For example, Friend Line is a service staffed by volunteers who talk to people seeking to increase their social interaction …

The way in which these services are developed and delivered is also likely to affect their success, with initiatives developed and run at a local level more likely to be successful (Jopling 2015).

Gateway services such as transport and technology services can serve to facilitate social interactions while enabling other effective interventions. At the same time, the absence of these services can increase loneliness.[212]

Ending Loneliness Together reported that loneliness is not equivalent to social isolation. Solutions that reduce social isolation may not reduce loneliness.[213]

Metro North Mental Health and Metro North Hospital and Health Service noted:

There is a wealth of evidence from medical, epidemiological, psychological and social literature showing that social connectedness is a strong predictor of mental health, physical health, cognitive health and general well-being outcomes. People with more social ties are healthier and happier, they live longer, have better mental health and are less prone to cognitive decline.[214]

The AHPA stated:

There is no one size fits all approach to addressing [social isolation and loneliness], and it is important to tailor interventions to suit the needs of individuals, specific groups or the degree of loneliness experienced (Fayoka, McCorry & Donnelly, 2020). As Fayoka et al. (2020) indicate, these assessments of need should involve the individual and/or group, be conducted early and the results of the assessment should inform tailoring of programs and evaluation. It is recommended that the degree and determinants of the individual's loneliness be explicitly explored to design the most appropriate program.[215]

Relationships Australia stated that a multifaceted service approach is required to address social isolation and loneliness, including individual case work, information and referral, group and community education, community promotion and awareness, collaboration and mapping to reduce duplication of services and better use of resources across the state.[216]

The Neighbourhood Hub highlighted that an important protective factor against social isolation is ensuring financial security, including maintaining payments such as the Australian Government's Jobkeeper and having employment and a sense of purpose.[217]

Associate Professor Lisa Fitzgerald and Associate Professor Allyson Mutch, School of Public Health, UQ, reported that connection and resilience are key to mitigating against social isolation and loneliness.[218] However, as submitted by Cairns Regional Council, resilience to social isolation and

---

[212]   Australian Government, PC, *Mental health,* Inquiry report no. 95, June 2020, p 383.

[213]   Ending Loneliness Together, *Ending Loneliness Together in Australia*, White paper, November 2020, p 7.

[214]   Submission 19, p 2.

[215]   Submission 69, p 4.

[216]   Submission 83, p 6.

[217]   Submission 23, p 2.

[218]   Submission 155, p 1.

loneliness is likely to be the result of a combination of protective factors.[219] The APS and Laidley Community Centre also suggested that, as is evident by the number of vulnerable groups, drivers, and protective factors identified, there cannot be a one size fits all approach to the prevention, mitigation and response to social isolation and loneliness.[220] Some of the more significant protective factors to mitigate social isolation and loneliness are outlined below.

3.3.1   Improving connection and building social capital

Promotion of social participation and inclusion is an important protective factor against social isolation and loneliness.

SPA submitted that a person's social support networks can play a critical role in the level of loneliness or social isolation experienced. Further, SPA summarised that social support networks are measured by the quality, not the quantity of relationships:

> For example, a person may have a smaller social support network but feel more supported than someone who has a larger network. Strong supportive relationships and quality contact with others can act as a protective factor for loneliness, and challenging relationships can increase experiences of loneliness. People without families have been found to experience higher rates of loneliness.[221]

The Uniting Church of Australia (Queensland Synod) stated that isolation and loneliness could be addressed by improving community connections.[222] Townsville City Council echoed this view, noting that protective factors known to mitigate social isolation and loneliness include connection with people outside a person's immediate family circle and opportunities for natural social interactions.[223]

Associate Professor Tegan Cruwys, Acting Professor in Clinical Psychology and Social Psychology, ANU, stated:

> There are also psychological resources that come from our social connections that are particularly beneficial for our health and those effects are quite strong on our mental health. Our team has definitely done some research that has shown that when people are part of groups, when they are embedded in communities and have that sense of belonging, there are all kinds of resources that flow from that. Some of it is really concrete—like when you need to borrow some money or move house there is someone who can step up and help you. Then some of it is less tangible: it is emotional support, it is a sense of purpose and it is a sense of agency that you can get things done when you need to get them done. All those psychological resources contribute to your mental health as well.[224]

Some submissions also highlighted the importance of building social capital as a protective factor against social isolation and loneliness. The Planning Institute of Australia (PIA) defined social capital as the close network of family and friends who generally live nearby, stating:

> Social capital is key to strong social fabric and there are built environment and community development strategies to build that capital. Elements in the built environment that build social capital include:
>
> - free or low-cost community facilities that offer general and targeted programs for community members
>
> - public spaces and local parks located near homes as sites of cultural expression and cultural solidarity

---

219   Submission 132, p 7.

220   Submission 129, p 3; Laidley Community Centre Inc., correspondence dated 1 October 2021, attachment, p 7.

221   Submission 65, p 8.

222   Submission 4, p 2

223   Submission 133, p 5.

224   Public hearing transcript, Brisbane, 11 October 2021, p 27.

- Infrastructure in the parks, including public toilets, that enable ways to build social capital in those spaces

- Accessible green spaces and natural areas to support the chance meeting of strangers

- Sports and recreation infrastructure to bring people together in organised activity

- Halls and meeting places (outdoor and indoor) to underpin group activity

- Public facilities like libraries to welcome and connect groups

- Community gardens or places where people can share common interest.[225]

Site visit to Momentum Mental Health in Toowoomba on 29 September 2021.

Support Groups Queensland Inc. (SGQ) agreed with this approach, noting that building quality relationships and increasing opportunities for social interaction are important protective factors. SGQ also submitted that as an example of this, Coolum Women's Shed have a strong and growing membership of diverse ages and backgrounds.[226]

However, it is important that people connect with the right social supports. Associate Professor Genevieve Dingle, UQ, advised the committee:

What you would see in a community group in Mount Gravatt Community Centre that might be around a 'crafternoon', where you are doing different arts and crafts, is fantastic, but a young man of 25 who has been out of work and out of education and who turns up to the crafternoon is going to see a bunch of middle-age, older women and feel like he does not fit there. We need to think about the different subgroups and where they are likely to feel at home so they can feel, 'There are people like me here.'[227]

Similarly, the Pacific Islands Council Queensland Inc. suggested that better CALD responsive community initiatives are needed, particularly for seniors.[228]

---

225 Submission 73, pp 2-3.

226 Submission 145, p 3.

227 Public hearing transcript, Brisbane, 11 October 2021, p 14.

228 Submission 156, p 3.

3.3.2 Urban planning

The PIA submitted that secure and stable housing is a protective factor for social isolation.[229] Strata Community Association Queensland (SCAQ) submitted that strata properties may provide strong protective factors against social isolation and loneliness by allowing for higher density of population closer to services, jobs and recreational facilities. SCAQ noted that shared facilities within strata properties may also provide opportunities for interaction that may otherwise not occur, particularly for individuals who may be isolated, stating:

> Strata gyms, tennis courts, pools and other recreational facilities provide opportunities for interaction within a very close vicinity, particularly for those unable to drive or with limited access to public transport. The spontaneous opportunities to engage in shared facilities in many bodies corporate can often lead to interactions that would not occur in a comparable community of detached or terrace housing. Bodies corporate tend to foster a sense of community amongst residents. Communal ownership of the common areas encourages a shared investment in the overall well-being of the scheme, both physical and its residents. All of these factors help minimize social isolation and loneliness.[230]

Some stakeholders also noted the use of green space as a protective factor for social isolation and loneliness.[231] SCAQ defined green space as things such as parks and vegetation cover, reporting:

> The University of New South Wales has recently published a study which found that there was a strong correlation between green space levels and a reduction in loneliness. The study found that adults who are resident in neighbourhoods with 30% or greater green space had vastly lower odds of being lonely than their peers living in areas where there is 10% or less green space. This effect was even more pronounced when individuals were living alone-with the odds of feelings of loneliness in these people being halved when living in a high green space area.[232]

The NHF recommended investment in infrastructure and green spaces to enhance built environments to promote social connection, health, and active living for all Queenslanders.[233] SPA and Anglicare Southern Queensland also highlighted green space as a protective factor against social isolation and loneliness.[234]

Robin Hewings, Campaign to End Loneliness UK, stated:

> People can feel lonely if they cannot walk about where they live, if they feel threatened. There is actually a relationship between proximity to green space and loneliness. You think they are two quite different things in a way, but actually if you feel comfortable and welcome where you live, and greenery is obviously a part of that, that actually is kind of really helpful for loneliness.[235]

3.3.3 Volunteering

Public Health England, in collaboration with the University College London Institute of Health Equity highlighted the benefits of volunteering as a protective factor against social isolation and loneliness.[236]

A number of submissions showed how volunteering can promote social inclusion and connectedness. For example, the Salvation Army noted that it has seen people experiencing social isolation and loneliness develop a sense of belonging to the community and a feeling of contributing to something

---

[229]   Submission 73, p 3.

[230]   Submission 28, p 4.

[231]   For example, submissions 25, 28, 65, 82, 126 and 152.

[232]   Submission 28, p 2.

[233]   Submission 25, p 1.

[234]   Submission 65, p 8; submission 82, p 7.

[235]   Public hearing transcript, Brisbane, 11 October 2021, p 18.

[236]   Public Health England, *Local action on health inequalities: Reducing social isolation across the lifecourse,* Practice resource, September 2015, p 47.

bigger.[237] The Neighbourhood Hub stated that access to volunteering is known to reduce social isolation and loneliness.[238]

The Uniting Church in Australia noted that volunteering is an important part of addressing isolation and loneliness, both for volunteers and those people receiving support from volunteers.[239]

St David's Neighbourhood Centre told the committee about one of their members, who successfully reduced her social isolation and loneliness through volunteering:

> One example of this is when someone who was new to the area came to inquire about a volunteering opportunity for herself so she could make some friends. During initial conversations it was identified she was the carer for her husband and had an interest in knitting. Due to the different activities available she is now volunteering at our Thrift Shop, attends the knitting group and her husband is connected in with our aged care program. They have both been able to form friendships, have expressed they have a purpose to their week and be supported to be a part of their new community. Through the centre, they have also connected in with other local services and her husband now also attends a local Men's Shed.[240]

Palm Beach Neighbourhood Centre (PBNC) stated that volunteering has many benefits and offers a solution to address social isolation and loneliness, however, noted the following challenges to volunteering:

> PBNC has the capacity to offer one or two volunteer positions a year, as this is limited to the Coordinator's capacity to carry the additional workload that comes with managing volunteers: recruitment, Blue Card requirements, inductions, training, and ongoing supervision. Volunteers are also less reliable in permanent roles, as they often have reasons as to why they are not able to participate in the workforce part time or full time and so more frequent absences occur and programs experience the flow-on results of that.

> Recently when asked about engaging a Care Army, I simply replied, "We would need a dedicated paid volunteer coordinator who could then engage a group or several groups of volunteers, as I do not have capacity, already wearing at least five hats around the place. There is no down time here and we run at a hectic pace".[241]

The PBNC stated that its current volunteer hours are approximately 70 per week, equal to those worked by paid staff.[242]

3.3.4   Mental health

Orygen stated that loneliness and social isolation in young people requires focused attention to minimise potential impacts on their mental health, recommending that interventions and approaches should focus on mitigating current experiences of loneliness and addressing previous experiences of loneliness and social isolation.[243]

The Foundation for Alcohol Research and Education stated that social connectedness has been found to be inversely related to rates of problematic alcohol and drug use, and submitted that interventions and programs based on fostering social participation can help reduce or protect against these problems and coexisting mental health issues.[244]

---

[237]   Submission 183, p 14.

[238]   Submission 23, p 4.

[239]   Submission 4, p 3.

[240]   Submission 10, p 2.

[241]   Submission 10, p 2.

[242]   Submission 99, p 10.

[243]   Submission 3, p 2.

[244]   Submission 154, p 5.

3.3.5   Physical activity

The NHF stated that physical activity is a protective factor known to mitigate social isolation and loneliness, highlighting the benefits of physical activity in reducing the effects of anxiety, depression and chronic disease.[245]

The U3A advised the committee that typical programs and level of social engagement offered by U3A allow the opportunity for all individuals to increase physical health and well-being and to become intellectually stimulated within a social setting.[246]

3.3.6   Digital inclusion

The Queensland University of Technology (QUT) Digital Media Research Centre submitted that digital inclusion is critical for developing and maintaining social connectedness, reducing isolation, and enabling Queenslanders from all parts of the state to fully participate in society.[247]

AHPA stated that increasingly, digital technologies can help to ameliorate physical isolation and, when used mindfully and with intention, can assist in improving social connections.[248] AHPA further stated:

> If technology is used to address [social isolation and loneliness], these initiatives should co-occur with building technological and digital literacy and improving access to the internet. This is essential, as all individuals should have equal access and the possibility for their connections to be enhanced. Use of technology should not be limited to those who can afford fast and reliable internet, large amounts of data, or those who are technology literate. There are various types of technological platforms available with varying degrees of complexity to wield and engage. The need to tailor approaches to technology usage and the platform may differ by life stage and technological literacy. Resources to support this technological development do exist.[249]

Kristen O'Brien stated that whilst digital intervention is beneficial in addressing social isolation and loneliness, socioeconomic status, digital literacy, physical impairment and limited education are all potential barriers to utilising technologically based interventions and strategies, running the risk of even wider implications for the ageing community.[250]

3.3.7   Aboriginal and Torres Strait Islander People

The IUIH submitted that Aboriginal and Torres Strait Islander peoples suffer disproportionately from mental health conditions, compared to non-Indigenous Australians, citing:

- In Queensland, mental and substance use disorders were the leading cause of total disease burden for Indigenous Australians, followed by injuries, cardiovascular disease and cancer (AIHW, 2016).

- In 2018–19, around 3 in 10 Indigenous Queenslanders had high to very high levels of psychological distress (31%, age-standardised)—a proportion that has not changed significantly since 2008—compared with 13% of non-Indigenous Australians (AIHW, 2020).

- In 2016–17, the age-standardised rate of hospitalisations due to injury or poisoning among Indigenous Queenslanders was 50 per 1,000 population, compared with 34 per 1,000 in 2004–05 (AIHW, 2020).

---

[245]   Submission 25, p 3.

[246]   Submission 49, p 1.

[247]   Submission 75, p 1.

[248]   Submission 69, p 3.

[249]   Submission 69, p 8.

[250]   Submission 70, p 3.

- The leading contributors to the burden of disease and injury amongst Queensland's Indigenous population varies by remoteness. Mental disorders contributed 28.8% to the Indigenous burden of disease in Queensland's Major Cities, 21.19% in Regional areas and 9.1% in Remote/Very Remote areas. In SEQ, mental disorders are the largest contributor to the Indigenous burden of disease, whereas cardiovascular disease is the leading contributor in Remote/Very Remote areas (Queensland Health, 2017).

- Suicide rates amongst Indigenous Queenslanders in the 25–34 and 35–44 age groups are more than double those of Queensland's non-Indigenous population (Australian Institute for Health and Welfare, 2021).[251]

IUIH further submitted that the high levels of chronic disease in Aboriginal and Torres Strait Islander people mean that many people are likely to experience coexisting physical and social or emotional health problems.[252]

Apunipima Cape York Health Council submitted that the specific protective factors enabling Aboriginal and Torres Strait Islander communities to feel strong and resilient include:

- housing employment and education (which affect everyone, not just Aboriginal and Torres Strait Islander communities)

- social connectedness and a sense of belonging

- connection to land, culture, spirituality and ancestry

- living on or near traditional lands

- self-determination

- strong community governance

- passing on of cultural practices.[253]

Apunipima Cape York Health Council advised the committee that protective factors include programs that:

- are developed by and for Aboriginal and Torres Strait Islander people

- are based on the principles of self-determination, human rights and social justice

- support community initiatives

- focus on culture as an enabler for good health and wellbeing

- support people from the Stolen Generation through healing programs and connection with family and culture.[254]

3.4   Factors unique to Queensland

3.4.1   Care Army

On 1 April 2021, the Queensland Government invited Queenslanders to join the Care Army to assist organisations throughout the state to provide a range of services for people who may not have friends, family or neighbours and required support during the COVID-19 pandemic.[255]

---

[251]   Submission 144, p 8.

[252]   Submission 144, p 8.

[253]   Submission 8, p 5.

[254]   Submission 8, p 5.

[255]   Volunteering Queensland, 'Care Army', www.volunteeringqld.org.au/volunteers/care-army.

The Care Army was designed to deliver food, medical and essential services to Queenslanders most at risk, including Queenslanders over 65 and over 50 if they are of Aboriginal and Torres Strait Islander descent, during the COVID-19 pandemic.[256]

Site visit to Momentum Mental Health in Toowoomba on 29 September 2021.

Researchers from UQ suggested that the Queensland Government could utilise its existing Care Army initiative to prevent social isolation and loneliness:

> The Care Army also provides social support to most at risk Queenslanders by teaching them about swapping the physical catch-ups with a telephone call or video-call, maintaining contact with family and friends through sending letters and postcards or group chats and informing them about online yoga and other appropriate exercise websites so that they could still exercise while staying at home. The Queensland government could encourage volunteers to continue this social support initiative even after recovery from the COVID-19 pandemic.[257]

Several submitters cited the Care Army as a successful initiative to prevent social isolation and loneliness.[258]

3.4.1.1 *Committee comment*

The committee notes the Care Army as a substantial resource unique to Queensland. The Queensland Government may consider investigating the role of the Care Army in assisting to address social isolation and loneliness in the future.

---

[256] Submission 72, p 12.

[257] Submission 72, p 12.

[258] Submissions 72, 74, 95 and 114.

3.4.2   Groups 4 Health

Groups 4 Health is a UQ manualised program that provides people with the knowledge and skills they need to build and sustain their social group and community belonging independently in ways that support their health and well-being.[259]

3.4.3   Neighbourhood and Community Centres

There are 127 state-funded NCCs around the state providing friendly, place-based, localised access to individual, family and community services.[260] There are centres in rural, remote and urban communities throughout Queensland. The centres provide services to a wide cross section of the community, including people who are marginalised or have significant needs.[261]

In addition, community connect services support vulnerable individuals and families with complex needs. The services can connect Queenslanders to social programs and support services, including counselling, parenting help, financial literacy or crisis supports. Community Connect services are available in 12 high demand NCCs.[262]

The submission from Associate Professor Dingle, Dr Leah Sharman and Mr Shaun Hayes, School of Psychology, UQ (Dingle, Sharman and Hayes), emphasised that community based programs within NCCs provide connections to the broader community and wider referral pathways.[263]

The DCHDE stated that NCCs:

> … provide the critical social infrastructure to communities across Queensland and often provide a first point of contact for people, a soft entry to the system, a place where people can feel safe and able to connect with other community members, groups and services. These centres and the people who work within them are place based experts for the community that they serve.[264]

Em James, General Manager, QFCA, explained the importance of NCCs at the public hearing in Brisbane:

> As we are speaking with you this morning, over 140 centres across Queensland are opening their front doors to their communities. By the end of this week, over 35,000 Queenslanders will have visited one of these centres. Neighbourhood centres are to local communities what hospitals are to health and schools are to education. Centres are place based, critical social infrastructure, and with adequate resourcing they really are the key to addressing social isolation and loneliness.[265]

Michael Henning, CEO, Maroochy Neighbourhood Centre stated:

> If a crisis occurs or people are feeling isolated or feeling lonely, where do they go? They go to a neighbourhood centre because they know there is a whole range of connections, whether it be services, programs, networks or whatever it is. We find that constantly, with all genders and all ages.[266]

---

[259]   UQ, submission 42, p 8.

[260]   DCHDE, public briefing, Brisbane, 30 August 2021, p 2.

[261]   Queensland Government 'Neighbourhood and community centres', www.qld.gov.au/community/your-home-community/groups-in-your-community/neighbourhood-community-centres.

[262]   Queensland Government 'Neighbourhood and community centres', www.qld.gov.au/community/your-home-community/groups-in-your-community/neighbourhood-community-centres.

[263]   Submission 93, p 7.

[264]   Public briefing transcript, Brisbane, 30 August 2021, p 2.

[265]   Public hearing transcript, Brisbane, 13 September 2021, p 6.

[266]   Public hearing transcript, Nambour, 30 September 2021, p 4.

Committee members with community members in Manunda on 20 October 2021.

Sandra Elton, Manager, North Townsville Community Hub, described the important work she does on a typical day in the North Townsville Community Hub, and how she helps address social isolation and loneliness within her community:

> I will paint you a picture of a recent day in our neighbourhood centre and then you can tell me if you think one worker is sufficient to meet the connection needs of our community. It is 9 am, opening time. The elderly ladies of our weekly social craft group make their way in, along with our team of beautiful volunteers.

> An Indigenous care worker has transported last night's domestic violence escapee to our centre with her two young children sleeping in the car. They are tired from their overnight drive from Cairns. She has facial injuries and is still in shock but needs food and clothing as she has escaped with only the clothes on her back. She is just one of many that we will see today who needs connection and a kind listening ear.

> Whilst she is breaking down in our courtyard telling her story to our temporary worker, I am working with the local cafe and our volunteers to pull together our community event, which is also happening today. As the many senior and socially isolated women start rolling in for their morning of fun, which I am also hosting, I am notified of a mentally distressed man who has accosted one of our volunteers in the car park. He is homeless and desperate and threatening to do something or hurt someone or himself. We manage to locate him, feed him and calm him, to identify and support his needs.

> While I am running the cent sale, through the morning I see through the window a steady stream of families, individuals, seniors and couples presenting to our front counter for crisis support. The temporary staff are run off their feet but I cannot help them.

> This is just one day in one centre. I am sure you are hearing these stories repeated all across the state. We tried closing our doors to crisis support two days a week earlier this year when we lost our last two temporary staff, but the need kept growing and intensifying. As a team we agreed that there was as much work in turning people away and telling them to put their crisis on hold as there was in taking care of their needs on the day that they needed help.

> This means more work for an already overstretched team that has been servicing compounding disasters in our community for two years and counting, first with the 2019 Townsville floods and then COVID started in 2020 and, as we all know, is still continuing. The recent reduction in JobSeeker, the end of JobKeeper and a chronic and escalating housing and homelessness crisis in Townsville have resulted in yet another wave of domestic violence victims, homelessness clients and mental health clients presenting to our centre for connection and support, among other things—and we are not even funded for homelessness or domestic violence.

Our little centre can trace the impact of disaster on our community. Our old normal disappeared with the receding flood waters of 2019. In its wake, our new normal is showing in our dataset as 17 times the volume of clients we used to service, without any extra staff or infrastructure. That is a 1,600 per cent increase and that is a permanent shift, except that now the temporary workers who have allowed us to do all of that work have left because there is no funding for a second worker for my centre.

The current neighbourhood centre funding model has us servicing a growing population of more than 45,000 people with just one worker. That worker is me and I am tired. If you guys can help me understand how we can better solve this problem, how I can turn away the homeless family paying $500 a week to live in a tent, the elderly lady who has lived in our community for 50 years and now lives on cereal as her pension does not allow her and her disabled son to afford rent and meat, the abused mother who needs clothes and food for her children, the suicidal man who is lashing out in desperation or the other 300-plus people per month I will no longer be able to service at my centre because I am just one worker, I would love to know.

As a sector we are in crisis but the solution is simple: support our request as a neighbourhood centre industry for better resourcing of neighbourhood centres now.[267]

3.4.4 Link workers and support staff

The committee received evidence from Associate Professor Dingle, UQ, in regard to some of issues facing link workers in Queensland, as well as their essential role:

Currently, link workers are not registered with the Australian Health Practitioner Regulation Authority like a lot of the other allied health and medical practitioners, unless they happen to have a background where they are trained as one of those. They do come from a diverse range of backgrounds. I do not think there is anything wrong with that. We have spoken about this in earlier meetings. We think people can come from a range of backgrounds that have really good community skills and knowledge. They may come from a teaching background; they may come from an English as a second language teaching background or a sport education background. There are a lot of different people who might play a role as link workers. What they critically need and what the clients need in terms of safeguarding and ethical oversight is really good quality training and supervision. We know from the link workers we have been working with that that is really lacking. They are very isolated themselves. Often they do not have any support and infrastructure and regular supervision and they just burn out. We have already lost a couple of our key link workers just in the few years that we have been working with this project. That is a real shame.[268]

Many NCCs provided information on how they rely on volunteer hours. The MGCC submitted that it engages more than 20 volunteers collectively contributing around 600 hours each week.[269] Community Plus Queensland Inc. stated that the West End Community House in Brisbane, has on average 25 volunteers a week, providing 100 hours of labour across 2 sites.[270] The Neighbourhood Hub reported that in the past financial year, it has had over 15 volunteers contributing a total of over 70 hours each week.[271]

Some submitters commented on the challenges of relying on volunteers. For example, Anglicare SQ stated that sufficient resourcing is required, including funding for a paid coordinator for volunteers, noting that recruitment, training and supervision of volunteers is a significant task that is

---

[267] Public hearing transcript, Aitkenvale, 19 October 2021, p 19.

[268] Associate Professor Genevieve Dingle, Associate Professor in Clinical Psychology, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 13.

[269] Submission 94, p 6.

[270] Submission 160, p 7.

[271] Submission 23, p 4.

unsustainable without paid support.[272] Volunteering Queensland contributed that volunteer engagement must be adequately supported to be sustainable and effective.[273]

3.4.5 Placement of social work students

Other submitters also spoke to the committee about the benefit of social work placement students in NCCs.

The QNMU suggested that the impact of COVID-19 may continue even after the end of the pandemic, which potentially means increased demand on mental health services post-pandemic, which will require an appropriately trained and experienced health workforce.[274]

The AASW stated that on top of the issues that geographical isolation presents, there is a significant shortage of skilled mental health practitioners in regional Queensland, due to difficulties in recruiting, training and retaining quality staff in those areas.[275]

Dr Shane Warren, from the School of Public Health and Social Work, QUT, stated:

> Each year we place approximately 450 human services and social work students with our industry partners in government and non-government agencies across all fields of practice. We have a great deal of experience and perspective around this really important topic of social isolation and loneliness.[276]

3.4.5.1 *Committee comment*

The committee appreciates the value and role of support staff within the sector, as documented by the immense contribution to the community made by social workers, social work students, link workers, volunteers and students on work placements.

Recommendation 3

The committee supports the establishment of a network of frontline professionals involved in preventing and responding to social isolation and loneliness, with a view to building sector capacity through opportunities such as online professional development, supervision and structured mentoring opportunities.

Recommendation 4

The committee recommends that the Queensland Government explore opportunities to place social work students in Neighbourhood and Community Centres across Queensland, to nurture university partnerships, build capacity of workers, attract staff and support programs responding to social isolation and loneliness.

3.4.6 Funding of Neighbourhood and Community Centres

Many submitters spoke to the committee about the funding of NCCs. Deb Crompton, CEO, MGCC stated:

> We have become extremely aware how neighbourhood centres across Queensland are underfunded and need more funding to be able to continue to provide the services we provide.[277]

---

[272] Submission 82, p 8.

[273] Submission 159, p 3.

[274] Submission 71, p 8.

[275] Submission 79, p 8.

[276] Public hearing transcript, Manunda, 20 October 2021, p 2.

[277] Public hearing transcript, Brisbane, 13 September 2021, p 2.

Ms Crompton further detailed the need for more funding of NCCs:

> I appreciate that the government has a limited bucket. For our neighbourhood centre, the number of people who come through the centre and the intensity of the work that we do, having only one worker at the front is just not enough to be able to do what we do.
>
> We had an Indigenous lady recently who was really unwell. We spent all day with her before the ambulance could come. We rang the ambulance at 11 o'clock. They were not there until after dark. We stayed with that lady. Every staff member spent some time with her, because there were other needs that the community centre had to do, to make sure that that lady was well. She is back well and she has visited us and is amazing, but people do not understand the intensity of the work that we do. I think there is a thought that people walk in our door and walk out five minutes later. They do not; they are there for hours sometimes. They are in critical need with mental health issues. The drug issues in the community are massive. People come in in that state, in a state of absolute disarray, not knowing what to do with themselves, and we deal with that. We deal with the clients in the most professional way we can, but staffing is the issue.
>
> We do not even have an alarm system at Mount Gravatt Community Centre. We are considered a large system. We have put our own little system in place. It is a neighbourhood centre, funded by government, but we do not have a button that we can press if one of our staff is in distress. There are little things that can be fixed, but they have not been fixed after all these years, and we have been there for 31 years. Funding is critical to have staff in a safe work environment and to have backup support. We do food parcels and emergency relief day to day. We are now doing community meals once a week which we never did before. With regard to our community meals, people are out there every Wednesday looking for food to keep them going for the rest of the week. It is the only meal they will get. We are all volunteering to do that. I hope that answers your question.[278]

QNMU stated:

> A troubling issue that impacts on social isolation and loneliness is the short funding cycle of community-based organisations and services. Short funding cycles, at times contracting services for only one year, results in organisations facing deep uncertainty over the sustainability of their service. This is compounded by short notice periods regarding whether funding will be renewed, at times only weeks prior to the contracted term. Insecure funding causes disruption, anxiety, and distress among participants and staff.[279]

Similarly, Gympie Community Place submitted:

> Gympie Community Place is a Queensland Government funded community centre. In recent years we were fortunate to receive considerable infrastructure investment from the State Government and in 2013 we were provided with use of a purpose-built community centre facility. This facility has enabled us to grow our services and connect with more people.
>
> - In 2012/2013 financial year, in our old premises, we had 6,200 people attend our centre and we provided information support to 2,800 people.
>
> - In 2018/2019 financial year (last normal pre-COVID period), in our new centre, we had 17,000 people come through the centre and we provided information support to 6,200 people.
>
> With a population of just under 53,000, this is a significant connection with people within our local community. This growth is incredibly positive, and it has allowed us to engage with more members of our community, but it has also placed significant pressure on the organisation and its staff. Our centre receives core funding of just $115,375 per year which is based on the traditional single worker model of many community centres.
>
> The complexity, the volume, and the scope of the work that this one worker is expected to undertake has risen dramatically over recent years, with no additional commensurate increase In funding and no

---

[278] Public hearing transcript, Brisbane, 13 September 2021, pp 2-3.

[279] Submission 71, p 6.

additional resources to support this growth. Now we simply have no more capacity for expansion within our current funding allocation.[280]

Likewise, LECNA commented:

> We need to urgently see an increase Neighbourhood Centre Investment to a minimum of 2.5 workers plus overheads per centre to ensure adequate resourcing of place-based pro-connection responses. Imagine what can be achieved with adequate resourcing - Neighbourhood Centres would have the knowledge to respond with even more solutions unique to their local community and will provide further long-term benefits. Increases in wellbeing and self-esteem enable people to feel better about themselves, find a purpose, form friendships and connections and for some even find meaningful employment.
>
> It is important to acknowledge the multi-faceted nature of this problem and the community solutions, which span Government Departments and require a whole-of-government approach.[281]

Other submitters argued the need for the Queensland Government to provide certainty of continual funding. Em James, General Manager, QFCA, advocated for the Queensland Government to commit to funding for at least 2.5 workers in community centres across Queensland, plus overheads.[282] Mr Mundy, Sector Development Officer, QFCA stated that the current funding model allows for roughly one worker to 250 people, noting that this is not sustainable for the future.[283]

The QFCA stated that the work done by NCC staff and volunteers can take a toll on workers.[284]

Mr Mundy, from the QFCA stated that while there is a pool of people who are qualified in social work, there is a lack of community development practitioners and people who have community development qualifications.[285]

3.4.6.1 *Committee comment*

The committee notes the need for increased resourcing of NCCs.

The committee recognises the need for NCCs to be adequately funded, and for the certainty of continuity of funding to be able to meet the needs of their local communities across Queensland. The committee therefore recommends that the funding model for NCCs across Queensland be reviewed, to better meet the needs of communities, in preventing and responding to social isolation and loneliness.

Recommendation 5

The committee recommends that the Queensland Government review the funding model for Neighbourhood and Community Centres across Queensland including consideration of measures to help stabilise the workforce, retain corporate knowledge and help ensure centres are best positioned to meet the emerging needs of their communities in preventing and responding to social isolation and loneliness.

---

[280] Submission 50, p 4.

[281] Submission 85, p 6.

[282] Public hearing transcript, Brisbane, 13 September 2021, p 6.

[283] Public hearing transcript, Brisbane, 13 September 2021, p 7.

[284] Public hearing transcript, Brisbane, 13 September 2021, p 8.

[285] Public hearing transcript, Brisbane, 13 September 2021, p 7.

4   Costs and benefits of addressing social isolation and loneliness

The committee received evidence from many stakeholders of the estimated costs to society and to the economy of *not* addressing the effects of social isolation and loneliness, as summarised in section 4.1 below.

Loneliness has a variety of impacts upon people's mental and physical health with effects on health and mortality comparable to those of smoking and obesity. Loneliness has been associated with increased costs, largely driven by health and social care resource use.[286] It has been hypothesised that lonely people are more likely to visit physicians to meet their need for interaction and interpersonal stimulation.[287] Some governments in Australia and internationally have recognised the extent of the challenge to address loneliness, and have identified the need to provide inclusive communities especially for older adults, identify the community supports that would address their specific needs, and to assist and enable people to self-manage their own challenges in order to remain socially integrated. The committee received evidence from a number of successful national and international initiatives as summarised in Chapter 5, below.

The committee heard evidence provided by stakeholders that these programs are varied in method and purpose, do not address all sectors of the community and are based on a small number of systematic reviews of new or emerging research evidence. In terms of quantifying the cost of social isolation and loneliness, the committee notes there is limited and often inconsistent evidence of cost effectiveness of programs or initiatives specifically focussed on social isolation and loneliness.[288] Further, cost estimates of available studies are likely to be under-estimated, 'given the lack of evidence of the impact of loneliness/social isolation on important cost categories, such as productivity losses'.[289]

A body of evidence is emerging on social prescribing as a form of intervention to address loneliness by linking participants to social networks within their local communities. Aspects of social prescribing are considered in Chapter 6 below.

The committee notes the sentiment expressed by a number of submitters that it would be economically beneficial to address the costs to society of social isolation and loneliness in order to observe the benefits of fulsomely addressing social isolation and loneliness.[290] Carers Queensland attested:

> Supporting people to socially engage has broader health and social care implications. People with strong social networks are less likely to be dependent on costly intensive support packages or services. Similarly, reducing social isolation enables a possible harnessing of potential contribution to the community through volunteering.[291]

---

[286]   Cathrine Mihalopoulos *et al*, 'The economic costs of loneliness: a review of cost-of-illness and economic valuation studies', *Social Psychiatry and Psychiatric Epidemiology*, 22 May 2019.

[287]   Kerstin Gerst-Emerson and Jayani Jayawardhana, 'Loneliness is a public health issues: The impact of loneliness on health care utilization among older adults', *American Journal of Public Health*, 105, 2015.

[288]   Lidia Engle *et al*, 'Reducing loneliness to prevent depression in older adults in Australia: a modelled cost-effectiveness analysis', *Mental Health & Prevention*, 24, 2021, p 8; Cathrine Mihalopoulos *et al*, 'The economic costs of loneliness: a review of cost-of-illness and economic valuation studies', *Social Psychiatry and Psychiatric Epidemiology*, 22 May 2019.

[289]   Cathrine Mihalopoulos *et al*, 'The economic costs of loneliness: a review of cost-of-illness and economic valuation studies', *Social Psychiatry and Psychiatric Epidemiology*, 22 May 2019.

[290]   For example, Roger Marshall, President, Logan East Community Neighbourhood Centre, Panel of QCA, public hearing transcript, Mount Gravatt, 28 September 2021, p 19.

[291]   Submission 11, p 7.

4.1 Estimated cost of social isolation and loneliness

The DCHDE advised:

> In the past five years, internationally and in Australia, attention on social isolation and loneliness has broadened from its relationship to individual morbidities, to seeking an ecological understanding of impacts on cultural, social and health systems and the cost to the economy. Addressing isolation and loneliness is increasingly understood as a potent preventative strategy for a broad range of health, social and economic problems.[292]

The PC's *2020 Inquiry Report on Mental Health* found that the costs of mental ill-health and suicide to the Australian community are substantial, totalling $43–70 billion in 2018-19. This estimate includes:

- direct expenditure on healthcare and other supports and services ($16 billion)

- lower economic participation and lost productivity ($12–39 billion)

- informal care provided by family and friends ($15 billion).[293]

According to the PC, the cost of disability and premature death due to mental ill-health, suicide and self-inflicted injury is equivalent to a further $151 billion. The social and emotional costs of lower social inclusion associated with mental ill-health, if quantified, would add to this.[294]

The Ending Loneliness Together submission noted the PC's 2020 Mental health report[295] as indicative of the significant impact of loneliness and social isolation across the lifespan of Australians and a major contributor to health system costs.[296] The report findings confirm those of the National Mental Health Commission in their recent report, *The economic case for mental health prevention: Summary*, which states:

> The most recent comprehensive data available indicates that, in 2016–17, the national recurrent expenditure on mental health–related services was around $9.1 billion. Every year, around 8 million working days are lost due to mental illness. Poor mental health also has economic consequences beyond healthcare, with other costs incurred such as in the areas of justice, aged care, housing and education.[297]

Ending Loneliness Together also refer to the additional economic burden or 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. 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. Tackling loneliness could therefore assist with reducing waiting time and improving access to health services.[298]

In regard to older people, Ending Loneliness Together advised that lonely older adults have a 58% higher risk of developing dementia compared to their less lonely peers. Loneliness adds to the cost of dementia in Australia, which is expected to rise to $16.7 billion in direct costs, and to $9.1 billion in indirect costs by 2036.[299] Studies indicate a greater increase in health care spending if lonely older adults develop other health conditions, such as depression, which incur substantial cost. Therefore,

---

[292] Correspondence written briefing, p 1.

[293] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No.95, 30 June 2020.

[294] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No.95, 30 June 2020, p 4.

[295] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No.95, 30 June 2020.

[296] Submission 30, p 3.

[297] Australian Government National Mental Health Commission, *The economic case for investing in mental health prevention: summary*.

[298] Ending Loneliness Together, *A National Strategy to Address Loneliness and Social Isolation: Pre-Budget Submission 2021-2022*, January 2021, p 10.

[299] Submission 30, p 6.

there is a compelling case for addressing loneliness to prevent depression in older adults and to mitigate the subsequent adverse health and economic impacts.[300]

Ending Loneliness Together further submitted that while the financial burden of loneliness on Australia's health service has not yet been quantified, equivalent costs to Medicare in the United States of America, using longitudinal data from older adults, have been estimated at US$6.7 billion annually.[301]

Dr Chiva Giurca informed the committee of an economic study of loneliness from 2017 in the UK:

> In the UK alone, there was a study from the London School of Economics [LSE] in 2017 quantifying £6,000 per person in terms of costs associated with loneliness and their care. If you add that together, I think the study from LSE showed a total of £2.5 billion per year in the UK alone spent on loneliness.[302]

Dr Giurca attested that analysis in Australia would likely result in similar cost burden per head of population indicators to the United Kingdom study cited above.[303]

4.1.1   Stakeholder views

Miles Morgan Australia submitted that, based on their research into ageing and aged care services in Australia, 'governments at every level will continue to face significant downstream costs due to the ageing population without an investment in combined interventions targeting both the nutritional and social challenges faced by older adults, including loneliness'.[304]

A number of community-based stakeholders provided general estimates of the significant economic burden of social isolation and loneliness in Queensland. For example, Louise Judge, Manager, Chinchilla Community Centre, submitted:

> All loneliness and social isolation comes at a huge cost to individuals, communities and government, and this is readily seen in very poor health outcomes and mental health outcomes in rural communities.[305]

According to Em James, General Manager, QFCA:

> This underinvestment [in social services] means that there are countless people across the state who are experiencing or are at risk of loneliness and social isolation who do not have access to the support they need. This has significant on-cost to us as a society.[306]

Madison Smee, Picabeen Community Centre, also stated:

> I think the consequences of not dealing with this crisis will end up costing the government millions in the long run. Some of our service users may end up in places like hospitals, rehabilitation and the justice system.[307]

---

[300]   Lidia Engle *et al*, 'Reducing loneliness to prevent depression in older adults in Australia: a modelled cost-effectiveness analysis', *Mental Health & Prevention*, 24, 2021, p 1.

[301]   Submission 30, p 5; Lynda Flowers *et al*, 'Medicare spends more on socially isolated adults', 2017, 'Medicare Spends More on Socially Isolated Older Adults', *Public Policy Institute*, November 2017.

[302]   Public hearing transcript, Brisbane, 11 October 2021, p 12; as at 6 December 2021 £1 is worth $1.75 Australian dollars.

[303]   Public hearing transcript, Brisbane, 11 October 2021, p 12.

[304]   Submission 33, p 1.

[305]   Public hearing transcript, Brisbane, 13 September 2021, p 3.

[306]   Public hearing transcript, Brisbane, 13 September 2021, p 6.

[307]   Public hearing transcript, Brisbane, 13 September 2021, p 12.

Public hearing held in Aitkenvale on 19 October 2021.

4.2 Potential benefits of addressing social isolation and loneliness

4.2.1 Economic indications

Cost benefit analysis suggests that the benefits of initiatives to address social isolation and loneliness exceed the costs of such initiatives. The DCHDE provided examples of the costs and identified benefits of some of the initiatives and programs funded by the department.

The DCHDE advised:

> [Mount] Gravatt Community Centre was allocated $144,780 in one off funding in June 2020 to respond to people experiencing social isolation, by applying the Ways to wellness program in conjunction with researchers from the University of Queensland. A further $434,340 over three years (from June 2021 to June 2024) was made available to the centre to continue the program.[308]

The DCHDE further stated: 'The UQ evaluation of the program is ongoing and incomplete. Findings regarding the efficacy of the Ways to Wellness project are not yet known'.[309]

In regard to assistance to NCCs, the DCHDE advised:

> The Queensland Government investment in NCCs increased from $12.7 million in 2013-14 to $18.9 million in 2020-21. The Queensland Government owns and maintains 54 of the 127 centres operated by community organisations across the State. Remaining centres are either owned by the organisation, local council, an independent landlord, or have other arrangements in place.[310]

In terms of cost benefit analysis the DCHDE provided the following with respect to NCCs:

> The Queensland Families and Community Association's Neighbourhood Centre Survey Results 2020 report states that $4.08 of social value goes back into communities from every $1 of state government funding. There are 1.83 million visitors that create over $77 .8 million of social connections. The 2,200 volunteers every week contribute 540,000 hours' worth over $23 million each year.

> Other research undertaken by Deloitte argues that NCCs provide significant economic benefits such as improved social capital. In Deloitte's report, Estimating the social impact of Gippsland's Neighbourhood Houses, it is estimated that the 20 NCCs in the Gippsland area contributed $15.63 million in benefits to the community, returning $2.78 in economic and social benefits for every $1 invested into their houses.

---

[308]   DCHDE, correspondence, 17 November 2021, attachment, p 1.

[309]   DCHDE, correspondence, 17 November 2021, attachment, p 2.

[310]   DCHDE, correspondence, 17 November 2021, attachment, p 2.

The most significant monetised benefit was in the reduction of social isolation in the community, amounting to $6.98 million in benefits to the community. Deloitte additionally indicated that there are further benefits from NCCs that cannot be quantified or monetised such as mental health outcomes, education and community safety benefits.[311]

Concerning the Digital Inclusion program, the DCHDE advised:

Community based essential digital skills programs create significant social return on investment of $4 to every $1 spent, and effectively helped to improve people's confidence and essential digital skills.[312]

The DCHDE provided the following analysis in regard to the Queensland Community Support Scheme:

The Queensland Government invested $37.15 million in 2020-21 to the program. In its first year, QCSS provided support to over 8,500 individuals through 335,456 hours of In-home and Community Connection supports across the State. In 2020-21 it is estimated that over 390,000 hours of support will have been delivered to eligible Queenslanders. 39% of QCSS clients (3,727 of 9,661) received Community Connection supports in 2020-21.[313]

A UK program to address loneliness in older people, *Together for Health*, in which people were offered a range of interventions including shopping, cleaning, befriending, being taken to social events, help with medication, reassurance, dog walking and post-hospital-discharge checks, was the subject of analysis by Leeds Beckett University in 2016. The analysis found that for every £1 invested in Together for Health, the social return on investment (ROI) is at least £4.84.[314]

Refer to Chapter 7, section 7.2 for estimated economic benefits of social prescribing in the UK.

Specifically addressing the burden of mental ill-health in Australia, the PC estimated:

Improvements to people's mental health increase their likelihood of employment and their expected income, while also improving their health-related quality of life. The benefits … are substantial and are mainly derived from improvements in people's quality of life — up to $18 billion per year (corresponding to an improvement in quality-adjusted life years of up to 84 000 annually). There would be additional annual benefits of up to $1.3 billion per year as a result of increased economic participation and productivity. These benefits would require expenditure of up to $4.2 billion per year and generate savings of up to $1.7 billion per year.[315]

The QFCA *Neighbourhood Centre Survey Results 2020* state that, 'For every $1 invested by the Queensland Government, the sector produces $4.08 in social value'.[316] This return on social investment was calculated from survey participants that were funded by the DCDSS Neighbourhood Centre program. The calculation compared the overall value of these NCCs with the level of centre funding allocated by the state government. Overall, centres returned at least $4.08 of social value for every dollar invested by the DCDSS into the Neighbourhood Centre Program.[317] Overall community value of neighbourhood centre activities was combined and extrapolated to 138 funded and unfunded NCCs. It was estimated that the total community value of the entire Neighbourhood Centre network in Queensland is $77,800,781.[318]

The National Mental Health Commission cited two loneliness intervention programs for older people to address social isolation, and reported that an assessment of their cost effectiveness indicated a

---

[311] DCHDE, correspondence, 17 November 2021, attachment, p 2.

[312] DCHDE, correspondence, 17 November 2021, attachment, p 3.

[313] DCHDE, correspondence, 17 November 2021, attachment, p 3.

[314] Anne-Marie Bagnall *et al*, *Measuring well-being outcomes in older people receiving help from the Age UK 'Together for Health' initiative: A social return on investment analysis: final report*, July 2016, p 6.

[315] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No 95, 30 June 2020, p 4.

[316] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No 95, 30 June 2020, p 5.

[317] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No 95, 30 June 2020, p 25.

[318] Australian Government, PC, *Mental Health Inquiry report: Actions and findings*, No 95, 30 June 2020, p 25.

positive ROI ratio and associated cost savings based on an analysis of cases of mental illness prevented.[319]

Associate Professor Dingle, UQ, advised the committee there has not been a cost analysis of loneliness or the economic benefits of funding specifically for psychological support and services and community supports through NCCs. Associate Professor Dingle cited a 2017 study into the benefits that the arts can bring to people's health and wellbeing in the UK, and stated:

> I feel like we have underestimated the importance and the impact of these social care options. It is not to replace anything; it is really that we need to think of them and take them seriously as a part of health.[320]

Public hearing held in Mount Isa on 19 October 2021.

4.2.2 Stakeholder views

Associate Professor Lisa Fitzgerald and Associate Professor Allyson Mutch advised: 'Addressing social isolation and loneliness will have major social and economic benefits, reduce the burden of loneliness, and reduce morbidity and mortality'.[321]

Associate Professor Dingle and others, found in a systematic review of 24 social group interventions that promote social connection to reduce depression symptoms, and published in February 2021, that these programs are 'an effective way to manage mild to moderate depression symptoms in a variety of populations'.[322] The review further concluded:

> … social group interventions offer a meaningful and effective way of managing depression and offer a viable approach to be used alongside antidepressant medication tapering and discontinuation.[323]

---

[319] The ROI ratio calculates gain or loss in relation to the initial investment of funding. A ROI ratio which is greater than $1 means that the cost savings are greater than the costs of the intervention. For example, a ROI of $1.50 means that for every $1 invested, $1.50 will be returned to the economy. Australian Government National Mental Health Commission, 'The economic case for investing in mental health prevention: summary', www.mentalhealthcommission.gov.au/getmedia/ffbf9cc5-f815-4034-b931-dfc0c1ecb849/The-economic-case-for-investing-in-mental-health-prevention.

[320] Public hearing transcript, Brisbane, 11 October 2021, p 16.

[321] Submission 155, p 2.

[322] Associate Professor Genevieve Dingle, Dr Leah Sharman, *et al*, 'The effects of social group interventions for depression: Systematic review', *Journal of Affective Disorders*, February 2021, p 67.

[323] Associate Professor Genevieve Dingle, Dr Leah Sharman, *et al*, 'The effects of social group interventions for depression: Systematic review', *Journal of Affective Disorders*, February 2021, pp 78-79.

Carers Queensland submitted:

> Supporting people to socially engage has broader health and social care implications. People with strong social networks are less likely to be dependent on costly intensive support packages or services. Similarly, reducing social isolation enables a possible harnessing of potential contribution to the community through volunteering.[324]

Ending Loneliness Together submitted that reducing excess costs to healthcare by improving prevention and early intervention so that people can manage their own loneliness – a key benefit identified from an evidence-based strategy to address loneliness and social isolation.[325]

---

[324] Submission 11, p 7.
[325] Submission 30, p 7.

5 National and international approaches to address social isolation and loneliness

As discussed in Chapter 3 of this report, social isolation and loneliness impact on people from all backgrounds and at various stages of their lifecycle. A number of different approaches have been adopted in Australia and internationally in an attempt to address the issue.

5.1 Australian approaches

Australian, state and territory and local governments have all provided varied funding packages and support to local councils and community organisations for programs to address the social isolation and loneliness of Australians.[326]

5.1.1 Australian Government

The Australian Government currently funds a number of schemes and programs aimed at addressing social isolation and loneliness, including:

- the Community Visitors Scheme (CVS) – a free service which arranges volunteer visits to older people to provide friendship and companionship and help develop social connections. The CVS focusses on the needs of older people considered to be at higher risk of feeling isolated[327]

- the Seniors Connected Program – a program scheduled to run from 2019-20 to 2023-24, with a budget allocation of $10 million (excluding GST) to address loneliness and social isolation experienced by Australian aged over 55 (aged 50 and over for Indigenous Australians).[328]

The program aims to expand the existing Friendline telephone support service and increase the number of Village Hub projects (community-led initiatives which provide social activities such as walking groups, yoga, trivia and fundraising events, digital skills mentoring and arts and cultural classes).[329]

The Older Persons COVID-19 Support Line also provides support to older persons who 'feel lonely or worry about a loved one'.[330]

5.1.2 Victoria

The Victorian Government has established the *Community Activation and Social Isolation* initiative to help people maintain important connections with family, friends and local community during the COVID-19 pandemic. There are two parts to the initiative:

---

[326] Australian Government, Australian Institute of Health and Wellbeing, 'Social isolation and loneliness', www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness-covid-pandemic.

[327] Australian Government, Department of Health, 'Community Visitors Scheme (CVS)', www.health.gov.au/initiatives-and-programs/community-visitors-scheme-cvs.

[328] Australian Government, Department of Social Services, 'Seniors Connected Program', www.dss.gov.au/communities-and-vulnerable-people-programs-services/seniors-connected-program.

[329] Australian Government. Department of Social Services, 'Seniors Connected Program', www.dss.gov.au/communities-and-vulnerable-people-programs-services/seniors-connected-program.

[330] Australian Government, 'Fact sheet: older persons Covid-19 support line', www.health.gov.au/sites/default/files/documents/2020/07/older-persons-covid-19-support-line-coronavirus-covid-19-older-persons-covid-19-support-line.pdf.

- people can call the COVID-19 hotline to receive emotional support if they are feeling lonely or disconnected

- people can be linked to a community connector in their local government area who will help connect them with local organisations who can provide ongoing emotional, practical or social support.[331]

The *Let's Stay Connected Fund* was also established by the Victorian Government to help communities stay connected during the COVID-19 pandemic. The program provided grants of between $5,000 to $200,000 to combat social isolation and loneliness issues in the community to:

- better connect participants with others in the community

- provide opportunities for the community to contribute or volunteer

- increase the capability of participants to connect with their community and support organisations

- ensure an equitable spread of support across both metropolitan and regional areas

- increase collaboration between Government and support services.[332]

In 2019, the Royal Australian College of General Practitioners reported on a social prescribing trial operating in Brimbank, Victoria. IPC Health, a local community health organisation, has been running a trial of social prescribing aimed at finding non-medical pathways for patients experiencing loneliness, isolation or struggling with nutrition.[333]

5.1.3   New South Wales

The New South Wales (NSW) Government recently established the *Combatting Social Isolation for Seniors during COVID-19 Grants Program*.

In 2020, the NSW Government awarded more than $700,000 in funding for projects to reduce social isolation for seniors during COVID-19. This included $100,000 from the Ministerial Advisory Council on Ageing for projects that supported their work plan.

Twenty-four organisations received funding to deliver innovative programs that helped older people connect with each other through online engagement or other methods that maintain social distancing. One project funded the provision of 30 iPads loaded with Skype, Zoom and FaceTime to hospitals, aged care facilities and community members to enable communication with family and friends.[334]

---

[331]   Victorian Government, Families, Fairness and Housing, 'Community services sector – COVID-19', www.dffh.vic.gov.au/community-services-sector-covid-19#community-activation-andnbspsocialnbspisolationnbspinitiativenbsp.

[332]   Victorian Government, Regional Development Victoria, 'Let's Stay Connected Fund', www.rdv.vic.gov.au/grants-and-programs/lets-stay-connected-fund.

[333]   Doug Hendrie, 'Social prescribing tackling loneliness and isolation', *NewsGP (RACGP),* 29 November 2019.

[334]   NSW Government, Communities and Justice, 'Combatting Social Isolation for Seniors during COVID-19 Grants Program', www.facs.nsw.gov.au/inclusion/seniors/overview/chapters/what-we-are-doing-under-the-strategy/combatting-social-isolation/successful-grant-recipients.

5.1.4   South Australia

In July 2021, the South Australian Government announced its *Community Connections Program* aimed at '… linking isolated adults with the right connections at the right time to improve individual mental health, independence, quality of life and overall health outcomes'.[335]

Under the program the state government will deliver $41.7 million to fund 12 weeks of targeted support to those who need extra help to live full and independent lives. Priority is given to unpaid carers, Aboriginal or Torres Strait Islander people, people from new and emerging CALD communities, people who are financially disadvantaged and people living in communities of persistent or location-based disadvantage.[336]

Community Connections is delivered across metropolitan and regional South Australia by not-for-profit organisations. The state government has also partnered with regional local health networks, Aboriginal community-controlled organisations, community passenger networks and care support organisations in the delivery of service.[337]

Support through the program may include helping people to get involved in local community activities, find new support groups, meet their neighbours or get extra help at home. As displayed in figure 1 below, the program comprises of:

- Regional Coordinating Partners coordinate the program across their region, ensuring all other partners work together to provide the most appropriate services and support for participants. The Regional Coordinating Partners work with the participant to find an appropriate service or community group to reach their agreed goal

- Community Partners deliver community-based programs, services and activities to help participants gain independence and make strong, sustainable connections with family, communities and other networks

- Carer Support Partners operate in a similar way to Community Partners, specifically supporting unpaid carers to engage socially beyond the home, actively participate in local community activities and increase social connection, community participation and inclusion, and

- Care Partners provide home-based health support to help participants become more independent.[338]

---

[335]   South Australia, Hon Steven Marshall MP, Premier, 'Innovative new program to combat social isolation', media release, 5 July 2021.

[336]   South Australia, Hon Steven Marshall MP, Premier, 'Innovative new program to combat social isolation', media release, 5 July 2021.

[337]   South Australia, Hon Steven Marshall MP, Premier, 'Innovative new program to combat social isolation', media release, 5 July 2021.

[338]   Government of South Australia, Department of Human Services, 'Community Connections', dhs.sa.gov.au/services/community-services/community-connections.

Figure 1: South Australia's Community Corrections partners and services

Source: Government of South Australia, Department of Human Services, Community Connections, https://dhs.sa.gov.au/services/community-services/community-connections

5.2 United Kingdom

5.2.1 Minister responsible for Loneliness

In January 2018, the UK Government appointed what was described as the world's first Minister for Loneliness, Hon Tracey Crouch MP.[339] The position was not a separate ministerial office, but an expansion of the remit of the Minister for Sport and Civil Society.

The intention of the new role was to ensure that loneliness reduction remains an enduring parliamentary priority. The role aims to raise awareness of loneliness and help people build connections to lead happier and healthier lives.

The UK Minister for Loneliness has called on mayors, council leaders, public sector leaders, business leaders, employers, community and volunteer groups, and everyday citizens, as it has been recognised that government alone cannot solve the public health epidemic of social isolation and loneliness.[340]

5.2.2 Loneliness Strategy

Following the Ministerial appointment referred to above, the UK Government published *A connected society: A strategy for tackling loneliness – laying the foundations for change* (Loneliness Strategy) in October 2018. The UK Government outlined three overarching goals:

- a commitment to improving the evidence base to better understand what causes loneliness, its impacts and what works to tackle it

---

[339] The Jo Cox Foundation, 'The Jo Cox Loneliness Commission', www.jocoxfoundation.org/loneliness_commission

[340] QCS, submission 185, p 15.

- to embed loneliness as a consideration across government policy, recognising the wide range of factors that can exacerbate feelings of loneliness and support people's social wellbeing and resilience

- to build a national conversation on loneliness to raise awareness of its impacts and to help tackle stigma.[341]

The Loneliness Strategy applies to England only, and emphasises that the creation of a 'socially connected society' was to be achieved through the efforts of government, civil society, local government, employers and individuals. The strategy specified objectives and programs in relation to:

- social prescribing, so that GPs can link their patients with services

- supporting the development of community organisations through infrastructure projects to develop under-utilised community spaces and community-led housing projects

- creating a transport network that supports people's social connectedness by connecting them with their community

- maximising the power of digital technology with targeted approaches for the elderly and disabled

- targeting vulnerable population groups

- arts, libraries and volunteering opportunities.[342]

The Loneliness Strategy included cross-government work to tackle loneliness, overseen by a Ministerial implementation group, to embed the consideration of loneliness across government policy making.

5.2.2.1 *Social prescribing*

The Loneliness Strategy committed the Department of Health and Social Care and the NHS England to expanding social prescribing, described as '… enabling organisations to refer people to a range of services that offer support for social, emotional or practical needs'.[343] See Chapter 6 of this report for further information about social prescribing.

The Loneliness Strategy included a commitment to making social prescribing a 'core element' of local provisions by taking the following actions:

- a universal national offer of social prescribing in place by 2023 – including a commitment to train 1,000 social prescribing link workers by the end of 2020-21, with more staff to be trained by 2023-24 – achieved by embedding link workers and making them available in every Primary Care Network (similar to Hospital and Health Services in Queensland)

- creating a database of social prescribing schemes

- publishing a best practice guide to social prescribing

- launching an online social prescribing platform for commissioners and practitioners

- piloting new accredited learning programs for link workers

- creating regional social prescribing steering groups.[344]

---

[341] UK Government, Department for Digital, Culture, Media and Sport, UK Loneliness Strategy, Strategy paper, October 2018, p 7.

[342] Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health, public briefing transcript, Brisbane, 30 August 2021, p 6.

[343] UK Government, Department for Digital, Culture, Media and Sport, UK Loneliness Strategy, Strategy paper, October 2018, p 25.

[344] UK Government, Department for Digital, Culture, Media and Sport, UK Loneliness Strategy, Strategy paper, October 2018, pp 25-26.

NHS England has also published the *Common outcomes framework for social prescribing*, which includes measurements used to evaluate the impact of social prescribing on individuals, community organisations and the health and social care system.[345]

In October 2019, the National Academy for Social Prescribing was established with government funding. The academy's role is to standardise the quality and range of social prescribing across England, increase awareness of its benefits, develop and share best practice, train and accredit practitioners and bring together organisations working in health, housing, local government, arts, culture and sport.[346]

The UK Loneliness Strategy also included funding for voluntary sector organisations who run referral and connector schemes.

5.2.2.2 *Housing and planning*

The UK Loneliness Strategy also included several commitments on housing, tenancies and planning to foster better communities, including:

- consulting on longer tenancies which could increase the 'length of time lived in a neighbourhood and the sense of belonging to it'

- diversifying the housing market, including growing the build-to-rent sector, where landlords build and operate dedicated private rental accommodation

- research into community-led housing (housing that is built or brought back into use by a local community group) and co-housing (an intentional community of private homes clustered around a shared space)

- promote the role of design quality and community cohesion in tackling loneliness

- running industry events to share evidence and best practice design to encourage engagement with communities.[347]

5.2.2.3 *Work and employment*

A number of actions and strategies were taken in relation to work and employment, including:

- frontline workers across the public sector were helped to recognise and act on loneliness, including social workers, 19,000 work coaches and other Jobcentre[348] claimant-facing staff

- a network for employers committed to tackling loneliness, chaired by the Campaign to End Loneliness and comprised of more than 30 organisations that employ over 900,000 people, met throughout the year to explore how to support employees to overcome loneliness.[349]

5.2.2.4 *Community spaces*

In addition, the UK Loneliness Strategy highlighted the role of community infrastructure in tackling isolation and preventing isolation. In doing so, the strategy sought to work across various government

---

[345] UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 29.

[346] UK Government, Department of Health and Social Care, 'New national academy set up', www.gov.uk/government/news/social-prescribing-new-national-academy-set-up.

[347] UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, pp 31-32.

[348] UK Government employment agency, similar to Centrelink in Australia.

[349] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, p 8.

departments, including those responsible for culture and sport, education, transport, work and pensions, business, the environment and food and rural affairs.[350] The strategy included:

- community hubs

- schools as community spaces – the Department for Education issued guidance for schools on maximising the use of their premises by the community

- underused railway property – Department for Transport ran training sessions on volunteering and social inclusion

- Jobcentres to encourage connections – local initiatives to bring together claimants from different backgrounds to build social connections

- exploring how businesses can provide community spaces outside of business hours

- loneliness in rural areas – including community hall improvements and holding roundtables with local organisations.[351]

The UK Government's *25-Year Environment Plan* (2018) seeks to use green space as a 'powerful tool for combatting isolation and loneliness'.[352]

5.2.2.5 *Transport infrastructure*

The UK Government's strategy outlined commitments to ensure that the transport network is 'inclusive and accessible, in particular for older and disabled people'.[353] The strategy included commitments to:

- partner with transport providers to develop ideas on how transport can be used to tackle loneliness, eg schemes to encourage passengers to engage with one another

- address disparities in access to travel through the Future of Urban Mobility Strategy

- mobility centre pilots – hubs that persons with a disability and older people can attend to gain professional information and assessment so they can gain or retain independence through driving.[354]

The UK Government's *Inclusive Transport Strategy* provided funding to deliver accessibility improvements at railway stations and develop fully accessible changing facilities at service stations.[355] The UK Government also announced, in February 2020, that it would invest in transport connections over the next 5 years to encourage the trial of on-demand ride sharing services in rural and suburban areas and improve local bus services.[356]

5.2.2.6 *Digital inclusion*

The UK Loneliness Strategy also sought to address the issue of digital inclusion, including the creation of a *Digital Inclusion Fund*, the *Future Digital Inclusion Program* (which supported 1.4 million adult

---

[350]   UK Government, Department for Digital, Culture, Media and Sport, 'UK Loneliness Strategy'*,* Strategy paper, October 2018, p 33.

[351]   UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 34.

[352]   UK Government, Department of Environment, Food and Rural Affairs, *A green future: Our 25 year plan to improve the environment,* 25 year environment plan, January 2018, p 72.

[353]   UK Government, Department for Digital, Culture, Media and Sport, 'UK Loneliness Strategy'*,* Strategy paper, October 2018, pp 40-41.

[354]   UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 35.

[355]   UK Government, Department for Transport, *Inclusive Transport Strategy: Achieving equal access for disabled people*, Strategy Paper, November 2018.

[356]   UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 36.

learners to engage with digital technology) and a fund to help libraries offer free Wi-Fi. The UK Government invested approximately $1.8 million in the *Nesta Tech to Connect Challenge* prize to encourage the design of solutions to tackle social isolation.[357]

The UK Government also featured loneliness in the criteria for bidding for an *Inclusion Innovation Fund*, which funded projects for the development of:

- smart homes, where older homeowners were trained in digital skills

- an application to allow people with Down Syndrome to monitor their weight and exercise levels

- technologies for end of life and palliative care patients to report on their health and support their families.[358]

The *Tackling Loneliness Network*, formed by the UK Government, was launched in April 2020 to help connect groups at risk of isolation. The network comprises over 70 organisations drawn from businesses, charities and the public sector, and has the following priority areas:

- youth loneliness

- loneliness in older people

- local and place-based approaches

- digital inclusion.[359]

5.2.2.7 *Arts, libraries and volunteering*

The UK Loneliness Strategy included initiatives aimed at increasing opportunities for people to volunteer or take part in local activities, including:

- encouraging older and 'hard to reach' people to take part in voluntary and community activity

- cultural programs as part of social prescribing

- libraries and their role in improving mental wellbeing and tackling loneliness.[360]

5.2.2.8 *Targeted support for younger people and students*

As outlined previously, younger people (16 to 24 years old) are at particular risk of loneliness due to the many transitions in their environment that young people experience and due to experiences of bullying and changes in family and work circumstances.

The UK Loneliness Strategy included targeted support for younger people and students, including:

- a national apprenticeship scheme for young people with special education needs or disabilities – employers encouraged to offer work experience, traineeships, apprenticeships and employment

- loneliness in relationships and sex education – statutory guidance issued by the Department for Education addressed the issue of loneliness in relation to mental wellbeing issues[361]

---

[357] UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 36.

[358] UK House of Commons Library, 'Briefing Paper Number 8514 – Tackling loneliness', 22 February 2021, p 36.

[359] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2021*, Policy paper, January 2021.

[360] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, commitment 48.

[361] UK Government, Department for Education, *Relationships education, relationships and sex education (RSE) and health education*, Statutory guidance, September 2021, p 33.

- researching the positive impact that uniformed youth groups (eg Scouts, Guides, Navy Cadets, Army Cadets and Air Cadets) have on improving inter-generational relationships and funding additional places for these programs[362]

- support for young people starting higher education courses, including the Education Transitions Network to identify areas of risk that can affect the mental health of people going to university, eg independent living, learning, relationships and wellbeing.[363] The University Mental Health Charter was also launched in December 2019.[364]

The UK Loneliness Strategy also highlighted pre-existing programs aimed at tackling loneliness in children and young people, including the Troubled Families Programme, supports for anti-bullying organisations in school and supports for prisoners to strengthen family ties.[365]

5.2.2.9 *Targeted support for armed forces community*

The UK Government's Veterans' Strategy was published in November 2018, which noted that loneliness and social isolation are experienced by many veterans. A key outcome for the strategy was that by 2028 veterans will be able to 'build healthy relationships and integrate into their communities'.[366]

Twenty-five military co-working hubs were established to act as communal meeting areas for military personnel and their families to seek to combat loneliness and create a greater sense of community. The Soldiers, Sailors, Airmen and Families Association was given a grant to support veterans and their families experiencing loneliness throughout the UK.[367]

5.2.2.10 *Targeted support for non-English speakers*

As recognised in this report, language barriers may be a factor in causing loneliness. The UK Government's Integrated Communities Strategy Green Paper outlined support for language courses and the Vulnerable Persons Resettlement Scheme was established to enable refugees to resettle and access additional language classes.[368]

5.2.2.11 *Targeted support for carers*

The UK Loneliness Strategy included components to tackle loneliness in carers through sport and physical activity, with a physical activity online hub developed to educate and inspire carers to be more active.[369]

---

[362] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, commitment 53.

[363] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, commitment 44.

[364] Student Minds, 'University Mental Health Charter', universitymentalhealthcharter.org.uk/.

[365] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, p 41.

[366] UK Government, Ministry of Defence, *Armed Forces Covenant – The Strategy for our veterans. Valued. Contributing. Supported.,* Covenant, November 2018, p 5.

[367] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, pp 41 and 42.

[368] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, p 42.

[369] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, commitment 46.

5.2.2.12 Targeted support for young people living in care

Commitments in the UK Loneliness Strategy in relation to young people living in care included:

- funding for the 'Staying Put' programme, under which young people in foster care can choose to remain with their foster carers until they are 21, and 'Staying Close' programme which supports young people leaving residential care

- extending personal advisor support to all care leavers to age 25

- funding to support young care leavers who are not in education, employment or training.[370]

5.2.2.13 People with a disability and those with a long-term health condition

In the UK Loneliness Strategy, the government noted that it had introduced a range of initiatives to help reduce loneliness for people with a disability and those with long-term health conditions. These included:

- *Improving lives: The future of work and disability* – a programme which encouraged employers to offer work placements and apprenticeships to young people with special educational needs or disabilities

- guidance for social workers to support people at risk of loneliness.[371]

The UK Government also cited its *Digital Inclusion Fund* and *Mobility Centre Pilots* as programmes to reduce loneliness among people with a disability.[372]

5.2.2.14 Tackling the stigma of loneliness

The UK Loneliness Strategy also stated that several campaigns and programmes would be run to reduce the stigma around loneliness. These included:

- a national conversation to raise awareness and reduce the stigma surrounding loneliness, eg the *Let's talk loneliness* campaign in June 2019 and the resources published on the campaign's website

- the *Every mind matters* campaign in October 2019, which delivered 800,000 tailored mental health action plans

- employer pledges – a pledge signed by 1,500 organisations employing 4 million people across England to change the way we all think and act about mental health in the workplace.[373]

5.2.3 Annual reporting on implementation of strategy

The UK Loneliness Strategy committed the government to publish annual progress reports on the loneliness agenda and the measures for success identified in the strategy, recognising that the strategy was just the start of its work on the issue.[374]

---

[370] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, p 44.

[371] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, p 45.

[372] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020, commitments 14 and 36.

[373] UK, House of Commons Library, Briefing Paper Number 8514 – Tackling loneliness, 22 February 2021, p 45.

[374] UK Government, Department for Digital, Culture, Media and Sport, UK Loneliness Strategy, Strategy paper, October 2018, p 11.

In January 2020, the UK Government published its first Loneliness Annual Report, setting out what had been achieved since the publication of the UK Loneliness Strategy.[375] The UK Government published its second Loneliness Annual Report in January 2021.[376]

5.2.4 Funding community groups and organisations

The National Academy for Social Prescribing has established, in collaboration with partners, a £1.8 million *Thriving Communities Fund* awarding small grants to community organisations across the UK aiming to support social connectedness and to help communities cope with COVID-19.[377]

5.2.5 All-Party Parliamentary Group on Loneliness

The UK Parliament established an All-Party Parliamentary Group on Loneliness. Its purpose is to 'drive forward cross-party work among parliamentarians to influence legislation and policy making in order to reduce loneliness and build on the work of the Jo Cox Commission on Loneliness.'[378]

During 2020, the APPG ran an inquiry into loneliness and conducted a survey of the public's views. The APPG's report presented the findings of its survey and provided a number of recommendations to government to tackle loneliness.[379]

5.3 Wales

In February 2020, the Welsh Government published *Connected Communities* – its first strategy for tackling loneliness and social isolation.[380] The strategy acknowledged the impacts social isolation and loneliness can have on people and set a number of priority areas for it to pursue, to reduce social isolation and loneliness:

- Priority 1: Increasing Opportunities for People to Connect

- Priority 2: A Community Infrastructure that Supports Connected Communities

- Priority 3: Cohesive and Supportive Communities

- Priority 4: Building Awareness and Promoting Positive Attitudes.[381]

The Welsh Government also allocated £1.4 million over 3 years for a Loneliness and Social Isolation Fund to test out innovative approaches to tackling loneliness and social isolation and/or scale up promising approaches to reaching out to those who are already lonely and/or socially isolated.[382]

---

[375] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2020*, Policy paper, January 2020.

[376] UK Government, Department for Digital, Culture, Media and Sport, *Loneliness Annual Report January 2021*, Policy paper, January 2021.

[377] Dr Chiva Giurca, National Academy of Social Prescribing, public hearing transcript, Brisbane, 11 October 2021, p 11.

[378] UK Parliament, 'Register Of All-Party Parliamentary Groups [as at 21 April 2021]', publications.parliament.uk/pa/cm/cmallparty/210421/loneliness.htm.

[379] UK Parliament, All Party Parliamentary Group on Loneliness, *A connected recovery: Findings of the APPG on loneliness inquiry*, Final report, December 2020.

[380] Welsh Government, Department of Health and Social Services, *Connected Communities, A strategy for tackling loneliness and social isolation and building stronger social connections*, Strategy paper, 2020, p 4.

[381] Welsh Government, Department of Health and Social Services, *Connected Communities, A strategy for tackling loneliness and social isolation and building stronger social connections*, Strategy paper, 2020, pp 6-8.

[382] Welsh Government, Department of Health and Social Services, *Connected Communities, A strategy for tackling loneliness and social isolation and building stronger social connections*, Strategy paper, 2020, p 8.

5.4   Japan

On 12 February 2021, Tetsushi Sakamoto was appointed as Japan's first Minister for Loneliness.[383] This followed COVID-19 lockdowns, an increase in deaths due to suicide for the first time in 11 years[384] and a rise in the number of women dying by suicide for the first time in 2 years.[385] Mr Sakamoto stated:

> It is essential that we get a firm understanding of the actual nature of loneliness and isolation and then establish a system of planning, checking and acting for related policy measures in each related administrative field…[386]

Professor Makoto Watanabe, Hokkaido Bunkyo University, acknowledged the need to address the problems of isolation and loneliness, but expressed scepticism that appointing a Minister for Loneliness would be a viable solution. He also highlighted the loneliness experienced by men experiencing long-term unemployment, people living alone, and 'hikikomori' – social recluses.[387]

Recommendation 6

The committee encourages the Queensland Government to reflect on the work and the research in other jurisdictions to identify best practice in addressing social isolation and loneliness.

---

[383]   'Japan appoints Minister for Loneliness to combat rising suicide rate', *CNN News*, 23 February 2021, https://edition.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-02-23-21/h_a2ee48751a558607849f3d6e0d30ac68.

[384]   Clea Skopeliti, 'Japan appoints 'minister of loneliness' after rise in suicides', *Independent*, 25 February 2021, https://www.straitstimes.com/asia/east-asia/japan-appoints-minister-of-loneliness-amid-rise-in-suicides.

[385]   Shogo Kodama, 'Japan appoints 'minister of loneliness' to help people home alone', *Nikkei Asia*, 13 February 2021, https://asia.nikkei.com/Spotlight/Coronavirus/Japan-appoints-minister-of-loneliness-to-help-people-home-alone.

[386]   'Japan: 'Minister of loneliness' tackles mental health crisis', *DW*, 23 April 2021, https://www.dw.com/en/japan-minister-of-loneliness-tackles-mental-health-crisis/a-57311880.

[387]   Edd Gent, 'The plight of Japan's modern hermits', *BBC Futures*, 30 January 2019, https://www.bbc.com/future/article/20190129-the-plight-of-japans-modern-hermits.

6   Social prescribing

6.1   What is social prescribing?

As outlined in Chapter 5, the UK and a number of other countries, such as the United States of America, Canada, Germany, Singapore, Norway and Denmark have incorporated social prescribing into the healthcare system to better address key risk factors for poor health, including social isolation and mental health problems.[388]

Social prescribing is defined by the University of Westminster as 'enabling healthcare professionals to refer patients to a link-worker, to co-design a nonclinical social prescription to improve their health and wellbeing'.[389] The Australian Association of Social Workers (AASW) outlined that the 'social prescribing' model of care refers to:

> … the practice where health professionals, including GPs, have the resources and infrastructure to link patients with social services – or even social groups – in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation.[390]

Figure 2: Model of the social prescribing process

Source: NHS England, Social Prescribing, https://www.england.nhs.uk/personalisedcare/social-prescribing/

---

[388]   Royal Australian College of General Practitioners, *Social prescribing roundtable: November 2019*, Report, November 2019, p iii.

[389]   Kristen O'Brien, submission 70, p 4.

[390]   Australian Association of Social Workers, submission 79, p 10.

Dingle, Sharman and Hayes advised that the UK is currently leading the global alliance for social prescribing. Their submission stated that the UK model has embedded social prescribing into primary care services in local commissioning districts. They have mobilised a new workforce of 1,700 link workers as part of the NHS Long Term Plan. Initial findings indicate that social prescribing decreases participants' loneliness and increases social and community connection, increases wellbeing, and improves various indicators of mental and physical health.[391]

6.1.1 Stakeholder views

A significant number of submitters supported the introduction of social prescribing in Queensland.[392] Ms Ali Palmer, Social Work Professional Lead, Redcliffe/Caboolture, and Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service noted:

> We definitely support the social prescribing model and think it is excellent… We see that there is a whole body of work that we need to do in a tertiary space to get our consumers ready to engage in that. There is also an opportunity for us to work with the community workers to help them to be able to manage our cohort.[393]

Submitters noted that while there is no widely agreed model for social prescribing, schemes commonly involve three components:

- a referral into the program, generally via a GP or other health or social care professional
- a series of consultations with a link worker
- supported connection to local groups and community organisations.[394]

Dingle, Dr Sharman and Mr Hayes, School of Psychology, UQ stated:

> The social prescribing project is informed by a social identity theoretical framework, which views loneliness as resulting from a lack of meaningful group memberships (such as family, school, work, cultural, faith, and activity-based groups). Such group memberships matter because they inform who we are – our social identities – which are the basis for our health and wellbeing.[395]

Associate Professor Dingle advised that the social identity approach to health has over a decade of research evidence indicating that membership to meaningful groups that a person feels highly identified with, produces a sense of connectedness and supports health and wellbeing.[396] The SPA submitted that 'social prescribing has a range of benefits which include improvements to factors such as health, economic, social and productivity, resulting in improvements in overall health and wellbeing'.[397]

Feros Care submitted that social prescribing is considered as the modern approach to healthcare and wellbeing:

> Social prescribing uses the contemporary health premise that in many instances, physical or mental illness is a manifestation of unmet social needs and that many people neither recognise the need, nor the ability

---

[391]   Dingle, Sharman and Hayes, submission 93, p 6.

[392]   For example, Central Queensland, Wide Bay, Sunshine Coast PHN, submission 39, p 6; Professor Catherine Haslam, Professor of Clinical Psychology, UQ, public hearing transcript, Brisbane, 11 October 2021, p 24.

[393]   Ms Ali Palmer, Social Work Professional Lead, Redcliffe/Caboolture, and Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service, public hearing transcript, Brisbane, 11 October 2021, part 1, p 19.

[394]   Dingle, Sharman and Hayes, submission 93, p 6; also see Central Queensland, Wide Bay, Sunshine Coast PHN, submission 39; SPA, submission 65; Community Mental Health Australia, submission 74.

[395]   Dingle, Sharman and Hayes, submission 93, p 4.

[396]   Dingle, Sharman and Hayes, submission 93, p 6.

[397]   SPA, submission 65, p 12.

to address it. Social prescribing focusses on "what matters to me", not "what's the matter with me". Rather than a reliance on medication as the prescribed solution therefore, an individual is supported with a social prescription, addressing, together with that person, all the social determinants of health that contribute to their health. [398]

Similarly, Associate Professor Dingle defined the social prescribing approach as a move away from traditional medical approach to problem solving:

> When you go to see a GP, a psychologist, a social worker or whatnot, the conversation opens essentially with, 'What's the matter with you? Tell us your symptoms and your problems and deficits.' It is that sort of thing and then we try to find a solution. Social prescribing is different from that because the key question is, 'What matters to you?' In fact, the answer to 'What matters to you?' is belonging. Belonging is a really key thing that can be very difficult for people to find. [399]

Tracey Johnson, Inala Primary Care, referred to her experiences in America, Canada and the UK, stating:

> I was really privileged that in America, Canada and the UK I came across what were GP embedded as well as neighbourhood centre embedded models whereby people were linking these high-need patients to local community resources. That might be a knitting group, a sporting club, a walking group—it can be a whole bunch of things that, depending upon the goals of the individual person, will get them out of the house, will give them a sense of purpose, will give them activity that will drive down some of their health presentations. [400]

A number of submitters highlighted the referral role played by GPs or other health or social care professionals and the current challenges for medical practitioners using traditional medical approaches to lifestyle changes versus the benefits of a social prescribing approach:

> … we know that telling people what to do never works. I used to do this in hospital and we all used to do this as clinicians—telling patients to exercise, to stop smoking or to get more connected—but we know that simply psychologically does not do the trick. When involving social prescribing, where you have a designated person who has been employed to look at and understand the true needs of the person, connect with them and then have a menu of activities and then accompany the individual along the way, it just seems to build upon the previous principles of motivational interviewing and shared decision making, which, again, are deeply rooted within evidence. [401]

Similarly, Associate Professor Dingle, UQ, outlined:

> I know that a lot of health professionals, including myself when I was a practitioner, will say, 'It might be good for you to go and join a gym,' or 'It might be good for you to join the group that is replanting in this forest area' or whatever it is. However, it is a very difficult thing for a person to just show up, by themselves and navigate, 'Do I fit in with this crowd? How do I even get there?' There are a number of things that would need to be considered for that to be a successful engagement. [402]

Ms Johnson stated that:

> Our challenge, as my wonderful team will tell you, is when you are trying to deal with somebody in 15 to 20 minutes. It is really hard to have that conversation and plan with them where they can go and find these things. A link worker is somebody a clinician can hand a patient over to in their GP practice. They then do the goal setting. They then do the individual planning about what is important to that person. If necessary, they will drive them to the relevant event. They will set up the social fabric within that

---

[398]   Feros Care, submission 150, p 15.

[399]   Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 13.

[400]   Tracey Johnson, CEO, Inala Primary Care, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 9.

[401]   Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 13.

[402]   Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 13.

community organisation to say, 'Hey, Nancy's coming this week. She needs this and that,' so that by the time Nancy arrives it is a very friendly environment. That sort of thing is incredibly important to actually take a patient from going, 'Yes, I need to exercise more,' to actually joining the walking club.[403]

SPA advised that social prescribing 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, or community groups.[404] The committee notes that these activities are typically supported by the non-government organisation, charity and volunteer sectors.[405]

Submitters noted the vital role played by a link worker in this approach. Associate Professor Dingle stated that:

> The link worker plays a really critical role in this by understanding what all of those barriers are and then helping that person to remove and navigate those barriers so that they can successfully engage…. it takes an average of eight separate sessions with the link worker before the person is likely to have found a group program that they really connect with and can feel supported by. From there they take off. They start to find friends and they do things outside of that group.[406]

SGQ called on medical and health professionals, the government and non-government sector, to demonstrate an increased commitment to social prescribing. They recommended that people join support groups, patient organisations and social groups that can connect people to other people that share the same journey and stated that peer support should not be an afterthought.[407]

The QFCA highlighted the important role played by NCCs, stating that:

> Integral to centres is the goal of fostering connection, belonging, participation and inclusion, and this is the antidote to social isolation and loneliness. Centres across Queensland are working every day in ways tailored to their local communities to achieve this. Centres facilitate involvement in both centre based activities and projects as well as broader community participation. That linking role is critical as it supports individuals to navigate the broader service system, access key supports and find meaningful opportunities for volunteering, mutual support and social connection so there is both a preventive and a crisis response together.
>
> As part of this linking role, neighbourhood centres also actively foster, engage and support local networks, community projects groups and organisations.[408]

Dr Giurca informed the committee about a social prescribing model in Frome, England, stating that:

> It is beautiful what has happened there. I am hoping that is where we are slowly moving towards. They have developed a whole ecosystem around the local community where they have started training the police service, firefighters, hairdressers, cab drivers to be aware of the facts around and the impacts of mental health. We know that 60 per cent of appointments are about mental health. They provided extra training free for everyone within the community. They have these community connectors, who could be anyone within the local community, who may notice when somebody is lonely and could then refer them further from there. We are now talking about placing the ownership of health into the hands of the people. I think that is a beautiful model that I personally hope to see more of across the world.[409]

---

[403] Tracey Johnston, CEO, Inala Primary Care, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 9.

[404] SPA, submission 65, p 11.

[405] QUT and ANU, submission 43, pp 7-8

[406] Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 13.

[407] SGQ, submission 145, pp 5-6.

[408] Em James, QFCA, public hearing transcript, Brisbane, 13 September 2021, p 6.

[409] Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, pp 13-14.

Dr Giurca also referred to the Global Social Prescribing Alliance, which has been developed in collaboration with the World Health Organisation, United Nations and World Health Innovation Summit. Dr Giurca stated that:

> … there are over 25 countries within that group, all of which are pioneering and moving forward with the idea of social prescribing and using it to change that culture that I mentioned and to look at long-term systemic change. The model is not the same everywhere. We know that in Portugal, for example, they started adding further education for social workers instead of hiring new link workers. They simply looked to the social workers they already had, added extra training and then supported them to become social prescribers. In Canada it is very similar, with community navigators similar to the UK.[410]

Dr Giurca advised that social prescribing officially became government policy 2 years ago and has been emphasised as one of the core pillars of the English NHS and the long-term plan, the roadmap launched by the government. Dr Giurca stated that 'The government has already surpassed its target of appointing over 1,000 link workers, also known as community navigators or social prescribers, to ensure that the psychological and social patient needs are met in addition to the biomedical ones'.[411]

Dr Giurca informed the committee that the National Academy for Social Prescribing was set up by the UK Government to support the establishment and delivery of social prescribing. Dr Giurca advised that:

> In collaboration with partners, we have built several programs supporting the agenda of tackling loneliness including a £1.8 million Thriving Communities Fund awarding small grants to community organisations across the UK and aiming to support social connectedness and to help communities cope with COVID-19.
>
> Other programs include a national academic partners network conducting evidence summaries, not only assessing patient outcomes but also looking at the economic impact of social prescribing on loneliness.[412]

In addition, Dr Giurca stated:

> My colleagues have also developed an innovation accelerator for knowledge exchange, an ambassador program, a clinical champion program and the aforementioned Global Social Prescribing Alliance, which is aiming to facilitate shared learnings across the globe including partners in Australia, of course. As part of this, we have developed a social prescribing playbook showcasing the building blocks of what good social prescribing looks like and reflecting on the challenges and limitations with examples from the UK and beyond its borders.[413]

---

[410] Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 15.

[411] Public hearing transcript, Brisbane, 11 October 2021, p 11.

[412] Public hearing transcript, Brisbane, 11 October 2021, p 11.

[413] Public hearing transcript, Brisbane, 11 October 2021, p 11.

Figure 3: Model of the social prescribing process
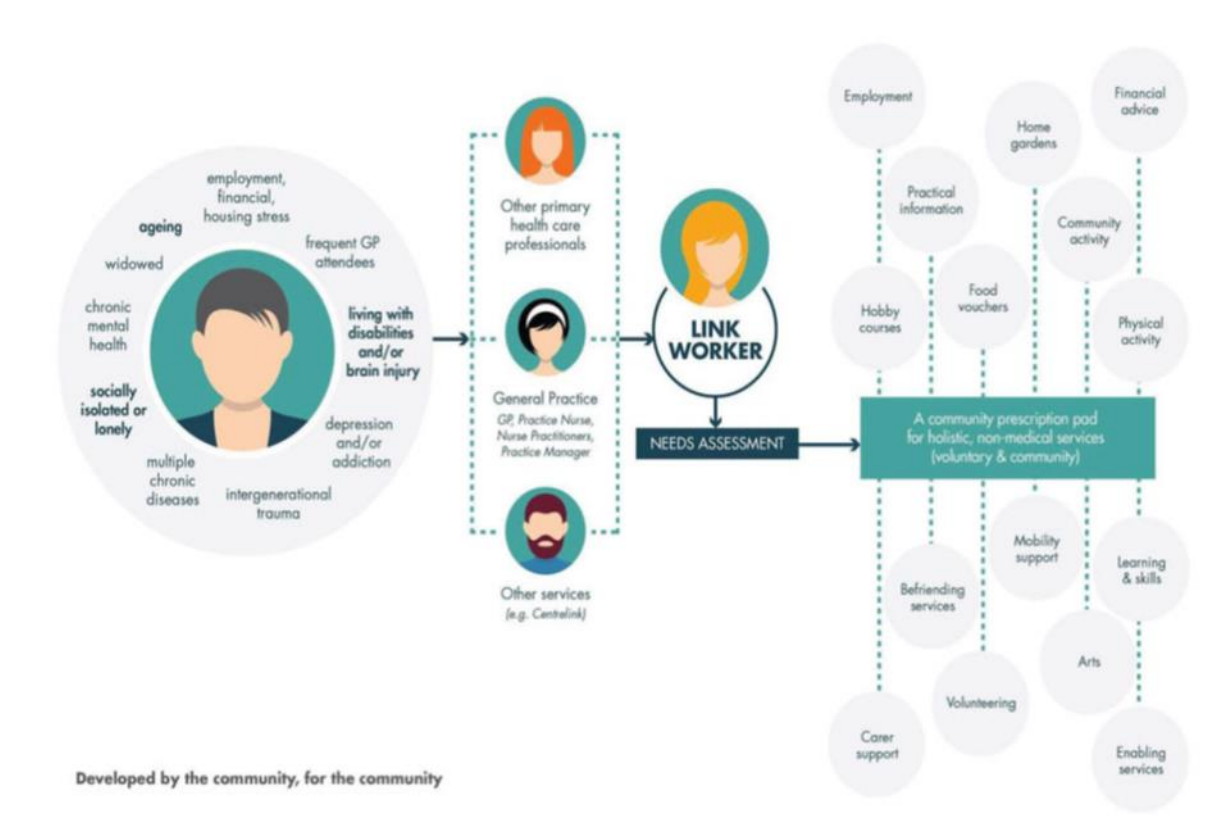
Source: QCA, submission 185, p 16.

The AASW was critical of the use of the term social prescription, stating that:

> While we support this model of care, the AASW rejects the use of the term 'social prescribing' to describe referral and linkage services, as it still reflects a biomedical understanding of social isolation where it needs to be 'treated' by a 'prescription'. Instead, the so-called social prescribing model is actually akin to the case management model commonly used by social workers in Australia.

> We want to refer to the AASW publication on case management which details the social work's role in identifing (sic) the social determinants contributing to their poor health and wrapping services around their needs. Therefore, we refer this approach as a 'wellbeing' model of care where service provision is structured around the needs of an individual.[414]

6.2 Positive results of social prescribing

The committee notes that benefits of social prescribing have been observed in the UK for some years as the body of evidence-based research continues to grow. A review conducted in 2017 of the evidence assessing the impact of social prescribing on healthcare demand and cost implications concluded:

> … the evidence for social prescribing is broadly supportive of its potential to reduce demand on primary and secondary care. The quality of that evidence is weak, however, and without further evaluation, it would be premature to conclude that a proof of concept for demand reduction had been established. Similarly, the evidence that social prescribing delivers cost savings to the health service over and above operating costs is encouraging but by no means proven or fully quantified.[415]

---

[414]   AASW, submission 79, p 11.

[415]   Marie Polley *et al*, *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications*, Report, June 2017, p 6.

Scottish researchers Smith and Skivington found significant beneficial effects on the health and wellbeing of patients and more widely, among participants in the scheme, 'with qualitative evidence that social prescribing services are very well liked by patients and GPs alike'.[416]

6.2.1 Stakeholder views

During its inquiry, the committee heard of the positive results observed from the application of the social prescribing model in other jurisdictions.

Feros Care stated that evaluations of social prescribing programs have proven to deliver improved outcomes for individuals in relation to loneliness, social isolation, well-being, connectedness, relief to health systems by reducing unnecessary demand on GPs, mental health and emergency services and social outcomes for communities. Feros Care stated that social prescribing has been found to:

- support people to achieve sustained improved health and wellbeing, building skills, confidence, capacity and self-efficacy in understanding and managing their own health

- use what exists to harness the power of mainstream, welfare and community and 'what already exists' to support health outcomes

- provide a contemporary solution to key public health focus areas being aged care, mental health prevention and early intervention and chronic disease.[417]

In relation to benefits to the patient, Dr Giurca advised that a recent study involving 10,000 patients, which looked at social prescribing as an intervention, found that 72.6% of the participants felt less lonely, using the loneliness scale that they assessed with study with. Dr Giurca also stated that 'They also reported a wide range of benefits including an increase in confidence as well as general wellbeing and having more purpose—they felt they had more purpose themselves'.[418]

A further benefit raised with the committee was 'freeing up time for health care professionals'. Dr Giurca stated that 'in a recent survey provided by the Royal College of General Practitioners 59% of all GPs considered social prescribing to be reducing their workload'.[419]

In relation to financial savings, Mr Robin Hewings, Program Director, Campaign to End Loneliness UK, stated that:

> … cashable savings, I think that is where social prescribing really comes through because, essentially, it reduces healthcare usage in primary care quite quickly. Essentially, people often go to see a GP, which in the UK costs about £35 per 10-minute appointment, when actually the reason they are going is not that they need to see an extremely experienced healthcare professional; their real issues are not clinical but social. Having a link worker who has the time to really spend with someone to sort out those social issues means that they are coming to the GP less. The one place where I think there is the strongest economic evidence, particularly in the short term, is around social prescribing; otherwise, I think it is really about value, not about savings.[420]

---

[416] Matthew Smith and Kathryn Skivington, Social and Public Health Sciences Unit, Institute of Health and Wellbeing, University of Glasgow, Community Links: Perspectives of community organizations on the Community Links Workers Programme pilot and on collaborative working with primary health care, March 2016; cited in M Polley et al, A review of the evidence assessing impact of social prescribing on healthcare demand and care implications', June 2017, University of Westminster.

[417] Feros Care, submission 150, p 16.

[418] Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 12.

[419] Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 12.

[420] Robin Hewings, public hearing transcript, Brisbane, 11 October 2021, p 19.

Dr Giurca refer to a study conducted by the London School of Economics (LSE), which quantified £6,000 per person in terms of costs associated with loneliness and their care. Dr Giurca stated that:

> If you add that together, I think the study from LSE showed a total of £2.5 billion per year in the UK alone spent on loneliness. The same study I mentioned earlier looked at the return on investment and the outcome was that for every pound invested through social prescribing they had a return of £3.42, so three times return on investment.[421]

Similarly, Associate Professor Dingle, UQ, stated that:

> There is the Creative health report from the UK that came out a couple of years ago where they have got health economists to say that if you spend £1 on someone joining a choir, being part of a dance group or whatever it will save you £11 in health care down the track. I am very interested in music and arts based health as well, and I think we have some really brilliant programs here in Queensland… That is a way we can look at this as social care. It is not completely separate to health; it is very much embedded in there. It is just in a different space so it is community rather than in a hospital.[422]

The research team from the School of Psychology, UQ, stated that its analysis of data from the Ways to Wellness Project and the pre and post 8 week surveys collected from 24 social prescribing clients to date indicated that the social prescribing approach is working, and that increasing meaningful group memberships may lead in the longer term to decreased loneliness and improved health and wellbeing, as illustrated below.

Figure 4: Preliminary outcomes of social prescribing over 8 weeks of group attendance
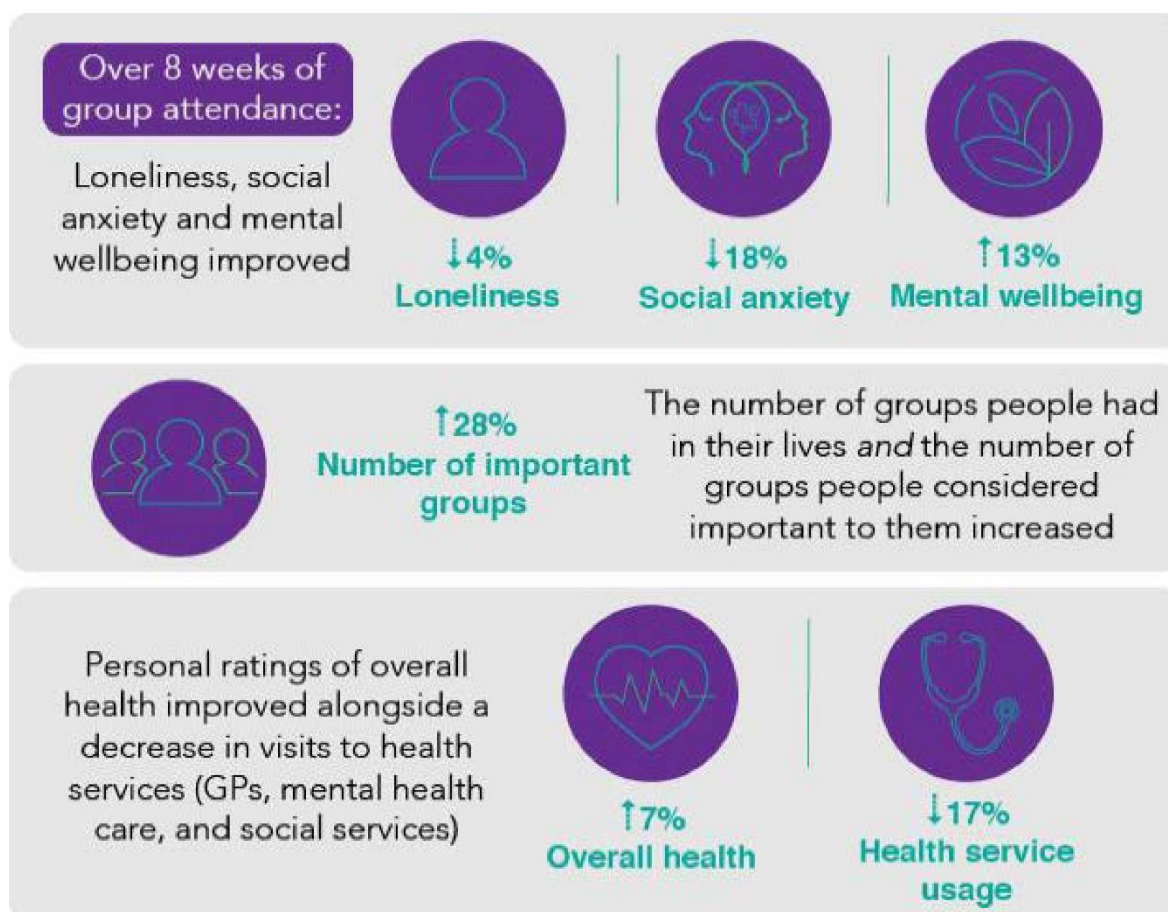
Source: School of Psychology, UQ, Submission 93, p 9.

---

[421]   Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 12.

[422]   Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 16.

6.3   Lessons learned from other jurisdictions

Submitters and witnesses to the inquiry raised a number of issues in relation to the implementation of a social prescribing model.

Dr Giurca highlighted the importance of ensuring that sufficient services and supports are available in the community. Dr Giurca stated:

> … it cannot be understated the importance of ensuring that the local ecosystem is built before social prescribing is being delivered as an initiative. We have seen different areas across the UK where link workers are struggling because there are not enough opportunities within the community. In the UK, funds such as the Thriving Communities Fund, which you can look at, tries to do just that. It tries to find gaps of opportunities within the local community, especially those most impacted by COVID or those most at risk of social determinants, and provide them with extra seed funding to develop the local community infrastructure. … It is crucial to realise that social prescribing will not exist unless there are those community support groups and unless they are being supported, otherwise it feels like we are shifting some of the patients from A&E into the community.[423]

Similarly, Mr Robin Hewings, Campaign to End Loneliness UK noted:

> There is no point having amazing social prescribing if there is nowhere for people to go to and they cannot get there or find out about it even if they could get there. These things are complementary. I think the value of thinking about it like that is that you can think, 'Well, if you have the community thinking about it across the whole population, you can think, "Where are our gaps?"' The gaps very often will be in that social prescribing community link worker area. I think it is really well focused on loneliness rather than broader, fuzzier kinds of things. It might be the case that the big issue is transport. That is also useful for particular providers. If you are running buses it is probably not a good idea if you suddenly try to do social prescribing, but if you are running buses you can link in with the social prescribers and the people running the groups so you can see how you can help people and see how to fit into that broader ecology.[424]

Researchers from QUT and ANU stated that questions are already being raised about the sustainability and costs of the social prescribing treatment model and the extent to which it alone can enhance client independence sufficiently to achieve longer term positive outcomes.[425]

Mr Hewings advised: 'I do not think we know that lack of funding for community groups is a really big barrier to social prescribing or not. It is clearly the case that the better the offer and the richer the offer the better it will be for people. If you say, "Well, there is only one thing you can do", that is clearly massively less compelling than if there are five or 10 things that people might be able to do'.[426] Mr Hewings added:

> I think there are actually more people doing service navigation and linking; there just are not very many people whose job title is that. How can we resource that to happen? How can we do that service navigation or linking in a good way? What are the databases that we can use so that every organisation does not have to establish their own database of local services but we have a central one? Is there a statewide website that we could have that breaks down into local areas? How can that link work be resourced? You have to have a mixture of people whose primary job is to do link work but also say that linking people to what they need is a job for everybody, for all service providers, and look at how we can support them to do that.[427]

---

[423]   Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 13.

[424]   Public hearing transcript, Brisbane, 11 October 2021, p 18.

[425]   QUT and ANU, submission 43, pp 7-8.

[426]   Robin Hewings, public hearing transcript, Brisbane, 11 October 2021, p 19.

[427]   Paul Martin, Executive Manager, Brisbane North, QPHN, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 34.

Dr Giurca raised the importance of ensuring that there is an adequate workforce, stating:

> In the UK I have the pleasure of leading a social prescribing champion scheme for over 20,000 junior doctors and medical students, and we are witnessing firsthand the effects of an increasing population, with numbers of those aged 60 or above set to double by 2050 and, therefore, increasing numbers of chronic diseases with limited tools to support those one in four patients who perhaps attend an appointment for pure social reasons, many of whom lack social connection and are isolated.[428]

Submitters also highlighted the importance of training and education for the social prescribers and the link workers. Associate Professor Dingle, UQ, stated:

> … before we decide to generate lots of funding for recruiting link workers we actually need the training, support and supervision structures there. I believe that in the UK model—I am closely following a lot of the global social prescribing movement—there is a National Academy for Social Prescribing. There is a link worker network, and they have regular update meetings, in-service training and that sort of thing. A lot of it has been online because of COVID, and I think that is great because it means people in all the different regions and rural areas can access that.[429]

Dr Giurca advised:

> Now in the UK we are at a stage where it is not so much about noise making and it is not so much about getting people to implement social prescribing; now it is more 'do we walk the talk?' and 'how do we make sure that we support the social prescribers to have enough capacity to deliver for those patients?' because we are now tempted to, even inappropriately, refer patients to them, and we have noted some of those things arising. From my perspective, those would be the biggest barriers—as well as, of course, education for the workforce to ensure they make appropriate referrals, to make sure they know that these services exist within the community and to involve them from the beginning.[430]

The MGCC also stated that professional development of staff was important to allow a flexible and transferable skills set because; '… emerging issues change. Communities change. There are always different crises that happen in community'.[431]

6.4   Social prescribing models in Queensland – Ways to Wellness Social Isolation Project

In Queensland, there are rising numbers of social prescribing programs in the community, located at and utilising NCCs.

These community-based programs provide connections to the broader community, and wider referral pathways. There are at least 2 formal social prescribing programs, including Ways to Wellness (Mount Gravatt) and Social Plus (Primary and Community Care Services, Gold Coast).[432]

During its inquiry, the committee heard from submitters about the positive work being undertaken by the Ways to Wellness Social Isolation Project.[433]

In 2018, the MGCC, together with the QCA, UQ and the Member for Mansfield, Corrine McMillan MP, formed a working group of local stakeholders to address the issue of social isolation and loneliness in the Mount Gravatt and surrounding areas. This led to the development and implementation of the Ways to Wellness Social Isolation Project.

---

[428]   Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 11.

[429]   Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 15.

[430]   Dr Chiva Giurca, public hearing transcript, Brisbane, 11 October 2021, p 13.

[431]   Deb Compton, MGCC, public hearing transcript, Brisbane, 13 September 2021, p 5.

[432]   School of Psychology, UQ, submission 93, p 7.

[433]   For example, submissions 64, 65 and 74.

The project was developed utilising an evidence-based social prescribing model that has been successfully implemented in the UK, the USA, and New Zealand. The MGCC procured funding from the DCHDE to employ a Community Link Worker to connect individuals and families to meaningful sources of group activities in their local community, with an emphasis on inclusivity, connection, and a sense of belonging.

The program utilises a strengths-based, person-centred framework that values the inherent skills, knowledge, and capacity of individuals. Referrals are received from general medical practices, outpatient clinics, allied health professionals, other community organisations and agencies and through self-referral. The social prescribing program provides medical practitioners with a non-medical referral option to community supports that can complement clinical care and improve health and wellbeing.[434]

Since the initial pilot in 2019, the Ways to Wellness Project has connected over 300 individuals and community members to local groups, activities, social and sporting clubs, volunteering opportunities, training, and employment. In addition to this, a network of Link Workers has been established and collaboration between the Centre and other local organisations has been established. The Centre has engaged with over 200 local community-based groups and organisations forming a network that is committed to promoting social cohesion and enhancing the health and wellbeing of not only Ways to Wellness participants, but the community.[435]

At a public hearing, a representative of the MGCC advised that it rolled out two different projects:

> One of the projects involved us getting referrals directly from GPs. I was placed in a GP surgery one day a week so that I could get direct referrals from those GPs. The medical practitioners would recognise someone as experiencing social isolation and loneliness, whether that be through their mental health, through conversations—through multiple presentations of patients for non-medical reasons. They would refer to me, the link worker. I would spend up to six months with them if they required. I would provide therapeutic and practical support. We have a huge network of other organisations that we engage with. We know exactly what is out there and available for people to experience. We would link them in with sources of group support. Someone would come in and they would identify their hobbies and interests as perhaps gardening, music and knitting. We would work then towards linking them in with those interest groups whilst also addressing some of those barriers to participation that were present across all of our clients. That was the holistic health project.

> The other project was community based. We would accept self-referrals and referrals from other agencies and community organisations. Often people would identify themselves as being lonely or socially isolated. …

> Once they were linked into those groups and some of those practical barriers were addressed, we would continue with them until they felt comfortable going by themselves. I would accompany them. I would introduce them to the groups and activities. I would join in with them if that was something that was going to increase participation. The model is quite simple, but the work that it does and the people we saw were quite complex.[436]

The MGCC stated that it '… works on a strengths based, person centred approach', advising that:

> When the client comes to the link worker, we set about creating a case management plan that includes that person's goals. It assess their needs and then has some measurable and attainable goals for that individual.

> …

---

[434]   MGCC, submission 94, p 4.

[435]   MGCC, submission 94, pp 4-5.

[436]   Elise Marr, MGCC, public hearing transcript, Brisbane, 13 September 2021, p 3.

Some people stay with us for up to 12 months or longer. It is assessed on a needs basis, the varying levels of complexity and depending on how complex the barriers are for people to participate. There is a plan and there is an exit strategy which we found works well.[437]

The UQ advised that 'Of the 216 contacts to Ways to Wellness, 169 clients successfully completed the intake process and were supported through Ways to Wellness'. Furthermore, it stated that:

On average, the time from referral to last contact with a client was 4 months (this includes clients still enrolled in Ways to Wellness). The average number of contacts with clients was 8, and these ranged from 1 to 33. They included phone calls, meetings at the community centre, home visits, and attending groups with clients. Link workers also had on average 1 unsuccessful contact with clients, and this ranged from 0-9. 72% of people were referred into groups available in the local community. While some of these clients are still in the program and are yet to be referred, approximately 20% were referred onto other services to assist with primary or other needs. At least 58% of those that were referred to groups attended at least one group program. However, we assume this figure to be higher as some people were happy to refer themselves and did not require further assistance other than knowing what groups were available.[438]

Recommendation 7

The committee recommends that the Queensland Government consider partnering with other levels of government to implement a state-wide trial of the social prescription model similar to that occurring through the Mount Gravatt Community Centre.

The committee also recommends that the Queensland Government seek the support of the University of Queensland to monitor and evaluate the effectiveness of the model, with a view to government reviewing the findings of such evaluation.

---

[437]   Elise Marr, MGCC, public hearing transcript, Brisbane, 13 September 2021, p 3.

[438]   Dingle, Sharman and Hayes, School of Psychology, UQ, submission 93, p 8.

7 Measuring social isolation and loneliness and effectiveness of strategies

7.1 Measurement of social isolation and loneliness

The terms of reference for the inquiry required the committee to investigate how social isolation and loneliness in Queensland should be measured, to determine if implemented strategies are effective.

As discussed in section 2.1, there are several definitions of social isolation and loneliness. Some submitters considered the need for better measurement of social isolation and loneliness, so that mitigating and protective factors can be targeted to where they are most needed. For example, Ending Loneliness Together noted the absence of uniform standards and guidelines within community and mental health sectors and recommended that the Queensland Government implement a standardised measurement and evaluation framework for social isolation and loneliness.[439]

The Central Queensland, Wide Bay and Sunshine Coast PHN highlighted the need for consistent and validated measures of social isolation and participation of communities, noting that current measures exist only at national level, and as a result, it is more difficult to provide solutions when visibility of issues at a community level are sub-optimal.[440]

Similarly, the QFCA recommended that the Queensland Government resource the QFCA to deliver additional NCC sector support, including implementing a NCC reporting framework which measures social isolation and loneliness.[441] This recommendation was supported by several submitters.[442]

The committee heard evidence about inconsistent definitions and ways of measuring social isolation and loneliness during its inquiry,[443] a point expressed by Professor Jo Badcock, Vice Chairperson and Vice Scientific Chair of Ending Loneliness Together:

> I think one of the first issues from my point of view is that without data we can do very little, so we need to take a look at what data is being collected. It is often very patchy, it is very variable and it uses different measurement tools. We need to get a consistent approach to how we measure loneliness, and that includes loneliness that is being measured at population survey level through to loneliness that is being measured at the community level and loneliness that is being measured by individual professionals, such as clinical psychologists, GPs and so on.[444]

However, some stakeholders also noted that the measurement of social isolation and loneliness may be a challenge.

Gympie Community Place encouraged caution in this area, stating that any proposed measurement techniques should not cause harm to vulnerable people.[445] Community feedback provided to Scenic Rim Regional Council suggested that measurement of social isolation and loneliness could be carried out locally, by community organisations.[446]

---

[439] Submission 30, p 4.

[440] Submission 39, pp 6-7.

[441] Submission 127, pp 21-22.

[442] For example, submissions 36, 37, 38, 40, 44, 47, 48, 54, 55, 56, 57, 60 and 63.

[443] For example, Dr Michelle Lim, Chairperson and Scientific Chair, Ending Loneliness Together, public hearing transcript, 11 October 2021, Brisbane, p 1; Catrin Noone, PhD Candidate, Durham University, Co-Founder, Early Career Loneliness Research Network, public hearing transcript, 11 October 2021, Brisbane, p 8; Phoebe McKenna-Plumley, PhD Candidate, Queen's University, Belfast, Co-Founder, Early Career Loneliness Research Network, public hearing transcript, 11 October 2021, Brisbane, p 8; submission 39, p 6; submission 74, p 4.

[444] Public hearing transcript, 11 October 2021, Brisbane, p 2.

[445] Submission 50, p 3.

[446] Submission 58, p 7.

7.2 Measuring social isolation and loneliness

7.2.1 Measures applicable in a range of settings

Despite the challenges of measuring social isolation and loneliness discussed above, a number of ways to measure social isolation and loneliness are available.

Table 1 summarises some well-known measures of social isolation and loneliness, some of which have been used extensively by researchers, such as the University of California Los Angeles (UCLA) Loneliness Scale and the de Jong Gierveld Loneliness Scale. Some researchers use variations of these scales, such as by only asking a selection of questions from the original versions.

7.2.1.1 *Committee comment*

The committee notes the variety of tools available to measure social isolation and loneliness.

Recommendation 8

The committee recommends that the Queensland Government identify the most suitable tool to measure social isolation and loneliness, in order to gather longitudinal data for the Queensland context, which will assist in the allocation of resources in the future.

Table 1 – Loneliness measures

Measure	Description	Examples of its use
University of California and Los Angeles (UCLA) Loneliness Scale*	Respondents answer 20 negatively-worded statements with one of 4 responses, each of which is assigned a score: 'I often feel this way' – 3 'I sometimes feel this way' – 2 'I rarely feel this way' – 1 'I never feel this way' – 0 The scores are totalled. The maximum score is 60, the minimum score is 0. Higher scores reflect higher reported loneliness levels.	Swinburne University of Technology and the Australian Psychological Society (2018); Swinburne University of Technology for the Victorian Health Promotion Foundation
de Jong Gierveld Scale*	The original de Jong Gierveld Loneliness Scale seeks one of the following 5 responses to 11 statements, some of which are positively worded, some of which are negatively worded: 'yes!' 'yes' 'more or less' 'no' 'no!' Each statement is scored depending on the response provided, and the scores are totalled. The total score ranges from 0 to 11. The higher the score, the higher the reported loneliness.	Consumers Health Forum of Australia – What Australia's Health Panel said about loneliness - March 2021
Lubbens Social Network Scale*	Usually aimed at older adults, respondents select one of 6 responses to 6 negatively-worded questions regarding issues such as how frequently they see or hear from their friends and family. Each response is scored 0 – 6. The scores are totalled, with the maximum score being 30 and the lowest 0. A score of 12 and lower is said to indicate someone is 'at-risk' for social isolation.	Swinburne University of Technology for the Victorian Health Promotion Foundation

Table 1 – Loneliness measures

Measure	Description	Examples of its use
Office for National Statistics (GB)	In addition to the three-item UCLA Loneliness Scale, respondents are asked 'How often do you feel lonely?' and can respond: 'Often/always' 'Some of the time' 'Occasionally' 'Hardly ever' 'Never'	Active Lives Adult Survey; Active Lives Children and Young People Survey; English Housing Survey; Community Life Survey; UK Tri-Service Families Continuous Attitude

* Denotes that there are variations of the scale that are used. Some variations may ask fewer questions than those described above, meaning maximum and/or minimum scores may differ from those outlined, and interpretation of results may need to differ from that presented.

In addition to the measures in Table 1, there are also a range of measures that, while seeking information on a range of issues, measure social isolation and/or loneliness to some extent, including:

- the Scanlon-Monash Index (SMI) of social cohesion,[447] which attempts to quantify Australia's social cohesion based on 5 areas: belonging, worth, social justice, political participation, and acceptance of diversity.[448] The Queensland Social Cohesion Implementation Committee has noted the usefulness of the SMI to measure Queensland's overall social cohesion[449]

- the Assessment of Quality of Life questionnaire,[450] which asks questions about how often someone feels socially isolated, how often they feel socially excluded, and how happy they are with their close relationships

- the Psychological Wellbeing Scale,[451] with question 30[452] asking whether people feel lonely because they have few close friends to share their concerns with

- the Ryff Scales of Psychological Well-Being,[453] with question 3 of 14 of the 'positive relations with others category'[454] asking whether people often feel lonely because they have few close friends to share their concerns

- the Duke Social Support Index,[455] with question 10 of the 35 question version asking respondents how often they feel lonely[456]

- the Australian-based Campaign to End Loneliness tool to measure loneliness,[457] where respondents provide one of 6 answers to 3 statements regarding their relationships with people.

7.2.1.2 Stakeholder views

Submitters endorsed the use of the UCLA Loneliness Scale and the de Jong Gierveld Scale. For example, the Institute for Social Science Research, UQ, stated that the Queensland Government could use the de Jong Gierveld Loneliness Scale to measure social isolation and loneliness both before and after a measure is implemented. This submission highlighted the benefits of this scale, noting it can be used

---

[447]   Andrew Markus, 'SMI: The Scanlon-Monash Index of Social Cohesion', *Public Opinion Fact Sheet 1*, Scanlon Foundation Social Cohesion Research Program, Monash University, August 2020.

[448]   Andrew Markus, 'Annual social cohesion report finds Australians have renewed trust in government', *Monash Lens*, 18 February 2021.

[449]   Queensland Government, *Thriving Cohesive Communities Action Plan for Queensland 2019–21 (Stage 2)*, 2019, p 3.

[450]   Monash University, Centre for Health Economics, 'AQoL-8D', Simplified Data Collection, 23 March 2017.

[451]   Stanford University, 'Psychological Wellbeing Scale', accessed 18 November 2021, https://sparqtools.org/mobility-measure/psychological-wellbeing-scale/

[452]   Stanford University, 'Psychological Wellbeing Scale', accessed 18 November 2021, https://sparqtools.org/mobility-measure/psychological-wellbeing-scale/#42-item-version

[453]   University of Wisconsin-Madison, Addiction Research Centre, 'Psychological Well Being Scales (WBS)', accessed 18 November 2021, https://arc.psych.wisc.edu/self-report/psychological-well-being-scales-wbs/

[454]   Dr Carol Ryff, 'Scales of Psychological Well-Being', *Institute on Aging*, University of Wisconsin, 2006, p 6.

[455]   Duke University, Medical Center Library & Archives, 'Test Instruments: Duke Instruments', 28 July 2021, https://guides.mclibrary.duke.edu/testinstruments/duke#dukesocialsupportindex

[456]   J Wardian, *et al,* 'Validation of the DSSI-10 to Measure Social Support in a General Population', *Research on Social Work Practice*, 34(1), p 101.

[457]   UK Campaign to End Loneliness, 'Measuring your impact on loneliness in later life', 2016, p 11.

---

in face to face interviews, telephone interviews, self-administered mail questionnaires and in an electronic data collection system.[458]

When asked for his views on how to measure loneliness, Mr Robin Hewings, Program Director for the Campaign to End Loneliness UK responded:

> It is not an easy thing to do and there are dilemmas about it. We did a report a few years ago, which still basically stands. There are two main academic measures: one is the UCLA loneliness measure and the other is the De Jong Gierveld (sic) loneliness measure. The UCLA one can be a bit shorter—it can be done in three questions—and it gives you an idea of how lonely someone is. De Jong Gierveld's (sic) is similar but it is structured to give you a sense of whether the loneliness that people feel is more to do with a lack of their closest social relationships or is more in that broader set of friends.[459]

The academic literature also considers the UCLA Loneliness Scale and the de Jong Gierveld Scale to be of merit. A 2020 journal article stated that the 3-item UCLA Loneliness Scale 'is one of the most widely-used measures to assess loneliness',[460] while a 2021 *Frontiers in Psychology* article claimed:

> In the international literature, the most used scales designed to measure loneliness are: (a) the De Jong Gierveld (sic) Loneliness Scale (DJG-LS; De Jong-Gierveld and Kamphuls, 1985) and (b) the University of California Los Angeles (UCLA) Loneliness Scale Version 3 (UCLA-LS-III; Russell, 1996).[461]

In addition, Friends for Good stated:

> The development of empirical scales, such as the UCLA Loneliness Scale and the de Jong Gierveld Loneliness Scale have greatly increased the ability to conceptualise loneliness. These scales differ in the questions asked and their use of the explicit wording about loneliness. The UCLA Loneliness Scale in particular has been widely used (in approximately 80% of empirical studies into loneliness) allowing for comparisons across time and between samples.[462]

7.2.2 Measures used in specific work

Some research does not use any established measures to quantify social isolation and loneliness, but instead uses its own measures. A selection of these measures, from Australian and international research, are discussed below.

Data gained using social isolation and loneliness measures that have already been compiled can provide a useful baseline measure if interventions to address social isolation and loneliness are introduced, and social isolation and loneliness are measured again using the same measures.

7.2.2.1 *Australian Bureau of Statistics – General Social Survey*

Approximately every 4 years, the Australian Bureau of Statistics (ABS) conducts its General Social Survey (GSS). The GSS collects data on the social characteristics, wellbeing and social experiences of people in Australia.[463]

---

[458]   Submission 72, p 10.

[459]   Public hearing transcript, 11 October 2021, Brisbane, p 18.

[460]   Bridget Shovestul, *et al*, 'Risk factors for loneliness: The high relative importance of age versus other factors', *PLoS ONE,* 15(2), February 2020, p 4.

[461]   Vincenzo Senese, *et al*, 'The Relationship Between Loneliness and Psychological Adjustment: Validation of the Italian Version of the Interpersonal Acceptance–Rejection Loneliness Scale', *Frontiers in Psychology*, 3 June 2020, p 2.

[462]   Friends for Good Inc, 'Loneliness in Australia: Research, Context and New Findings', 2019, p 4; note that footnotes in the quote have not been replicated in this document.

[463]   ABS, 'General Social Survey: Summary Results, Australia', 29 June 2021, https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release.

The 2019 and 2020 GSS asked if people:

- had had face to face contact with family or friends living outside the household at least once a week in last 3 months

- had other forms of contact with family or friends living outside the household at least once a week in last 3 months

- had been able to get support in times of crisis from persons living outside the household

- had family or friends living outside the household to confide in.[464]

GSS data is available for each state and territory. Data for the 2019 and 2020 surveys are available, meaning there is baseline data both of these years. It could be argued that 2019 figures may be preferable to 2020 figures, because the 2020 figures may have been influenced by the impacts of Covid-19 and measures taken to slow its spread.[465]

7.2.2.2 Queensland Social Survey

The Queensland Social Survey (QSS) has been conducted annually since 2017. While the focus of the QSS is to collect Queenslanders' views on domestic and family violence, the 2021 QSS asked respondents the following questions relevant to social isolation and loneliness:

- in the last three months, how often they communicated with people they knew, but did not live with

- whether they would like to communicate with these people more often

- who else they would like to communicate more often with

- the main barriers to communicating with people more often.[466]

The QSS has collected data for 2021, which could be a useful baseline to measure the effectiveness of any interventions introduced to address to social isolation and loneliness, as highlighted by Dr Messer, Acting Director, Community Needs Analysis and Investment, DCHDE.[467]

7.2.2.3 Australian Institute of Health and Welfare

Since 1993, the AIHW has produced its *Australia's welfare* report every two years.[468] The reports cover welfare themes such as support for Indigenous Australians, aged care, people with disability, justice and safety, employment and income, education and skills, housing, and welfare expenditure and workforce.[469]

The *Australia's welfare 2021* report collected data on social isolation and loneliness, such as the proportion of people reporting loneliness:

- during the past week, by age

---

[464]   ABS, 'General Social Survey: Summary Results, Australia', June 2021.

[465]   ABS, 'General Social Survey: Summary Results, Australia', September 2020, https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2019.

[466]   Queensland Government Statistician's Office, 'Queensland Social Survey 2021, Domestic and Family Violence Survey Report', August 2021, p 20.

[467]   Public briefing transcript, 30 August 2021, Brisbane, p 4.

[468]   Australian Government, AIHW, 'Australia's welfare 2021 data insights', August 2021, p vi.

[469]   Australian Government, AIHW, 'Australia's welfare 2021 data insights', August 2021, p vi.

- during the last four weeks, by household composition and location[470]

- during the last four weeks, by age and sex in May, June and October 2020.[471]

While the data is not broken down by state, the questions above may be useful for measuring loneliness in Queensland.

7.2.2.4 *ABC Talks Survey*

A joint submission from researchers from UQ and ANU highlighted that the ABC's Australia Talks Survey used a number of questions relevant to social isolation and loneliness, such as:

- to what extent do you feel isolated from others?

- to what extent do you feel lonely?

- are you an active member of any organisations, clubs or societies?[472]

7.2.2.5 *New Zealand General Social Survey*

Every two years, the New Zealand (NZ) GSS is conducted. The GSS covers a wide range of social and economic outcomes, and shows how people in different groups within NZ are faring.[473]

The GSS asks whether people have felt lonely in the last 4 weeks, to which respondents can reply 'none of the time', 'a little of the time', 'some of the time' or 'most/all of the time'.[474] While the results are not applicable to Queensland, the questions asked may be of interest for inclusion in any measures of loneliness in Queensland.

7.3 The need to adopt measures of social isolation and loneliness

To assess the usefulness of an intervention on Queenslanders' social isolation and loneliness, and to compare the effectiveness of different interventions, appropriate methods of measuring social isolation and loneliness would need to be adopted. This was a point made by submitters,[475] including Caxton Legal Centre Inc.:

> Should the Queensland Government decide to implement a social isolation and loneliness reduction strategy, in order to assess its impact, it is recommended that parties involved be required and assisted to undertake progressive evaluation using a simple measurement tool suitable for the Queensland context.[476]

Central Queensland, Wide Bay and Sunshine Coast PHN advocated the need for consistent and validated measures of social isolation and participation of communities, stating:

> Currently, measures available to understand this issue exist only at a national level through the General Social Survey (social capital measures such as participation, support, feelings of safety and trust, volunteering rates and life satisfaction) or proxy indicators (such as housing data, rurality, and household

---

470 Information available for Victoria, NSW and the rest of Australia.

471 Australian Government, AIHW, 'Social isolation and loneliness', 16 September 2021.

472 Submission 43, pp 2-3.

473 New Zealand, Stats NZ, 'Information about the New Zealand General Social Survey (GSS)', 19 March 2018, https://www.stats.govt.nz/help-with-surveys/list-of-stats-nz-surveys/information-about-the-new-zealand-general-social-survey-gss.

474 New Zealand, Stats NZ, 'Wellbeing statistics: 2018', 26 June 2019, https://www.stats.govt.nz/information-releases/wellbeing-statistics-2018. The Excel file including the questions and data is available from: https://www.stats.govt.nz/assets/Uploads/Well-being-statistics/Well-being-statistics-2018/Download-data/wellbeing-statistics-2014-18-time-series.xlsx.

475 For example, submission 39, p 6; submission 172, p 10; submission 185, pp 4 and 7.

476 Submission 162, p 17.

income). It is therefore made more difficult to provide solutions when visibility of issues at a community level are sub-optimal.

Thus, being enabled to capture liveability indicators, such as those set by Vic Health (walkability, public transport, social infrastructure and services, employment, food, housing, and public open space) would allow greater monitoring and understanding of the issue at the community level. We recommend that local governments and the state have a role in supporting the collection of this data on behalf of communities to better understand and monitor what is going on.[477]

Regarding the adoption of a specific loneliness measure in Queensland, the QAMH considered:

The suitability of the UCLA Loneliness Scale (version 3) should be considered for measuring loneliness in Queensland to determine if strategies are effective.[478]

7.3.1.1 *Committee comment*

The committee recognises the need for consistent definitions and measurements of social isolation and loneliness, to ensure that any intervention and protective measures introduced to mitigate social isolation and loneliness can be appropriately analysed to ensure efficient investment in strategies identified are working effectively.

7.4 Leveraging current investment to prevent, mitigate and address social isolation and loneliness

The committee received evidence from a spectrum of stakeholders suggesting that current programs and initiatives that may be leveraged to prevent, mitigate and address the drivers and impacts of social isolation and loneliness in Queensland. Stakeholders presented information and recommendations from both a macro and micro perspective. Significant themes of these responses included the positive impact of social prescribing, in particular the Ways to Wellness program, and the contribution that NCCs make in Queensland (refer to Chapters 3 and 6, above).

The Community Services Industry Alliance stated:

Investment within government as well as investment in services delivered externally by partners, such as the community services industry, could be in scope. For example, existing DCHDE program areas could be points of leverage to respond to social isolation, including housing, financial inclusion, home care support, social cohesion, neighbourhood centres and homelessness services. Adjacent reform or actions areas in volunteering, housing and homelessness and neighbourhood centres represent further opportunity for leverage.[479]

Marilyn Wright stated:

There would be advantages of a whole of Government approach -perhaps drawing on that adopted in the UK across departments especially of health, planning, community services, transport and employment. Treasury Department would also play a role in funding preventive community programmes which long term would reduce costs in high care.

There are financial advantages of prevention. Early intervention to reduce health costs and encourage self-reliance. Prevention would reduce demands on general health services, youth, aged and mental health by redirecting vulnerable people to effective community support early.[480]

In addition, some stakeholders suggested that there may be opportunity to collaborate with peak bodies to better elevate the knowledge around effective interventions, and discuss delivery and leveraging of existing interventions.[481] A selection of the viewpoints that considered how current

---

[477] Submission 39, pp 6-7.

[478] Submission 74, p 10.

[479] Submission 111, p 18.

[480] Submission 41, p 2.

[481] For example, submission 126, p 22.

investments across all sectors may be leveraged to address issues relating to social isolation and loneliness in Queensland are included below.

7.5 Australian Government Primary Health Networks

In 2015, the Commonwealth PHN Program established 31 PHNs nationally to strengthen primary care and improve patient-centric service integration. There are 7 PHNs in Queensland.[482]

PHNs are primarily funded by the Commonwealth Department of Health with the aim of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time, through:

- increased understanding of local health needs,

- the development of effective partnerships fostering integration (particularly with Hospital and Health Services)

- innovative ways of commissioning services.[483]

Public hearing held at Nambour RSL on 30 September 2021.

According to the submission from the CEOs of QPHNs:

> The focus of the QPHNs is on primary care through the support of General Practitioners, and working with a range of government and community organisations, service providers and the community to develop and better integrate health and community care services, and improve access to services with an emphasis on those most vulnerable people at risk of poor health outcomes.[484]

Similarly the submission of the Central Queensland, Wide Bay, Sunshine Coast PHN stated PHNs are 'ideally positioned to foster further system integration across state and federal health jurisdictions as well as the interface with disability, aged care, and community services, and continue to work strategically towards true integration across sectors'.[485]

---

482   Submission 149, p 2.

483   Submission 52, p 3.

484   Submission 52, p 3.

485   Submission 39, p 4.

The Brisbane South PHN submitted that they work closely with service providers (Residential Aged Care Facilities, home care providers), GPs and community organisations to deliver their programs and initiatives. Their submission stated:

> Because of the way PHNs work, accessing and activating strong community and primary care networks, they are uniquely placed to respond to social issues that cross numerous government departments and systems.[486]

In their submission, the CEOs of QPHNs recommended that the Queensland Government consider working collaboratively with the QPHNs to leverage from:

- the existing network and capability of PHNs as commissioning organisations that can codesign and support targeted interventions that meet local needs throughout Queensland

- build responses that are informed by statewide data as well as drawing from QPHN local need assessments

- leverage QPHNs' ingrained knowledge and understanding of their communities and vulnerable groups within them

- tap into QPHNs' ability to plan, respond and scenario test program responses in clinical and community settings.[487]

The Brisbane South PHN suggested a number of recommendations in relation to the PHN network, including that the Queensland Government:

- work with PHNs to deliver or enhance social prescribing initiatives in primary care and coordinate efforts across the primary care sector

- engage with PHNs to support and deliver reformed NCCs, focused on place-based approaches

- investigate joint funding models to prevent siloed approaches and deliver a holistic, whole-of-government response to people experiencing social isolation and loneliness in the community. PHNs are a commissioning body and can be used to deliver joint initiatives across a number of state government departments with visibility across the system.[488]

7.5.1.1 *Committee comment*

The committee also acknowledges the role of federally-funded PHN nurses and other federally-funded staff working within the health sector to address social isolation and loneliness.

Recommendation 9

The committee recommends that the Queensland Government advocate to the Commonwealth Government the work of federally-funded primary health network nurses and other Commonwealth-funded positions in addressing social isolation and loneliness, including for primary health network nurses to be allocated to major medical centres where needed.

7.6 Queensland Government services and programs targeted to support vulnerable and disadvantaged groups and those most at risk

The terms of reference for this inquiry sought information and stakeholder views in regards to state services and programs that may be categorised within 13 specified societal areas. Each of these 13

---

[486] Submission 149, p 2.

[487] Submission 52, p 7.

[488] Submission 149, p 8.

areas are presented below, along with relevant information provided to the Inquiry from each state government department, and other stakeholders.

7.6.1 Health and mental health

As outlined in Chapter 3, poor or declining health or mental health can be a cause and driver of social isolation and loneliness. Queensland Health noted that:

> Health can often be a person's first point of engagement with social or government services at all life stages and has an important role in the identification of people who might be socially isolated or at risk of loneliness.

> Queensland Health provides services across the life course for Queenslanders from prenatal care to specialised care for older people including an important linking role with the Commonwealth aged care sector.[489]

Queensland Health provided details of a range of its associated services and programs. These included the following:

> Queensland Health is committed to a number of key strategies, programs and investments that support overall wellbeing and mental health for all Queenslanders and the provision of workplaces that are inclusive and supportive for Queensland Health employees. As a major employer, the strategies in place to assist Queensland Health employees have a wide reaching impact.

> Queensland Health has issued support resources, including the *Leading and managing people in the new normal: line manager pack*, to support managers and staff in remote working and combatting isolation and loneliness during COVID-19 pandemic and beyond.

> For most Aboriginal and Torres Strait Islander people, positive social and emotional wellbeing means being resilient, being and feeling culturally safe, having and realising aspirations and being satisfied with life. Positive social and emotional wellbeing also supports those living with mental health problems and mental illness to recover and can be instrumental in protecting people from the impacts of suicide, problematic alcohol and other drug use, and some mental illnesses. In targeting programs and services to support Aboriginal and Torres Strait Islander peoples who may be impacted by social isolation and loneliness, it is critical that Aboriginal and Torres Strait Islander communities are at the centre of decision-making, driving those initiatives centred around cultural, social and emotional wellbeing.[490]

Public hearing held in Aitkenvale on 19 October 2021.

---

[489]   Queensland Health, correspondence, p 1.

[490]   Queensland Health, correspondence, pp 3-4.

7.6.1.1 *Stakeholder views*

Inala Primary Care provided the following observations and recommendations about health programs:

> We need a coordinated, culturally safe and appropriate care coordination service in health care settings. This service needs to be adequately funded and equitable to all as we know social isolation can disproportionally affect lower socioeconomic communities as people within these communities have lower "reserves" to deal with negative "shocks" in their lives. The Mater M-CHooSE program is a health and social care coordination service for culturally and linguistically diverse patients and our research has shown it has led to better overall health outcomes for many patients. Yet we are yet to see adequate and stable funding for such a unique and helpful service. The Ways to Wellness and Groups4Heath programs are making positive impacts in the communities they operate in, but they need ongoing support to continue to evolve and reach a level of scale that would see community-wide change.[491]

Apunipima Cape York Health Council noted that its organisation's skillsets assisted in their efforts to care for their clients:

> Apunipima adheres to a family centred model of comprehensive primary health care which sees clients as people embedded in families and communities empowered to make informed decisions about their life and health. Working within this family and community centred empowerment framework assists in mitigating social isolation and loneliness.
>
> …
>
> Having such a workforce that understands the issues which confront communities regarding historical and local perspectives which impact on social isolation and loneliness is essential in addressing these factors.[492]

Save Our Sons Duchenne Foundation made the following comments and recommendations in relation to the contributions that their organisation (and others similar) make for their communities:

> … more investment needs to be leveraged at all levels of government and the private sectors to ensure that more services and programs … are delivered and provided in such a way, as to ensure greater inclusion and consideration of the needs of rare disease communities such as the DMD and BMD community.
>
> Save Our Sons Duchenne Foundation believes the Queensland State Government can play a key role in coordinating the different tiers of Government in this effort while providing the brokerage that may be necessary to deliver a range projects and programs which are designed to mitigate and address the drivers of social isolation and loneliness. For example, mental health and well-being initiatives which are cognisant of and adapted to the various phases of the Duchenne and Becker disease life cycle, public awareness campaigns which raise awareness of inclusion issues (and which are underpinned by a philosophy that people are only disabled to the extent our society excludes them), public works programs which increase wheelchair accessibility and facilities etc.
>
> As providers of many services and programs, the State Government is ideally placed to ensure that its agencies are delivering services with inclusion issues, policies and practices centre-stage. These agencies are also best placed to consult with disadvantaged rare disease communities and their representative organisations about the types of programs and infrastructure which should be delivered to ensure that issues of isolation and social exclusion are mitigated.[493]

Other stakeholders suggested ways that current investment could be leveraged to prevent, mitigate and address the drivers and impacts of social isolation and loneliness across Queensland.

For example, the NHF noted that the Queensland Walking Strategy is a positive example of a whole of government response to support people to walk more, by providing the infrastructure and encouraging population behaviour change. The NHF stated that the Queensland Government led the

---

[491] Submission 66, p 4.

[492] Submission 8, p 7.

[493] Submission 24, p 27.

way through this innovative program but the last Queensland State Budget did not allocate adequate funding to support the next action plan. The NHF suggested that current government funding could be leveraged to provide further and ongoing spending to support physical activity and the social connection that this promotes.[494]

Warren King commented that greater recognition and visibility of loneliness as a major health factor needs to occur in all government programs, and the provision of existing home care services should specifically include catering for mental health, social isolation and loneliness mitigation.[495]

Central Queensland, Wide Bay and Sunshine Coast PHN suggested that there is value in investing in initiatives that support an integrated health and social care system, such as through link workers or social prescribing.[496] This view was supported by QAMH.[497]

7.6.2 Transport

The Department of Transport and Main Roads highlighted the following 2 programs from within its jurisdiction that assist towards improving social isolation and loneliness:

School Transport Assistance Scheme

The School Transport Assistance Scheme helps students travel to and from school when access to education facilities is impeded by distance, disability or financial disadvantage. The scheme also helps students from areas designated as drought declared. Eligible families receive assistance with rail transport, kilometre-based school services (bus or ferry), fares-based school services (bus or ferry), conveyance allowance and safety-net assistance.

Taxi Subsidy Scheme

The Taxi Subsidy Scheme (TSS) subsidises taxi travel—half of the total fare, up to a maximum of $25 per trip—for people with severe disabilities. TSS pays half the value of a member's taxi fare, up to a maximum fare of $50. There is no limit on the number of taxi journeys a member may take to attract the subsidy. The subsidy is paid to taxi drivers—members have no additional costs. TSS membership lasts for a maximum of 5 years. To extend your membership, you must reapply before the expiry date. If you have a temporary disability, 6 to 12-month memberships are available.[498]

7.6.2.1 *Stakeholder views*

The AASW recommended 'that the Queensland government collaborate with the private transportation sector to subsidise the transportation costs for people who reside in regional and remote Queensland to receive formal and informal care.'[499]

Expanding on its submission, the AASW stated:

Our members work with people who do not have reliable and affordable means to receive formal care and informal care. For formal care like mental health services, people without a car usually have to wait for public transportation that is not reliable in regional localities. People receiving care from the National Disability Insurance Scheme … would have received supported transportation when they have mobility needs. However, people who are not eligible to this program receive no transportation support for medical appointments or other formal care. For informal care, this includes visiting family and community members who are not in the same regional localities or residing in metropolitan Queensland. However, flying from regional to metropolitan airports can be very costly due to the small number of flights that operate on these routes. This is a structural barrier for poorer Queensland in regional and remote area

---

[494]   Submission 25, p 5.

[495]   Submission 87, p 2.

[496]   Submission 39, p 6.

[497]   Submission 74, p 9.

[498]   Department of Transport and Main Roads, correspondence, June 2021, pp 1-2.

[499]   Submission 79, pp 9-10.

to maintain social connections with their family and community members in other parts of Queensland. The lack of transportation options also particularly impacting older Queenslanders in regional araes (sic). Our members in Townsville have reported that older people living alone or in residentual (sic) aged care facility do not have means of transportation to visit their community members, which is a clear risk factor of social isolation.

Evidence has shown that transportation subsidies have assisted people from regional and remote areas in participating in social activities and accessing essential care, as they reduce out-of-pocket costs. For example, the Local Fare Scheme—airfare subsidy for regional and remote Queensland is a successful collaboration model between the Queensland government and airlines to drastically reduce the cost of transportation for people living in designated regional localities. A similar model can be used to subsidise the transportation costs for individuals to attend essential services and social activities in remote and regional areas via rideshare or taxi services.[500]

7.6.3   Housing

The DCHDE provided the following background in relation to the approximately 71,348 social housing tenancies across Queensland:

There are tenants in social housing in Queensland consist of a broad range of cohort groups that may be vulnerable to isolation and loneliness. Further, as the social housing portfolio is dispersed across the state including rural areas, access to services or support can be constrained due to supply, distance and delivery method and cost.

Of the 43,094 people who accessed Specialist Homelessness Services in Queensland in 2019-20, 34% were experiencing domestic and family violence, 25% had a mental health issue and 20% were vulnerable young people aged 15-24.[501]

In terms of fostering tenant engagement, the DCHDE noted its *TenantConnect* program which partners with Tenants Queensland 'to encourage tenants (public housing and private renters) to get to know their neighbours, connect with their community, promotes volunteering and the services delivered through NCCs and public libraries.'[502]

Ms Irene Violet, Acting Assistant Director-General, Community Services, DCHDE, further advised that:

Housing and Homelessness Services invests in a range of housing and homelessness programs, guided by the Housing Strategy and the housing action plans. They aim to support vulnerable and disadvantaged people and households in our community and to build cohesive communities. Some of the services are designed, of course, to maintain tenancies and make sure that we have specific services to assist some of the most vulnerable people in our community. Access to secure, safe, appropriate and affordable housing is a fundamental right of all Queenslanders and plays a key role in preventing social isolation and loneliness.[503]

Ms Elizabeth Bianchi, Executive Director, Strategic Policy and Legislation, Seniors and Disability Services, DSDSATSIP, added:

… there is obviously only a small proportion of [National Disability Insurance Scheme] participants who are eligible for specialist disability accommodation. The Queensland government then remains responsible for accessible housing for anyone with disability outside of that cohort. Again, it is primarily the lead by our colleagues at the Department of Communities, Housing and Digital Economy but the recently launched Housing and Homelessness Action Plan has some quite specific strategies around increasing the level of accessible housing for people with disability.[504]

---

[500]   Submission 79, pp 9-10.

[501]   DCHDE, correspondence, p 2.

[502]   DCHDE, correspondence, p 15.

[503]   Public briefing transcript, Brisbane, 30 August 2021, p 2.

[504]   Public briefing transcript, Brisbane, 30 August 2021, p 17.

7.6.3.1 *Stakeholder views*

Ms Elizabeth Brown, CEO, Access Community Housing Company, outlined the role of that organisation and the current demands for social housing:

> We provide social housing to people who meet the eligibility criteria from the Department of Communities, Housing and Digital Economy. The demographic of our tenants is that nearly 80 per cent of our tenants identify as Aboriginal and Torres Strait Islander people, 25 per cent of our tenants are elderly and 25 per cent of people would be in receipt of the disability allowance. Certainly over the last 12 to 18 months we have seen a significant increase in the demand for social housing. The increase in rents in the area of up to 10 per cent, as well as reduced vacancy rates of 0.6 per cent, have significantly impacted on people who may be unemployed or underemployed or whose circumstances have changed. We are certainly seeing more people on the social housing waiting lists and more people pushed into homelessness—all of which is contributing to greater social isolation within the community.[505]

Ms Abbie Grant-Taylor, Secretary, Gympie Community Place, highlighted current issues around housing and homelessness:

> For us at the moment it is in crisis, and I do not use that term lightly. We are seeing auctions for rental properties. We are seeing families who are unable to be housed. People with good rental histories are no longer able to get into properties. We are just stunned at how much prices are going up.[506]

Ms Karyn Walsh, CEO, Micah Projects added:

> Every local community is seeing people displaced. People who have been renting places for 20 years have been sold out now. We see lots of people in Brisbane from other communities. People will want to go back sometimes, so we will try and get people back to where they want to go. It is certainly a bit of a crisis now. It was a crisis before COVID; it is a crisis now because so much is going off the private rental market. We do not have enough. We are not building fast enough. We do not have enough housing, so then people are being displaced even further, so you have overcrowding.[507]

Ms Jessica Vidafar, General Manager, Access Community Housing Company said:

> Homelessness is a growing need in our community and a community housing provider like us exists to meet that need, but there is a growing homeless population. From our point of view, people who are homeless have significant barriers. They include domestic and family violence, loss of employment, family and relationship breakdown, poor physical and mental health—health is a significant part of social isolation and loneliness—and lack of meaningful interactions.[508]

The PIA stated good neighbourhood planning could significantly contribute to a reduction in social isolation and loneliness, and suggested that current funding could be leveraged in several ways, including:

- minor amendments to the narrative of the Liveable Communities component for the State Planning Policy 2017, to promote a people focus as the foundation of built form
- inclusion of minimum open space guidance for neighbourhood scale, higher density areas and at property scale to ensure the opportunities for spontaneous meetings and site or street scale gatherings
- targeted funding programs to retrofit older neighbourhoods to create social fabric, accessible communities, street activation, open space and shade
- development of tools such as a neighbourhood planning toolkit for social inclusion.[509]

---

[505] Public hearing transcript, Manunda, 20 October 2021, p 12.

[506] Public hearing transcript, Nambour, 30 September 2021, p 9.

[507] Public briefing transcript, Brisbane, 30 August 2021, p 33.

[508] Public hearing transcript, Manunda, 20 October 2021, p 12.

[509] Submission 73, p 5.

Recommendation 10

The committee encourages the Queensland Government to advocate to city councils of major centres to ensure adequate provision of green space, parks, toilet access, infrastructure and planning, access to transport and meeting places such as libraries, and social infrastructure, to promote mitigating factors that alleviate social isolation and loneliness.

7.6.4 Education

The committee notes a number of intersecting issues that contribute to social isolation and loneliness, which exacerbate the problem. The Department of Education provided the following details of 'a number of department initiatives that may be leveraged to contribute to preventing, mitigating and addressing the drivers and impact of social isolation and loneliness across Queensland'.[510]

Student Learning and Wellbeing Framework

The department's Student Learning and Wellbeing Framework (the Framework) assists schools to implement a whole-school approach to supporting students' wellbeing and mental health. The Framework emphasises that a core component of a whole-school approach is to create an environment where all students feel safe, supported and included, and where:

- social and emotional skills are explicitly taught and modelled to students to ensure they are well equipped to talk about their emotions and build trusting positive relationships with peers and adults;

- students are taught coping skills and help-seeking strategies through the curriculum focused on mental health and wellbeing;

- student help-seeking behaviour is actively promoted and encouraged; and

- the support available from internal and external support services is promoted to students to ensure they know how to get help if they are concerned for their own or others' wellbeing.

All schools, including those in vulnerable and disadvantaged areas, are encouraged to use the Framework to implement and strengthen their whole-school approach, ensuring all students learn in an environment where they feel accepted, respected, included and supported by others.[511]

Student Wellbeing Package

Commencing on 1 July 2021, funding for a $100 million Student Wellbeing Package will deliver on the Queensland Government's election commitment to:

increase the number of wellbeing professionals in Queensland state schools by up to 464 full time equivalents … over three years to ensure that every student can access support for their wellbeing at school; and

a pilot program placing General Practitioners (GPs) in 20 Queensland state secondary schools in areas of greatest need.[512]

Support for Aboriginal and Torres Strait Islander students

The department is co-designing localised strategies with Aboriginal and Torres Strait Islander peoples as well as operating a number of initiatives, through contracts with external providers, that are designed to specifically promote and support the attendance and retention, engagement, achievement, and health and wellbeing outcomes of Aboriginal and Torres Strait Islander students who live in remote and discrete communities.[513]

---

[510] Office of the Director-General, Department of Education, correspondence, 24 June 2021, p 1.

[511] Office of the Director-General, Department of Education, correspondence, 24 June 2021, p 2.

[512] Office of the Director-General, Department of Education, correspondence, 24 June 2021, p 2.

[513] Office of the Director-General, Department of Education, correspondence, 24 June 2021, p 2.

<u>Supporting schools and students in rural and remote Queensland</u>

The Queensland Government has established four Centres for Learning and Wellbeing (CLAWs) to provide professional learning to school leaders and teachers, and wellbeing support to staff, students and families across rural and remote Queensland. A key function of the CLAWs is to facilitate inter-agency wellbeing support for students, which includes:

- facilitating support for students with mental health issues; and

- building the capability of staff to support these students through the delivery of mental health first aid programs through the CLAWs.[514]

7.6.4.1 *Stakeholder views*

The BYS highlighted that:

Engagement in education and employment is a protective factor for young people, enabling access to friendships and mentors. There needs to be significant investment in early intervention and prevention programs within educational institutions to keep young people engaged and motivated at school. For young people who are unable to attend mainstream schooling due to learning difficulties or expulsion from school, there needs to be a range of educational programs offering alternative delivery of Queensland curriculum conducive to the challenges of young people experiencing homelessness and complex trauma. Collaborative models of service delivery that support facilitated outreach and access to supports and services in the community for young people who attend alternative schooling pathways is a priority.[515]

7.6.5 Employment and training

The DESBT provided the following information in regards to employment and training programs:

<u>Skilling Queenslanders for Work</u>

The Skilling Queenslanders for Work (SQW) initiative is a suite of targeted skills and training programs supporting Queenslanders to gain the skills, qualifications and experience needed to enter and stay in the workforce.

…

A broad range of cohorts that generally face barriers to their participation in training and the labour market are the key participants under SQW. Those target groups include young people, mature-age job seekers, First Nations people, people with a disability, women re-entering the workforce, Australian Defence Force (ADF) veterans and ex-service members, recently released prisoners and people from culturally and linguistically diverse backgrounds.

SQW projects are delivered within a specific timeframe in a community-based setting at no cost to participants. A key feature is the delivery of employment tailored support with funded community based organisations able to provide appropriate specialist or support services to address personal, health and social issues to disadvantaged participants. These may include social isolation and loneliness. Since 2015, $443.16 million has been committed under the SQW initiative (with $402.11 million actual expenditure) to assist 71,000 disadvantaged Queenslanders. As at 31 May 2021, 59,390 people have been assisted with 36,684 gaining jobs.[516]

<u>Skills Disability Support</u>

DESBT also supports the participation of people with disability in VET through the Skills Disability Support (SDS) initiative.

…

---

[514] Office of the Director-General, Department of Education, correspondence, 24 June 2021, p 3.

[515] Submission 161, p 6

[516] DESBT, correspondence, p 1.

SDS services are successful in assisting students with a disability to achieve their training goals and go onto achieve positive employment outcomes. This helps people with a disability to maintain connectedness, supports resilience and can help with isolation. The Queensland Government has invested $3.25 million under the SDS initiative since 2015.[517]

Training and skills investment

Under the Queensland Government's vocational education and training … investment arrangements, there are a range of pathway options suited to the different needs of individuals at various stages of their career journey including those experiencing disadvantage and barriers to employment. In 2020/21, over $500 million was invested to support over 200,000 Queenslanders…[518]

First Nations Training Strategy

DESBT is developing a First Nations Training Strategy (FNTS), under the Queensland Government's Future Skills Fund. The FNTS is supported by a $5 million (over two years) funding commitment by the Queensland Government, and will assist in connecting First Nations people with training opportunities that provide pathways to local jobs and contribute to the growth potential of local economies. The FNTS will also support progress towards meeting the recently updated Closing the Gap targets which set an ambitious agenda for increasing participation and attainment by Aboriginal people and Torres Strait Islander people in employment, skills and training over the next 10 years.[519]

7.6.6   Sport and recreation

The DTIS advised that it 'recognises that participation in physical activity or through volunteering in the many sport and active recreation settings available across Queensland can be a preventative factor for social isolation and loneliness and help bring communities together.'[520] The DTIS added:

The opportunity to leverage the benefits of social engagement through sport and recreation settings is not limited only to those playing sport, but to the many spectators and volunteers that fill important roles such as referees, umpires, coaches, administrators and on governance boards. While participation in sport, including through volunteering, provides opportunities for social inclusion, the Department is also aware of research linking the availability and access to green spaces and the natural environment to lower levels of loneliness. [521]

In relation to improving sporting opportunities in Queensland, the DTIS highlighted that:

… the Queensland Government's 10-year *Activate! Queensland! 2019-2029* strategy is working collaboratively across agencies, levels of governments, and industry stakeholders, to deliver high quality and inclusive sport, active recreation and broader physical activity opportunities to enrich Queenslanders' way of life.[522]

Andrew Sly, Assistant Director-General, Sport and Recreation, DTIS, outlined that the *Activate! Queensland* program focuses on the following four priority areas:

empowering more Queenslanders to enjoy physical activity—more people more active more often; inspiring activity in places and spaces that invite active lifestyles; creating partnerships to maximise the impact of government and industry actions; and driving success at the elite level and delivering and promoting world-class knowledge and facilities.[523]

… the Department of Tourism, Innovation and Sport has provided or approved funding totalling over $81 million to deliver a range of initiatives and programs. This includes the delivery of a $27 million

---

[517]   DESBT, correspondence, p 2.

[518]   DESBT, correspondence, p 2.

[519]   DESBT, correspondence, pp 2-3.

[520]   DTIS, correspondence, 25 June 2021, p 1.

[521]   DTIS, correspondence, 25 June 2021, p 2.

[522]   DTIS, correspondence, 25 June 2021, p 1.

[523]   Public briefing transcript, Brisbane, 30 August 2021, p 25.

investment in sport and rec infrastructure approved under the Active Community Infrastructure program. That also included two community use-of-schools projects. Opening up schools for community use, it goes without saying, is a very important thing that our department supports 100 per cent.[524]

7.6.6.1 *Stakeholder views*

The NHF was supportive of the Queensland Walking Strategy, saying that it 'is a positive example of a whole of government response to supporting people to walk more through providing the infrastructure and way finding to support walking and encourage population behaviour change.'[525] The NHF added:

> The Queensland Government led the way through this innovative program, however, in the last Queensland Budget, did not allocate adequate funding to the next Action Plan. More and ongoing spending on infrastructure and programs is needed to support active transport and physical activity and the social connection that this promotes.[526]

The QAMH highlighted that:

> There is also an opportunity to improve integration in the community for individuals through local sports clubs. In a recent member forum, our members highlighted when people move to a new area, they often seek to become more involved in community, and build new social connections through sports clubs. QAMH have recognised the importance of this cross-sector collaboration through a recent agreement with QSport, the peak body for organised, affiliated sport across Queensland. The focus of the agreement is to promote easier access to community sport for people living with mental health issues by forging connections between sporting clubs and community mental health organisations across Queensland. These connections will not only offer physical health benefits but together provide more opportunities for people to connect and improve their mental wellbeing.[527]

7.6.7 Community services and facilities

The DCHDE advised of its support for community service peak organisations:

> The department funds a number of community service peak organisations to support Queensland communities, including vulnerable and disadvantage groups. The department works with stakeholders and communities to achieve its strategic outcomes including increasing the social and economic participation of Queenslanders and building relationships and inclusion to support communities; investing in local communities and services; delivering jobs and quality services in the regions; and improving the capacity and capability of clients, communities, stakeholders and staff.

The department provided almost $2.5 million in funding to four peak organisations in 2020-21 including:

- $1,552,872 to Queensland Council of Social Service
- $475,917 to Volunteering Queensland
- $153,568 to Queensland Families and Communities Association
- $300,092 to Queensland Meals on Wheels.[528]

The DCHDE also outlined its support for NCCs:

> The Queensland Government investment in NCCs increased from $12.7 million in 2013-14 to $18.9 million in 2020-21. The Queensland Government owns and maintains 55 of the 127 centres operated by

---

[524]   Public briefing transcript, Brisbane, 30 August 2021, p 25.

[525]   Submission 25, p 5.

[526]   Submission 25, p 5

[527]   Submission 74, p 8.

[528]   DCHDE, correspondence, p 8.

community organisations across the State. … Remaining centres are either owned by the organisation, local council, an independent landlord, or have other arrangements in place.[529]

The role, funding and staffing of NCCs are discussed in more detail in sections 3.4.5 – 3.4.7, above.

7.6.7.1 *Stakeholder views*

Recovered Futures submitted that many social and community services programs funded by the Queensland Government are aimed at addressing the health and wellbeing needs of vulnerable people, citing NCCs as an example. Recovered Futures stated that effective responses to isolation include outreach to additional individuals through programs already being delivered, such as Queensland Men's Sheds and veterans' organisations.[530]

Gympie Community Place suggested that current Queensland Government funding could be leveraged through existing NCCs, stating:

> You already have investment, infrastructure, and resources within all of your community and neighbourhood centres across Queensland. We just need some more resources to enable us to increase our capacity and focus into this space. We can help you make a difference here if you help to resource us to do so.[531]

Researchers from the Institute for Social Science Research and Life Course Centre, UQ, suggested that the Queensland Government could leverage additional funding to expand the Ways to Wellness project established in MGCC, to enable all of Queensland's NCCs to reduce social isolation and loneliness.[532]

This view was supported by Dingle, Sharman and Hayes, who stated:

> A state-wide roll-out of social prescribing could be implemented efficiently and cost-effectively using existing infrastructure such as neighbourhood and community centres that have group rooms, kitchen, and bathroom facilities to support social activities and informal socialising opportunities. This infrastructure would need to be accompanied by funded link worker positions and administrative support in each location to ensure effective communication between referring stakeholders, participants, and community group providers.[533]

A number of other submitters agreed with these views.[534]

7.6.8   Digital inclusion

The DCHCE advised that digital inclusion is:

> … important to ensure that all members of the community, particularly disadvantaged and vulnerable Queenslanders, are able to access information, work online and stay connected online. Older people are one of the least digitally included groups in Australia, with reported lower levels of affordable internet access and digital skills, thereby increasing their risk of social isolation and loneliness. The department is working with Volunteering Queensland, Queenslanders with Disability Network and GIVIT to assist in bridging the digital divide so vulnerable people can be supported to access online services.
>
> Queensland Government's co-investment of $21.9 million in the federal Mobile Black Spots Program over the past six years has contributed to the delivery of 304 new or upgraded mobile base stations which has helped to improve mobile coverage, reduce costs, and enable more Queenslanders to connect with their communities and services. In addition to delivering over 33,000 square km of new coverage, and services to over 14,000 Queensland residences, this increased connectivity also increases the potential for service

---

[529]   DCHDE, correspondence, p 9.

[530]   Submission 29, p 2.

[531]   Submission 50, p 4.

[532]   Submission 72, p 12.

[533]   Submission 93, p 10.

[534]   For example, submissions 94, 118, 127, 140,

providers to make social inclusion programs more widely available, affordable and targeted to those who are vulnerable or most in need.[535]

7.6.8.1 Stakeholder views

UQ's Institute for Social Science Research and Life Course Centre expanded on the benefits of governments supporting digital inclusion:

> The Federal Government has initiated several programs to increase digital literacy among Australians, particularly older Australians. One of these initiatives, known as *Be Connected* is a $47.2 million Australian Government initiative that aims to support and enable older Australians to develop their digital skills and confidence as well as helping them to understand the benefits of being connected online. The program started in 2016 and was scheduled to conclude in June 2021.

> Drawing evidence and insights from 915 program participants and stakeholders, McCosker et al. (2020) conducted a mixed methods study including a two time point survey to measure change as a result of participation in *Be Connected*. The research team conducted a social [ROI] analysis to determine the program's efficiency and social value and found a significant reduction in loneliness over the time that learners were involved with the program. The findings further showed that survey participants' social connectedness increased due to their ability to connect with family and friends digitally. The program invested in successful online resources through the Learner Portal (beconnected.esafety.gov.au) that offered a vital template and touchpoint for learners, Network Partners and Digital Mentors. The findings further demonstrated good value for money:

> "$4.01 is created in social value for every $1 invested. Be Connected has created an additional $229.5 million in social value".

> *Be Connected* established a geographically diverse network of program partners operating in each Australian state and territory including Queensland.[536]

Australian War Widows Queensland's submission also commented on the importance of digital inclusion, advising that:

> Australian War Widows Queensland has previously received funding through the "Be Connected program" which we used to educate many of our widows in phone technology. We encourage the continuance of such programs. We can all do more in helping isolated elderly people to be more connected to the outside world.[537]

The AHPA stated:

> Technology can be a useful conduit to enable connection, particularly when physical distance is required. Social media is a popular mechanism to grow connections and to foster sociability. While social media is often perceived as a double-edged sword, in that it can cultivate connections but can also result in the potential for bullying and harassment as well as unrealistic portrayals, comparisons and interactions, there is the potential for social media to be harnessed as a tool to protect against … social isolation and loneliness. If technology is used to address [social isolation and loneliness], these initiatives should co-occur with building technological and digital literacy and improving access to the internet. This is essential, as all individuals should have equal access and the possibility for their connections to be enhanced. Use of technology should not be limited to those who can afford fast and reliable internet, large amounts of data, or those who are technology literate. There are various types of technological platforms available with varying degrees of complexity to wield and engage. The need to tailor approaches to technology usage and the platform may differ by life stage and technological literacy.[538]

---

[535]   DCHDE, correspondence, p 16.

[536]   Submission 72, pp 13-14.

[537]   Submission 13, pp 1-2.

[538]   Submission 69, pp 7-8.

Warren King recommended that:

> Schemes similar to The Digital Community Visitor scheme run by the Nundah Activity Centre, Brisbane North PHN, could be set up and extended to … isolated people to allow social contacts with others without the need for them to learn how to use or set up the IT systems.[539]

The AHPA also made suggestions about how current investment in digital inclusion could be leveraged:

> If technology is used to address [social isolation and loneliness], these initiatives should co-occur with building technological and digital literacy and improving access to the internet. This is essential, as all individuals should have equal access and the possibility for their connections to be enhanced. Use of technology should not be limited to those who can afford fast and reliable internet, large amounts of data, or those who are technology literate. There are various types of technological platforms available with varying degrees of complexity to wield and engage. The need to tailor approaches to technology usage and the platform may differ by life stage and technological literacy.[540]

7.6.9 Volunteering

In regards to volunteering, the DCHDE said:

> Queensland volunteers make a significant contribution to the community in many different ways, including to support responses to the issues associated with social isolation and loneliness. Volunteering provides a wide range of opportunity for meaningful connection, participation and contribution to community, as well as provision of practical support and social connection to vulnerable Queenslanders.[541]

The DCHDE highlighted the Care Army initiative which was launched on 1 April 2021 in order to support seniors and vulnerable Queenslanders during the COVID-19 pandemic:

> More than 28,500 Queenslanders registered to assist with Care Army work. More than 6000 Care Army volunteers received an offer of a volunteering opportunity, and more than 70 organisations around the state have used Care Army volunteers.

> The Queensland Government has funded Volunteering Queensland $250,000 for the Care Army Mobilisation Project which will look at ways Care Army volunteers can support a broader range of vulnerable groups and be called upon again to assist during disasters. The project will provide Care Army volunteers with opportunities to continue to be engaged and offer opportunities to upskill, build knowledge and personal development experiences and continue to give back and make a difference to their communities.[542]

7.6.9.1 *Stakeholder views*

Volunteering Queensland made the following 4 recommendations:

> Understand the supply and demand of formal volunteering geographically across Queensland Research is required to map the supply of volunteers in Queensland and measure it against local demand. This will result in volunteering initiatives, support and resources being directed to the areas of greatest need. It will also identify where services that address social isolation and loneliness have the biggest volunteer workforce shortfall.[543]

> Enhance support provided to volunteer-involving organisations Volunteer-involving organisations require greater support to address known challenges and enhance their capacity, capability and resilience. When volunteer-involving organisations have the information and resources to effectively manage volunteers,

---

[539] Submission 87, p 3.

[540] Submission 69, p 8.

[541] DCHDE, correspondence, p 8.

[542] DCHDE, correspondence, p 5.

[543] Submission 159, p 12.

they are more equipped to deliver services that address social isolation and loneliness issues in the community.[544]

Promote interest and awareness of volunteering and its benefits To maximise the strong benefits of volunteering in combatting social isolation, a promotional campaign is needed to motivate the general public to volunteer, targeted to geographical areas of need.[545]

Acknowledge and specifically mention volunteer involvement in all government and non-government workforce frameworks

Measuring, celebrating and tracking the impact of formal volunteering allows for volunteer management strategies to be implemented effectively. Consideration of volunteers in workforce strategies provides clear direction, especially in times of sudden change or adversity.[546]

Queensland Council of Social Service (QCOSS) said:

Volunteering is an effective way to prevent, mitigate and address the drivers of social isolation and loneliness across Queensland. QCOSS endorses Volunteering Queensland's submission to the Inquiry and would like to reinforce their recommendation to enhance capacity, capability and resilience of volunteer-involving organisations so that they are more equipped to deliver services that address social isolation and loneliness in the community.[547]

Central Queensland, Wide Bay and Sunshine Coast PHN suggested how current Queensland Government could be leveraged, stating:

The power and reach of volunteers cannot be underestimated in this space and should be actively leveraged due to the wide-ranging positive impacts volunteering can create in communities. More resources (including provision of training and upskilling and other support) supporting volunteers to work with needs of communities is required in the same way as the paid workforce.

Initiatives such as the Community Visitors Scheme (CVS) leverages the power of volunteers to reduce social isolation through providing companionship to older people with vulnerable risk factors. In addition, these programs provide entry points for assessment of social isolation and mental wellbeing and as such volunteers provide a valuable workforce that could be leveraged with training and upskilling as well as providing appropriate and universal tools for such assessments and referrals.

Whilst such servicing is underway in our rural communities, funding could be further used to enhance the workforce of volunteers to support solutions and enable more vulnerable groups to be reached.[548]

Recommendation 11

The committee recommends that the Queensland Government consider the development of online induction and training opportunities for volunteers who contribute to programs aimed at preventing and responding to social isolation and loneliness.

7.6.10 The arts and culture

The DCHDE provided the following details in relation to the impact of arts and culture on improving social isolation and loneliness:

Arts, culture and creativity can be powerful catalysts, offering new and different ways of responding to the social challenges faced in Queensland, from individual health and wellbeing to community recovery and rejuvenation.

…

---

[544]   Submission 159, p 13.

[545]   Submission 159, p 12.

[546]   Submission 159, p 14.

[547]   Submission 88, p 5.

[548]   Submission 39, pp 5-6.

Arts and culture fosters community belonging and trust; reduces isolation; and assists individuals and communities to recover from disasters. Arts is important to Queenslanders in connecting with and sharing their cultural background.

…

In 2020, the Queensland Government committed $22.5 million over two years through the Arts and Cultural Recovery Package of the Queensland Government's plan to Unite and Recover for Queensland Jobs. This funding supports actions in *Sustain 2020-2022*.[549]

7.6.10.1 *Stakeholder views*

A New Approach (ANA), an arts and culture think tank, advised that:

Arts and culture, when used in both clinical and wellbeing settings, has been shown to deliver positive physical and mental health outcomes. The relationship between engagement with arts and culture and health is indirect but strong and is evidenced by recent Australian and international research.[550]

Taking a national perspective, ANA added:

In research conducted by ANA in 2020 with middle Australians and then in 2021 with young middle Australians, the evidence was clear that arts and culture are central to daily life. Both groups reported that arts and culture build community connection, reduce social isolation, and improve health outcomes. They also felt strongly that access should not be dependent on where you live.

Now in a time of crisis, arts and culture are more critical than ever. Research shows that, during and following major crises, effective arts and cultural activities are those that aim to reconnect affected communities, strengthen people's connection to place, provide opportunities for reflection and commemoration, and foster a shared sense of hope and optimism. A systematic and strategic approach to developing a strong, rich cultural life that brings people together and strengthens communities is required.[551]

7.6.11 Community development

In regards to community development, the DCHDE advised that:

The department invested $133.8 million in 2020-21 in the delivery of a range of community services initiatives and programs which assist and support vulnerable and disadvantaged groups, build community capacity and connection, and help prevent and address issues related to social isolation and loneliness. This community services investment reaches to and engages with a broad spectrum of vulnerable and disadvantaged cohorts across Queensland, making connection and assisting where required. This community connection, directly and indirectly, mitigates and addresses the drivers and impacts of social isolation and loneliness.[552]

7.6.11.1 *Stakeholder views*

Relationships Australia Queensland noted its annual Neighbour Day initiative:

Neighbour Day is a year-round grass roots community development campaign that aims to increase individual and community social connections, foster healthy relationships, reduce loneliness and promote social inclusion. The culmination of the Neighbour Day Campaign is celebrated on the last Sunday in March every year, with the aim of fostering strong personal connections that last year-round.

People are encouraged to connect with their neighbours and the members of their local communities. A lack of social connectedness has significant impact on a person's mental and physical health as well as engagement and cohesion with the wider community. National initiatives such as Neighbour Day enable

---

[549] DCHDE, correspondence, p 17.

[550] Submission 53, p 5.

[551] Submission 53, p 1.

[552] DCHDE, correspondence, p 4.

the delivery of vital community education, in the context of a person's lived experience, while working to prevent loneliness, isolation and depression.[553]

7.6.12   Planning for accessible, inclusive and connected communities

The Department of State Development, Infrastructure, Local Government and Planning provided the following information in regards to planning:

> … under the Economic Development Act 2012, the Deputy Premier, as the Minister with portfolio responsibility for Economic Development Queensland can declare Priority Development Areas (PDAs) to "facilitate economic development, and development for community purposes".
>
> The development schemes within PDAs incorporate planning and urban design principles to create vibrant, inclusive and connected communities through housing diversity, building design, open space and environmental areas to help people congregate and ensure they interact.
>
> When developments occur within PDAs, these planning and urban design principles provide the foundation for nurturing inclusive and connected communities to address the issue of social isolation.
>
> In addition, the *Planning Act 2016* (Planning Act) sets out state-wide and regional planning policies to be considered by each local government in Queensland.
>
> In doing so, the land use planning and assessment framework under the Planning Act aims to support better outcomes for people, places, the environment and the economy. The planning framework is only one aspect of each of those components and works in an integrated manner to be fair, balanced, transparent and accountable.
>
> Planning can contribute to, but is not the only influence, supporting:
>
> - housing diversity and affordability
>
> - places that support liveable cities and communities
>
> - having the right infrastructure in place for growing communities, jobs and the economy
>
> - the provision of green space and natural environment.[554]

7.6.12.1 *Stakeholder views*

The PIA noted that they accept 'the evidence that social isolation and loneliness impact health outcomes, quality of life and mortality'.[555] In regards to their specialist area, the PIA made the following recommendations:

- Minor amendments to the narrative of the Liveable Communities component of the … State Planning Policy 2017, to promote a people focus as the foundation of built form. For example the South East Queensland Regional Plan commences this with the concept of fairness as a sustainability goal.

- Inclusion of minimum open space guidance for neighbourhood scale, higher density areas and at property scale to ensure the opportunities for spontaneous meetings and site or street scale gatherings

- Targeted funding programs to retrofit older neighbourhoods which creates social fabric, accessible communities, street activation, open space and shade which coincides with PIA's call for action on climate. Physically healthy places contribute to social wellbeing

---

[553]   Submission 83, p 5.

[554]   Department of State Development, Infrastructure, Local Government and Planning, correspondence, 1 July 2021, p 1.

[555]   Submission 73, p 1.

- Capacity building and education in our profession. PIA operates a robust professional development program and would welcome participation by social professionals to fully articulate the benefits and components of planning for a strong social fabric

- Development of tools such as a neighbourhood planning toolkit for social inclusion. Currently the profession has a range of non-statutory guidance which practitioners can access to ensure best practice approaches are employed. A toolkit may include practical guidance to develop small-scale local polices on community gardens, pocket parks, localised active transport strategies, as prioritised by those communities.[556]

The PIA summarised that, 'good planning, placemaking, neighbourhood planning, the provision of open space and a balanced approach to access and mobility can significantly contribute to a strong social fabric and combat social isolation and loneliness.'[557]

The NHF said:

> Planning reforms resulting in a new Model Code for Neighbourhood Design is a progressive response by the Queensland Government to encouraging better neighbourhood design. The new code aims to facilitate the creation of walkable neighbourhoods that support healthy and active communities; and a neighbourhood design and layout that creates well-integrated, well serviced, compact and connected neighbourhoods.

> The way the environment is designed, planned, and built can affect how physically active people will choose to be. Towns and cities, neighbourhoods, public spaces and places, shopping areas, and town and neighbourhood centres designed for all stages of life will result in greater use and physical activity; and provide for increased social interaction and inclusion. This can improve health outcomes, especially greater levels of general well-being and fitness.[558]

Recommendation 12

The committee recommends that the Queensland Government investigates the opportunities to co-locate State and Commonwealth Government funded, and non-government organisations where possible, to support efficiency and client access across communities.

---

[556] Submission 73, p 5.

[557] Submission 73, p 5.

[558] Submission 25, p 5.

8   Role, scope and priorities of a state-wide strategy

8.1   Identifying the parameters of a state-wide strategy

The committee notes the support expressed by Queensland Health and DCYJMA representatives for the development of a state-wide strategy to address social isolation and loneliness. David Harmer, Senior Director, Social Policy and Legislation Branch, Queensland Health, supported the development of a state-wide strategy, while clarifying 'it will be important to understand the problem clearly first and how it affects Queenslanders from all backgrounds, ages, genders and cultures'.[559] Kate Connors, Acting Executive Director, Strategic Policy and Legislation, DCYJMA, stated:

> We think it is timely for the development of a statewide strategy that engages with all Queenslanders, including vulnerable and disadvantaged individuals and groups, and addresses how the drivers and causes of social isolation are not experienced uniformly across Queensland but do vary between people, families and communities.[560]

8.1.1   Stakeholder views

A considerable number of stakeholders expressed their support for an overarching strategy to address social isolation and loneliness,[561] and provide 'a framework for collaboration between community groups, community service providers, and local and state governments'.[562] Kelly Buckingham, Regional Manager, Multicultural Australia provided this foundation statement:

> The impact of loneliness and isolation on mental and physical health cannot be understated. Research glaringly reports that people with higher levels of loneliness are found to have significantly poorer mental and physical health than less lonely people. These experiences of physical and mental health may cause an individual to withdraw from social interactions, making it more difficult for them to overcome loneliness. A statewide strategy on social isolation and loneliness is an important entry into the consideration of the social resilience, economic security and social cohesion of our Queensland community.[563]

The AIHW submitted that the role of a state-wide strategy should be:

> … to fund agencies to work alongside existing community services to incorporate strategies to reduce social isolation. This should be built into funding agreements, not bolted on afterwards. It would involve delivering outputs that ensure every agency has a role in seeking out, contacting and referring people in social isolation to a range of natural and funded supports.[564]

The AIHW also submitted that priority should be given to groups such as 'single parents, ageing people, rural and remote residents through bringing existing organisations, such as neighbourhood centres, into key roles in outreach programs'.[565]

The Central Queensland, Wide Bay and Sunshine Coast PHN submitted the need for a state-wide strategy to support cross-sector collaboration and a systems approach that would support and benefit social isolation experienced by all sectors of the community.[566] Their submission reasoned:

> The issue of isolation and participation spans across all aspects of society and fittingly, is not an issue that

---

[559]   Public briefing transcript, Brisbane, 30 August 2021, p 6.

[560]   Public briefing transcript, Brisbane, 30 August 2021, p 11.

[561]   For example, submissions 30, 64, 65, 74, 82, 106, 119, 125, 129, 130, 133, 138, 143, 150, 155, 163, 166, 185, 187 and 188.

[562]   Submission 125, p 4.

[563]   Public hearing transcript, Toowoomba, 29 September 2021, p 12.

[564]   Submission 29, p 3.

[565]   Submission 29, p 3.

[566]   Submission 83, p 6.

can be solved in isolated silos by a single sector or discipline. Solutions will require a systems approach that acknowledges that different sectors, different levels of government and non-government sectors have related and dependent elements which when in interaction, forms a unitary whole approach needed to address social isolation.[567]

Anglicare Southern Queensland[568] and Relationships Australia Queensland concurred,[569] with the latter arguing that a state-wide strategy should consider that not one size fits all in regard to social isolation, particularly with the recent impacts of COVID-19, and the disparity of the types of barriers experienced in metro, remote and regional areas. Their submission stated:

> A multifaceted service approach requires individual case work, information and referral, group and community education, community promotion and awareness, collaboration, and mapping to reduce duplication of services and better use of resources across the state.[570]

A considerable number of submitters supported social prescribing as a priority for the development of a state-wide strategy.[571] The submission of Dingle, Sharman and Hayes stated:

> A state-wide roll-out of social prescribing could be implemented efficiently and cost-effectively using existing infrastructure such as neighbourhood and community centres that have group rooms, kitchen, and bathroom facilities to support social activities and informal socialising opportunities.[572]

Conditional to the state-wide adoption of social prescribing, Aged and Disability Advocacy stressed the importance of sufficient and appropriately-funded and trained staff, as 'critical to the success of any strategy, if policies are to be effective for affected individuals located across Queensland'.[573]

The committee notes the submissions of a number of stakeholders who recommended that NCCs play a central role in a state-wide strategy to address social isolation and loneliness.[574] As illustrated by the Caloundra Community Centre:

> We don't believe that top down directed or same-size-fits-all state-wide approaches to addressing loneliness and social isolation will produce good value for money outcomes. Locally developed and locally lead initiatives, as demonstrated around Queensland by Neighbourhood Centres, are needed to enable local residents to solve social issues from the ground up.[575]

Uniting Church of Australia (Queensland Synod) also recommended a community-centred approach:

> … the Queensland Government expand and increase its current investment in existing initiatives that use place-based, community capacity building principles and integrated service responses such as: Neighbourhood and Community Centres; the statewide roll out of social prescribing programs such as *The Ways to Wellness Social Isolation Project*; programs under the *Thriving Cohesive Communities* initiative; the *TenantConnect* and *Community Connections* project, including the *Reducing Social Isolation* campaign.[576]

---

[567]   Submission 39, p 7.

[568]   Submission 81, p 13.

[569]   Submission 83, p 6.

[570]   Submission 83, p 6.

[571]   See submissions 79, 87, 93, 145 and 185.

[572]   Submission 93, p 2.

[573]   Submission 158 p 7.

[574]   Submission 85, 87, 130 and 140; and discussed by Alana Wahl, Manager, Laidley Community Centre, public hearing transcript, Toowoomba, 29 September 2021, p 2.

[575]   Submission 140, p 4.

[576]   Submission 187, p 17.

The benefits of aligning a community-based or place-based approach to addressing social isolation and loneliness was observed by QFCA:

> The underlying causes and drivers of loneliness and social isolation in Queensland communities are as diverse as the local expressions of them. Neighbourhood Centres understand the causes and solutions for loneliness and social isolation using a local place-based lens.[577]

As submitted by Central Queensland, Wide Bay, Sunshine Coast PHN:

> … evidence from Victoria suggests that more effective solutions to address broad challenges facing communities, such as social isolation, need to be community-driven.[578]

Irene Violet, Acting Assistant Director-General, Community Services, DCHDE, provided the department's stance on a place-based focus:

> One of the key components of this is our network of neighbourhood and community centres that we have across the state. They provide the critical social infrastructure to communities across Queensland and often provide a first point of contact for people, a soft entry to the system, a place where people can feel safe and able to connect with other community members, groups and services. These centres and the people who work within them are place based experts for the community that they serve.[579]

The QFCA and Griffith University in their 2021 research report, *Enhancing Community Development in Neighbourhood Centres*, called on the government to enhance place-based community programs: 'If place-based infrastructure is a priority of [Queensland] Government, then NCCs are perfectly positioned at local level to bring communities into the process'.[580]

Em James, General Manager, QFCA, further attested:

> Neighbourhood centres are to local communities what hospitals are to health and schools are to education. Centres are place based, critical social infrastructure, and with adequate resourcing they really are the key to addressing social isolation and loneliness.

> Neighbourhood centres are place based. That means there is really in-depth knowledge … of local issues, including a nuanced understanding of the diverse experience, factors and causes of social isolation and loneliness and the very complex framework and other issues that lead into that in individuals.[581]

Recommendation 13

The committee recommends that the Queensland Government consider a consistent approach among neighbourhood and community centres, mapping services and programs available locally, to support place-based responses to social isolation and loneliness.

8.1.2 Interaction with existing Queensland and national strategies

Many submitters to the committee's inquiry expressed support for a state-wide strategy that interacts with existing state and national strategies, and with specific reference to their respective communities, causes and interests.

For example, Friends for Good submitted that the role of a state-wide strategy would be 'developing a policy framework to understand and address the issues surrounding loneliness and isolation, setting

---

[577] Submission 127, p 6.

[578] Submission 39, p 5, citing Victorian Government, Department of Premier and Cabinet, 2021, *A framework for place-based approaches*, p 3.

[579] Public briefing, Brisbane, 20 August 2021, p 2.

[580] Enhancing Community Development in Neighbourhood Centres, 2021, p 46.

[581] Public hearing, Brisbane, 13 September 2021, p 6.

targets and working with the not-for-profit sector and other stakeholders to deliver a preventative action orientated approach to address these problems'.[582]

The WWILD Sexual Violence Prevention Association submitted that a state-wide strategy should collaborate with national and other state-wide strategies, in relation to national disability strategies, domestic and family violence disability strategies and focus on LGBTIQ+ people with disability.[583]

The NHF strongly supported the development of a state-wide strategy which would include the *Queensland Walking Strategy*, *Queensland Cycling Strategy*, *Activate! Queensland Strategy for physical activity and movement*, the *Queensland Housing Strategy* and *Rural and Remote Health and Wellbeing Strategy* to reduce inequity. The NHF also recommended that the Queensland Government's *Healthy Places, Healthy People* program be implemented, 'so that built environment infrastructure projects that preference health considerations are prioritised'.[584]

Multicultural Australia called for a state-wide strategy that would 'interact with national programs, strategies, and interventions around racism and discrimination; the work of the Royal Commission into Violence, Abuse, Neglect and Exploitation of people with disability, as well as consider a digital inclusion strategy'.[585]

8.1.2.1 *Committee comment*

The committee appreciates the importance expressed by many stakeholders of addressing social isolation and loneliness among vulnerable groups within the community with an encompassing state-wide strategy that draws on, and connects, specific existing national, state and local council programs to people's specific needs.

8.1.3   Recognition of social isolation and loneliness by executive government

The committee received suggestions from stakeholders to a ministerial portfolio for social isolation and loneliness, 'to help strengthen state government action, provide a platform for federal lobbying, and raise media and public awareness'.[586] The MGCC recommended the Queensland Government allocate responsibility for coordinating a whole of government state-wide strategy to a senior Minister,[587] while SPA and Anglicare SQ called for a stand-alone Minister for Social Isolation.[588]

In contrast, Nicola Whichelow submitted she would not advocate for a Minister for Loneliness, but rather preferred 'an active committee regularly gathering key findings and sharing ideas and results of projects so that we can continue to work on and build on findings'.[589]

8.1.3.1 *Committee comment*

The committee notes the suggestions of stakeholders to prioritise social isolation and loneliness at an executive level.

8.2   Towards a state-wide strategy model

The committee is appreciative of the number of stakeholders who submitted state-wide model strategies for consideration.

---

[582]   Submission 119, p 6.

[583]   Submission 182, p 17.

[584]   Submission 25, p 8.

[585]   Submission 163, p 15.

[586]   Submissions 64, 66, 85 and 87.

[587]   Submission 65, p 2.

[588]   Submission 94, p 7; submission 82, p 13.

[589]   Submission 90, p 3.

The committee notes the model suggested by researchers from UQ, who recommended that 'the solution to (and prevention of) loneliness and its driving factors is to help Queenslanders to develop meaningful group memberships'.[590] Their submission recommended that social prescribing to community-based group activities tailored to the individual's interests and needs be central to a state-wide model so described:

A state-wide roll-out of social prescribing could be implemented efficiently and cost effectively using existing infrastructure such as neighbourhood and community centres that have group rooms, kitchen, and bathroom facilities to support social activities and informal socialising opportunities.

This infrastructure would need to be accompanied by funded link worker positions and administrative support in each location to ensure effective communication between referring stakeholders, participants, and community group providers.

Currently, link workers are not registered with the Australian Health Practitioners Regulation Authority (unless they are registered as a member of a health profession) and they come from a diverse range of backgrounds. Therefore, an effective and safe new workforce of social prescribing link workers will require modular (online) training, mentoring and support in specific topics such as: mental health, domestic violence, trauma informed care, ethical practice, addictive behaviours.

To ensure that suitable referrals are coming to social prescribing services, a state-wide promotion campaign will be needed to educate the public and referring agents such as GPs and other health providers about social prescribing and how to engage with it.

As for any implementation, it is recommended that funding be allocated to research and evaluation so that the QLD Government is collecting data on what works, where, and how; and to inform future fine tuning of the social prescribing approach in the QLD context.[591]

8.2.1 Public awareness raising and education

Submitters stressed the need for an awareness-raising campaign and community education to highlight the prevalence of loneliness and availability of supports for those experiencing loneliness.[592] For example, Associate Professor Dingle, UQ, stated:

To ensure that suitable referrals are coming in to those social prescribing services, we really need a statewide promotion campaign. We spend our time explaining 10 times a day what social prescribing is to everybody we talk to. It is just not that well understood in Australia yet in the way that it is, say, in the UK, Canada and other places. We kind of need to rely on there being a stronger understanding in the general community about what this is about, what you get out of it, how you access it and how it all works so that we are not only getting people who are the most severe and complex coming through, which is what is happening at the moment.[593]

The APS advised that:

… there cannot be a one size fits all approach to the prevention, mitigation and response to social isolation and loneliness. The APS advises that effective multi-stepped responses to vulnerable members of the community will be required. This includes prevention strategies and redirection of socially vulnerable people to appropriate, effective low-intensity early intervention community-based supports through to specialist mental health treatment services based on their assessed needs.

As loneliness can affect anyone, anytime, health promotion science has a vital role to play. Strengthening community social capital for improved awareness of social isolation and loneliness, stigma reduction, and

---

590   Submission 93, p 2.

591   Submission 93, p 10.

592   Submissions 29, 150, 163 and 183.

593   Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 14.

more inclusive communities to reduce the experience of social isolation and loneliness is critical, especially for those more vulnerable members of the community.

The APS recommends that state-wide strategic initiatives for social isolation and loneliness be co-designed with the community and include all sectors, industries and people with lived experience or at increased risk of social isolation and loneliness (e.g., youth, older people). A co-designed approach will begin to raise awareness and education about social isolation and loneliness in the community.[594]

8.2.1.1 *Committee comment*

The committee encourages the Queensland Government to highlight the preventative factors of social isolation and loneliness and raise awareness of the support services available.

8.2.2 Evidence gathering for effective delivery

The submission of Professor Catherine Haslam, Professor Jolanda Jetten, Professor Alexander Haslam and Associate Professor Tegan Cruwys noted the lack of data on the value of implementing strategies such as social prescribing as part of UQ's G4H program. They submitted that research is needed 'to determine the longer-term benefits and sustainability of these approaches in supporting public health'.[595]

SPA noted that access to accurate population-level data was crucial to targeted prevention policy and program resourcing, development and implementation.[596] The submission recommended 3 actions to create reliable data:

- investment in data collection on social isolation at the community level
- plan and deliver, in consultation with stakeholder organisations, a biannual state-wide survey to capture the level of loneliness and social isolation experienced by Queensland residents
- Queensland Treasury commission analysis on the economic impacts of loneliness.[597]

The Moreton Bay Regional Council also assigned priority to gather and evaluate evidence to address social isolation and loneliness. The Council recommended a state-wide strategy that would 'Encourage, through funding, initiatives that seek to evaluate the impacts of community led programs focused on reducing social isolation and loneliness'.[598]

Further, John Scoble, Facilitator with the Social Inclusion Project Inner West, and the Brisbane Residents United Inc, stressed the importance of information access:

There is a reasonable amount of activity through government, corporations, NFPs and individuals directed at addressing social isolation and loneliness. Unfortunately these efforts are often blinkered and silo'd. This results in:

- duplication of effort
- a lack of collaboration and the synergy that comes from this
- lack of knowledge of services available to meet the specific need being addressed at any time
- sub-optimal outcomes for the socially isolated, lonely, vulnerable and disadvantaged.[599]

---

[594]   Submission 129, pp 3-4.

[595]   Submission 43, p 10.

[596]   Submission 65, p 15.

[597]   Submission 65, p 15.

[598]   Submission 125, p 4.

[599]   Submission 4, p 2; submission 190, p 8.

Brisbane Residents United Inc stated:

> Investment by the Queensland government could be directed towards information sharing, development of local networks, including community centres, and public education about services. We would advocate strongly for locally focused, community led and government supported activities.[600]

8.2.3 Service provision and access

The committee notes submissions that stress the importance of matching appropriate and relevant services to people in the community who experience social isolation and loneliness in a myriad of different circumstances throughout Queensland. Associate Professor Dingle, UQ, submitted:

> Our team recommends that the solution to, and in fact the prevention of, loneliness and its driving factors is to help Queenslanders to develop meaningful group memberships. When I say that, it is because we have looked at a whole range of different approaches to loneliness. Some of them are very one-on-one, so peer-support type things and friendship things. Those are fine. They play a role. However, we really believe and there is a lot of research and theory around the fact that really it is your meaningful groups and communities that are where the action is with this problem. Based on the evidence presented in this submission and also on our readings of international research, we recommend that the best way to do this is through social prescribing to community based group activities that are tailored to that individual's specific interests and needs… We have some details in here, and you have heard from previous speakers, that those things will be different for each person. It is a very multifactorial issue and it will affect different subgroups in the community in different ways…. We know from the Ways to Wellness project that we have been involved in researching that It can roll on from there, but there is a lot of front-end work. If you are not doing that front-end work, you may find that the person does not get through the door or does not engage well and then that further entrenches the issue: they do not want to try again because they have not had a positive experience.[601]

Paul Martin, Executive Manager, Brisbane North, QPHN, noted some of the considerations that should be integrated into a state-wide service delivery model, based on his learnings from the UK:

> The other thing on the service navigation is that I spent some time in the UK, where they have the Citizens Advice bureau model where people can go and get information and referrals on any topic. In Australia we have a mental health one, but you have to label yourself and then you have to go to a place that has that label and that is when you get help. We do not really have a place for generic help where you do not have to label yourself. You can just contact them to find out information about what is happening in your local community—informal supports as well as formal supports. There is something around how we do navigation differently that is not about splitting people up into disease groups or illness groups or social disadvantage groups; it is about citizens being able to find out what is happening in their local community.
>
> Mr BENNETT: It is like a hub? Is that what you are talking about? We have heard a lot of that conversation and that is similar: they are under one roof or a one-stop shop. Is that what you are talking about?
>
> Mr Martin: Yes. It is about that gateway into a range of different services and supports and that gateway being accessible for people and people not having to label themselves to access that gateway or perhaps people thinking, 'I'm going to out myself as a bit of a lonely person and I do not really want to do that so I am not going to go near something that has "loneliness" on the tin. But if it has a broader welcoming approach, I might go along to that.' Actually, a whole bunch of other people will go along to it for other things as well and then we get an efficient use of service navigation. Service navigation is a bit of the flavour of the month at the moment, but what we have is a mental health service navigator, a nurse service navigator, an aged-care service navigator. They do not work together. They do their own thing.

---

[600] Submission 190, p 8.

[601] Associate Professor Genevieve Dingle, UQ, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 13.

They have their own databases. Can we bring them together somehow and have a community navigator?[602]

8.2.4 Information sharing

The National Association for Prevention of Child Abuse and Neglect called on the committee to consider features of the Ending Loneliness Campaign, in regard to developing evidence-based practice and policy:

> 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.[603]

The Moreton Bay Regional Council recommended a state-wide strategy include the development of 'a portfolio of local and national case studies of successful programs to provide guidance to new initiatives'.[604] Similarly, Ending Loneliness Together supported the development of 'a Loneliness and Social Isolation specific online database, to help consumers and healthcare professionals find local, evidence-based programs and services targeting loneliness that best suit their needs or those of their patients'.[605]
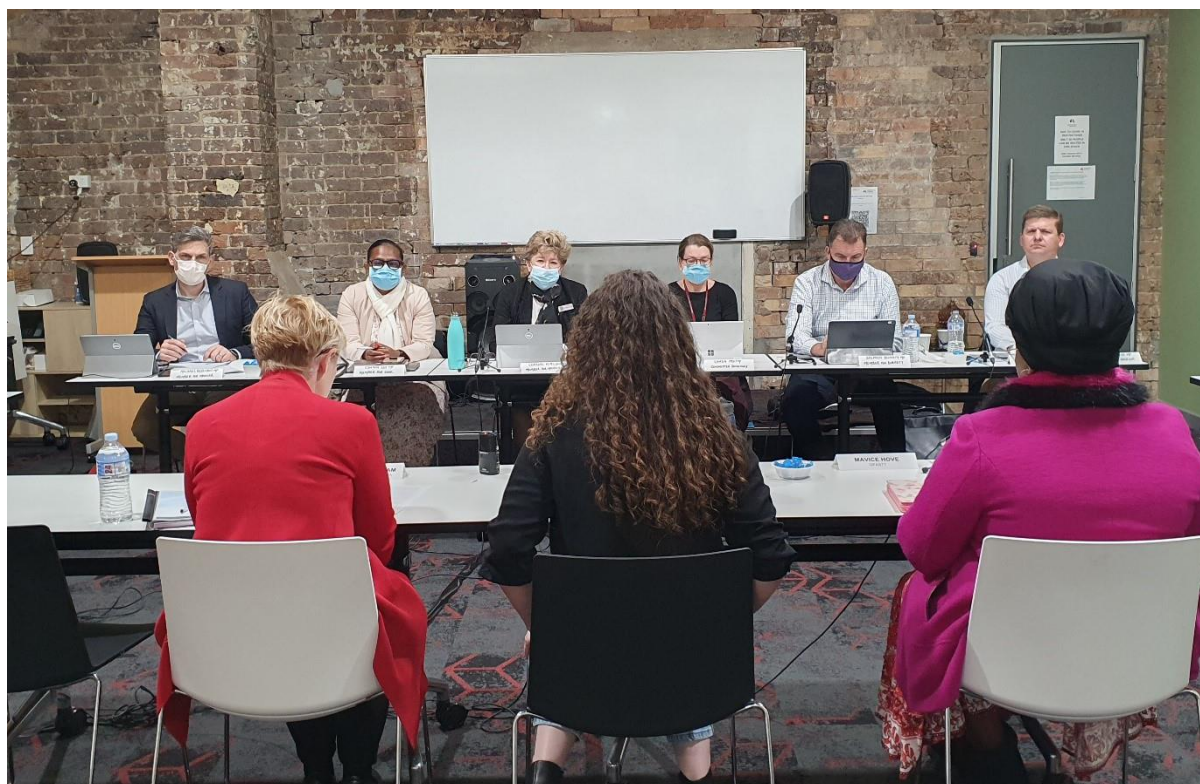
Public hearing in Toowoomba on 29 September 2021.

---

[602] Paul Martin, Executive Manager, Brisbane North, QPHN, public hearing transcript, Brisbane, 11 October 2021, Part 1, p 33.

[603] Submission 141, p 5.

[604] Submission 125, p 5.

[605] Submission 30, p 4.

The Donald Simpson Community Centre recommended:

> That the Queensland Government establish a database of centres which is regularly updated to allow identification of centres which provide relief from social isolation and to avoid the necessity for those centres constantly to provide full evidence that they are serving that purpose.[606]

The Uniting Church of Australia (Queensland Synod) called for a community database on a national level, which the committee notes. The submission recommended:

> 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).[607]

8.2.5 Committee summary comment

The committee acknowledges the priorities of the many submitters who contributed to the inquiry, and their importance both to their own community and to the wider Queensland community. The committee supports the development of a state-wide strategy that will connect new and existing services to the identified and individual needs of the community without being too prescriptive. All recommendations in this report should be considered within this context and through the lens of addressing social isolation and loneliness.

Recommendation 14

The committee recommends that the government develop a 10-year state-wide strategy to address social isolation and loneliness which should:

a) Identify the social determinants and preventative factors of social isolation and loneliness

b) Detail examples of successful strategies through published case studies to help guide best practice

c) Encourage communities to access, publish on and utilise *My Community Directory* or similar resources to raise awareness of the organisations who provide local support for individuals who experience social isolation and loneliness

d) Identify opportunities for improved digital access and inclusion in preventing and responding to social isolation and loneliness, including in regional, remote, and very remote communities

e) Explore the role of infrastructure that supports strong social outcomes, including Neighbourhood and Community Centres, in implementing place-based approaches to preventing and responding to social isolation and loneliness

f) Investigate and analyse the research related to the effectiveness of a social prescribing model of addressing social isolation and loneliness in Queensland through the use of link workers, including social workers

g) Further investigate the socio-cultural factors causing social isolation and loneliness in remote First Nations communities, including access to housing.

---

[606] Submission 5, p 10

[607] Submission 187, p 19.

Appendix A – Submitters

Sub #	Submitter
001	Robert Heron
002	Community and Oral Health
003	Orygen
004	John Scoble
005	Donald Simpson Community Centre
006	Margaret Redsell
007	Queensland Men's Shed Association
008	Apunipima Cape York Health Council
009	Logan Together
010	St David's Neighbourhood Centre
011	Carers Queensland
012	Brisbane City Council
013	Australian War Widows Queensland
014	Jenny Pinzon
015	Kavita Bisht
016	Catherine Collins
017	Matthew Reece
018	Confidential
019	Social Work Professional Leaders within Metro North Mental Health, Metro North Hospital and Health Service
020	Metro North Mental Health
021	Josephine Coco
022	Outback Futures
023	The Neighbourhood Hub
024	Save our Sons Duchenne Foundation

025	National Heart Foundation of Australia
026	Gold Coast District Neighbourhood Watch
027	Picabeen Community Centre
028	Strata Community Association Queensland
029	Richmond Fellowship Queensland
030	Ending Loneliness Together
031	Access Community Housing
032	The Services Unions
033	Miles Morgan Australia
034	Dementia Australia
035	Somerset Regional Council
036	Bundaberg Neighbourhood Centre
037	Burdekin Community Association Inc
038	Emerald Neighbourhood Centre
039	Central Queensland Wide Bay Sunshine Coast Primary Health Network
040	Rollingstone Community Centre
041	Marilyn Wright
042	Rainbow Families Queensland
043	Prof. Catherine Haslam, Prof. Jolanda Jetten, Prof. S Alexander Haslam and A/Prof. Tegan Cruwys
044	Monto Neighbourhood Centre
045	Diabetes Queensland
046	Relationships Australia
047	North Shore Community Centre
048	Bowen Neighbourhood Centre
049	U3A Network Queensland Inc
050	Gympie Community Place

051	Music Broadcasting Society of Queensland Ltd
052	CEOs of the Queensland Primary Health Network
053	A New Approach
054	Maleny Neighbourhood Centre
055	Nerang Neighbourhood Centre
056	Mossman Support Services
057	Mareeba Community Centre
058	Scenic Rim Regional Council
059	Deception Bay Neighbourhood Centre
060	East Creek Community Centre
061	Legacy Brisbane
062	Queensland Family and Child Commission
063	SANDBAG Inc
064	Southside Uniting Church
065	Suicide Prevention Australia
066	Inala Primary Care
067	Soul Explorer
068	Neami National
069	Australian Health Promotion Association Queensland Branch
070	Kristen O'Brien
071	Queensland Nurses and Midwives' Union
072	Institute for Social Science Research and Life Course Centre
073	Planning Institute of Australia Queensland Division
074	Queensland Alliance for Mental Health
075	QUT Digital Media Research Centre
076	New Farm Neighbourhood Centre
077	Caravan Parks Association of Queensland Inc

078	Nambour Community Centre
079	Australian Association of Social Workers
080	Village Community Services Inc
081	Australian Red Cross Queensland
082	Anglicare Southern Queensland
083	Relationships Australia Queensland
084	The Community Place, Northside Connect and Picabeen Community Centre
085	Logan East Community Neighbourhood Association
086	Kyabra Community Association
087	Warren King
088	Queensland Council of Social Service
089	Centacare Brisbane
090	Nicky Whichelow
091	TransitCare
092	Logan City Council
093	Dr Genevieve Dingle, Dr Leah Sharman and Shaun Hayes
094	Mount Gravatt Community Centre
095	Meals on Wheels Queensland
096	The Australia Institute
097	North Townsville Community Hub Inc
098	Murilla Community Centre Inc
099	Palm Beach Neighbourhood Centre
100	Redland Community Centre
101	Carinity Fassifern Community Centre
102	Communify
103	Maroochy Neighbourhood Centre Inc
104	Nik Kotlarov

105	Elorac Place Community Centre
106	Queensland Positive People
107	Pomona and District Community House
108	Queensland Council for LGBTI Health
109	Fiona Hayward
110	Care Goondiwindi Ltd
111	Community Services Industry Alliance
112	Laidley Community Centre Inc
113	Sherwood Neighbourhood Centre Inc
114	Queensland Mental Health Commission
115	Queensland Network of Alcohol and Other Drugs
116	Brisbane Housing Company
117	ECHO Empowering Services
118	Benarrawa Community Development Association
119	Friends for Good Inc
120	Kingston East Neighbourhood Neighbourhood Group
121	RSL Queensland
122	Stepping Stone
123	St Vincent de Paul Society Queensland
124	Gailes Community House
125	Moreton Bay Regional Council
126	Council on the Ageing (COTA) Queensland
127	Queensland Families and Communities Association
128	Stephen Andrew MP, Member for Mirani
129	Australian Psychological Society
130	Co.As.It.
131	Australian Longitudinal Study on Women's Health

132	Cairns Regional Council, Human and Social Sub-Committee
133	Townsville City Council
134	Townsville Community Law Inc
135	Bethania Community Centre Inc
136	Port Douglas Community Service Network
137	Whitsunday Suicide Prevention Network
138	Dr Lewis Atkinson
139	Heather Douglas
140	Caloundra Community Centre
141	National Association for Prevention of Child Abuse and Neglect
142	Good Things Foundation Australia
143	End Loneliness Inc
144	Institute for Urban Indigenous Health
145	Support Groups Queensland
146	Cairns Community Legal Centre
147	Vietnamese Community in Australia Queensland Chapter Inc
148	Defence Force Welfare Association Queensland Inc
149	Brisbane South Primary Health Network
150	Feros Care
151	PeakCare Queensland Inc
152	Dr Amy MacMahon MP, Member for South Brisbane
153	Hervey Bay Neighbourhood Centre
154	Foundation for Alcohol Research and Education
155	A/Prof. Lisa Fitzgerald and A/Prof. Allyson Mutch
156	Pacific Islands Council of Queensland
157	National Council of Women Queensland
158	Aged and Disability Advocacy Australia

159	Volunteering Queensland
160	Community Plus Queensland Incorporated
161	Brisbane Youth Service
162	Caxton Legal Centre Inc
163	Multicultural Australia
164	John Duncombe
165	Australian Neighbourhood Houses and Centres Association
166	Queensland Walks
167	Chinchilla Community Centre
168	National Seniors Australia
169	North Burnett Community Service
170	Older Women's Network
171	Momentum Mental Health
172	Micah Projects
173	Australian College of Nurse Practitioners
174	Martin Connah
175	Gary Denis McLean
176	Encircle Ltd
177	Mackay Regional Council
178	Home Education Association Queensland Chapter
179	Dr Anne Smith
180	Confidential
181	Queenslanders with Disability Network
182	WWILD and Queer and Disability Services and Professionals Network
183	The Salvation Army Australia
184	Legal Aid Queensland
185	Queensland Community Alliance

186   Queensland Law Society

187   Uniting Church in Australia

188   Community Information Support Services

189   Pormpur Paanthu Aboriginal Corporation

190   Brisbane Residents United Inc

191   Kenmore Bridge Club Inc

192   Palliative Care Queensland

193   School of Public Health and Social Work, QUT

194   The Public Advocate

195   TDSA Ltd

196   Community Plus Queensland Incorporated – *video submission*

Appendix B – Officials at public departmental briefing – 30 August 2021

Department of Communities, Housing and Digital Economy

- Dr Stacey Messer, Acting Director, Community Needs Analysis and Investment
- Irene Violet, Acting Assistant Director-General, Community Services

Queensland Health

- Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch
- David Harmer, Senior Director, Social Policy and Legislation Branch

Department of Children, Youth Justice and Multicultural Affairs

- Wayne Briscoe, Executive Director, Multicultural Affairs, Strategy
- Kate Connors, Deputy Director-General, Strategy
- Helen Missen, Acting Executive Director, Strategic Policy and Legislation, Strategy

Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

- Elizabeth Bianchi, Executive Director, Strategic Policy and Legislation, Seniors and Disability Services
- Jason Kidd, Executive Director, Strategic Policy and Legislation, Aboriginal and Torres Strait Islander Partnerships
- Max Wise, Assistant Director-General, Disability and Seniors Connect

Department of Transport and Main Roads

- Ishra Baksh, Executive Director, Mobility as a Service
- Sally Stannard, Acting Deputy Director-General, TransLink

Department of Education

- Margaret Gurney, Assistant Director-General, State Schools, Operations
- Dr Regan Neumann, Assistant Director-General, State Schools, Rural Remote and International
- Leon Proud, Assistant Director-General, State Schools, Indigenous Education
- Hayley Stevenson, Executive Director, State Schools, Operations

Department of Tourism, Innovation and Sport

- Chad Anderson, Executive Director, Sport and Recreation
- Andrew Sly, Assistant Director-General, Sport and Recreation

Appendix C – Witnesses at public hearing – Brisbane – 13 September 2021

Mount Gravatt Community Centre

- Deb Crompton, Chief Executive Officer
- Elise Marr, Social Isolation And Loneliness Link Worker, Specialist In Service Delivery To Clients

Queensland Families and Communities Association

- Em James, General Manager
- Christopher Mundy, Sector Development Officer

St David's Neighbourhood Centre

- Kellie Griffiths, Centre Manager

Logan East Community Neighbourhood Association

- Gillian Marshall, Executive Community Manager

Picabeen Community Association Inc

- Madison Smee, Social Work Student
- Jill Warren, Centre Manager

Queensland Men's Shed Association

- Gerald Barber, Vice-President
- Rob Collins, Secretary
- John Greatrex, President

U3A Network

- John Armstrong, Vice-President
- Gail Bonser, President
- Joy Conolly, U3A Southern Gold Coast Member and Tutor
- Colin Maddocks, Communication Officer

Queensland Positive People

- Mark Counter, President, Board
- Chris Howard, Executive Programs Manager
- Melissa Warner, Chief Executive Officer

Queensland Council for LGBTI Health

- Peter Black, President
- Julia Geljon, Volunteer, Community Visitors Scheme

Rainbow Families Queensland

- Heather Corkhill, Member, Steering Committee

Micah Projects

- Karyn Walsh, Chief Executive Officer

Appendix D – Witnesses at public hearing – Mount Gravatt – 28 September 2021

Office of the Public Advocate

- Dr John Chesterman, Public Advocate

Volunteering Queensland

- Amanda Nixon, Senior Manager, Projects
- Zac Reimers, Policy and Advocacy Lead

Queensland Community Alliance

- Thelma Cawley
- Ben Edwards
- Pooran Hansen

Communify

- Karen Dare, Chief Executive Officer

Multicultural Australia

- Rose Dash

Rail, Tram and Bus Union

- Annie Humphries

Logan East Community Neighbourhood Centre

- Roger Marshall, President

Appendix E – Witnesses at public hearing – Toowoomba – 29 September 2021

Chinchilla Community Centre

- Louise Judge, Manager

Laidley Community Centre

- Alana Wahl, Manager

Queensland Alliance for Mental Health

- Jennifer Black, Chief Executive Officer
- Emma Griffiths, Director Advocacy and Communications
- Leanne Kelly, Project and Policy Officer

Multicultural Australia

- Kelly Buckingham, Regional Manager—South-West Region
- Tanja Miljevic, ParentsNext Adviser

Queensland Program of Assistance to Survivors of Torture and Trauma

- Mavice Hove, Community Engagement Worker

Appendix F – Witnesses at public hearing – Nambour – 30 September 2021

Maroochy Neighbourhood Centre Inc

- Teula De Gars, One Roof Project Worker

- Mark Ellis, Coordinator, Community Development Program

- Mr Michael Henning, Chief Executive Officer

Gympie Community Place

- Vikki Cousins, Coordinator

- Abbie Grant-Taylor, Secretary

Nambour Community Centre

- Angela Rondo, Acting Manager and Thriving Families Coordinator

Appendix G – Witnesses at public hearing – Brisbane – 11 October 2021 AM

Clubs Queensland

- Kelly Egan, Chief Executive Officer
- Dan Nipperess, General Manager

Inala Primary Care

- Dr David Chua, Research and Collaborations Manager
- Tracey Johnson, Chief Executive Officer
- Dr Sue Williams, Clinical Director and General Practitioner

The University of Queensland

- Associate Professor Genevieve Dingle, Associate Professor in Clinical Psychology
- Dr Leah Sharman, Postdoctoral Research Fellow
- Professor Catherine Haslam, Professor of Clinical Psychology
- Professor S Alexander Haslam, Professor of Social and Organisational Psychology
- Professor Jolanda Jetten, Professor of Social Psychology

Australian National University

- Associate Professor Tegan Cruwys, Associate Professor and Clinical Psychologist

Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service

- Jade Cullen, Social Worker Advanced, The Prince Charles Hospital
- Ali Palmer, Social Work Professional Lead, Redcliffe/Caboolture
- Carissa Uzabeaga, Social Work Professional Lead, The Prince Charles Hospital

Queensland Primary Health Network

- Libby Dunstan, Chief Executive Officer, Brisbane North
- Paul Martin, Executive Manager, Brisbane North

Appendix H – Witnesses at public hearing – Brisbane – 11 October 2021 PM

Ending Loneliness Together

- Dr Michelle Lim, Chairperson and Scientific Chair
- Professor Jo Badcock, Vice Chairperson and Vice Scientific Chair

Early Career Loneliness Research Network

- Phoebe Mckenna-Plumley, Co-Founder; PhD Candidate, Queen's University, Belfast
- Catrin Noone, Co-Founder; PhD Candidate, Durham University

National Academy of Social Prescribing UK

- Dr Bogdan Chiva Giurca, Development Lead, Global Social Prescribing Alliance; Clinical Champion Lead

Campaign to End Loneliness UK

- Robin Hewings, Program Director

Appendix I – Witnesses at public hearing – Mount Isa – 18 October 2021

Mount Isa Family Support Service and Neighbourhood Centre

- Leeanne Harris, Manager

Selectability Mount Isa

- Helen Davis, Regional Coordinator

Outback Futures

- Selena Gomersall, Chief Advocacy Officer/Founder
- Peter Whip, Community Representative

Mount Isa Pensioners Association

- Greg Langtree, Treasurer

North West Queensland Indigenous Catholic Social Services

- Father Mick Lowcock

Appendix J – Witnesses at public hearing – Townsville – 19 October 2021

Selectability Townsville

- Sally Bawden, General Manager
- Rebecca Patterson, Mental Health Hub Manager

Rollingstone Community Centre

- Christine Martin, Centre Manager

Townsville Community Law Inc

- Jane Andreassen, Seniors Intake and Support
- Bill Mitchell, Principal Solicitor

Townsville City Council

- Stacey Gibson, Tourism and Population
- Donna Jackson, Principal Inclusive Communities

North Townsville Community Hub

- Sandra Elton, Manager

ABIS Community Co-operative Society Ltd

- Jan Pool, Chief Executive Officer

Appendix K – Witnesses at public hearing – Cairns – 20 October 2021

Queensland University of Technology

- Dr Shane Warren, Lecturer, School of Public Health and Social Work

Mareeba Community Centre

- Miriam Fejo, Cultural Practice Adviser

- Julie Theakston, Manager

- Ashlee Wilkinson

Mossman Support Services

- Erica Mast, Community Connect Worker

- Heather McGillivray-Taylor, Manager

Port Douglas Community Service Network

- Emma Travers, Manager

Apunipima Cape York Health Council

- Yvonne Cadet-James, Research Coordinator

- Frankie Clive, Chief Executive Primary Health Care

Access Community Housing Company

- Elizabeth Brown, Chief Executive Officer

- Jessica Vidafar, General Manager

Cairns Community Legal Centre

- Tracey Ashton, Social Worker

Salvation Army

- Major Ben Johnson

Appendix L – Witnesses at public hearing – Thursday Island – 21 October 2021

Pormpur Paanth Aboriginal Corporation

- Ganthi Kuppusamy, Chief Executive Officer

Private capacity

- Aunty Ivy Trevallion

Torres Shire Council

- Dalessa Yorkstone, Chief Executive Officer
- Gabrielle Walsh