# EVIDENCE GUIDE

## Loneliness: A public health challenge

## The science behind the issue

**Loneliness is common, can affect anyone, at any point in their life.**

Critical life transitions can be stressful and negatively impact upon social connections and supports, increasing social vulnerability, isolation and the risk of the developing loneliness.

Loneliness is more common among two groups:

- young people aged 16-25 years; and
- older people aged 75 years and above.

The Australian Psychological Society (APS) 2018 Loneliness Report highlighted that nearly 30% of Australians don't feel part of a group of friends, while 1 in 4 don't feel they have a lot in common with the people around them.

The VicHealth (2019) Young Australian Loneliness Survey found that more than 1 in 3 young adults (aged 18–25) reported chronic loneliness (problematic to their mental and physical health). Young women reported higher levels of loneliness than young men.

Young people tend to report more social loneliness e.g. deficit in the quantity of social relationships. Where those aged 30 years and above report more emotional loneliness e.g. deficit in the quality of social relationships (VicHealth, 2019).

**Loneliness can have wide ranging negative health effects.**

Loneliness has been consistently linked to higher levels of co-morbid anxiety and depression. Chronic loneliness has been linked to a higher risk for cardiovascular disease, sleep problems, inflammation, poor immune responses, dementia, stroke, increased risk of suicide and can increase chances of mortality (Cacioppo, 2011; Bastian, 2015; Valtorta, 2016).

The health risks presented by chronic loneliness, specifically perceived social isolation, is very similar in magnitude to that of obesity, smoking, lack of access to care and physical inactivity (Alcaraz, 2019).

## KEY MESSAGES

1

Loneliness is a public health challenge.

(Holt-Lunstad, 2017)

2

Loneliness does not discriminate by age or background.

(Lim, 2016)

3

Loneliness is preventable and modifiable.

(O'Rourke, 2018)

# UNDERSTANDING THE TERMINOLOGY

While the terms loneliness, social isolation, belonging and social connection are closely related, they are distinct concepts. Yet they are often used interchangeably and to describe the same thing.

Due to the inconsistent use of the terms to describe loneliness, as well as their measurement, evaluating the effectiveness of interventions or estimating the economic and health burden of loneliness can be difficult.

## LONELINESS

is defined as a mental state arising from a perceived deficiency between desired and actual social relationships in both quality (emotional) and quantity (social). (Alspach, 2013).

Loneliness can be mild, transient, reactive or chronic. The chronic form of loneliness is a significant risk factor for poor mental and physical health (Masi, 2011).

## SOCIAL ISOLATION

is defined as limited or the absence of social contacts. It is also defined as a state in which the individual lacks a sense of belonging and engagement with others (Nicholson, 2009).

Social isolation does not mean a person is experiencing loneliness but may lead to loneliness.

## BELONGING

is defined as a psychological understanding of how a person is accepted in the world around them (Crisp, 2010).

## SOCIAL CONNECTEDNESS

is defined as the degree with which an individual has constructive relationships with others that involve shared goals which benefit society (Townsend, 2005).

# INTERVENTIONS

**Developing effective interventions is not a simple task as there is no single underlying cause of loneliness.**

There are different types of loneliness interventions: Information supports (websites, directories, phone lines etc); Individual (one-to-one) based programs; and community based social and health promotion interventions (group activities, neighbourhood level or environment e.g. residential facility).

**There is no one-size-fits all approach to loneliness interventions.**

Interventions that are tailored to the circumstances and needs of individuals, specific groups or the type of loneliness are more likely to be successful. No evaluated interventions have been found to cause harm.

**Psychological interventions have shown evidence of reducing loneliness.**

Interventions that address negative thoughts underlying loneliness seem to help combat loneliness more than those designed to improve social skills, enhance social support or increase opportunities for social interaction (Masi, 2011; Käll, 2019).

This result is not to say that community engagement and social groups are not important and these too can lead to positive mental health effects and reduce feelings of loneliness (Johnson, 2018; Steffens, 2016).

1

Those aged 16-25 years & those aged above 75 years

2

Socially excluded groups and vulnerable people

# WHO'S AT RISK?

Loneliness doesn't discriminate but some groups are more vulnerable. Evidence shows that loneliness increases with age (Arsenijevic, 2018).

Race is a strong predictor of social isolation resulting in loneliness, disproportionately affecting Indigenous Australians and people from refugee or migrant backgrounds (Acaraz, 2019).

Other socially excluded groups such as single parents, unemployed, people with a disability, carers and LGBTIQ people have also been reported to have a higher risk of developing loneliness (Casimiro, 2016).

# RECOMMENDATIONS

## POLICIES FOR ACTION

- Adopt the above definition of loneliness in all policies.
- Adopt loneliness as an indicator that your organisation measures as part of routine health assessment screening for all consumers.
- Include validated loneliness items as part of your staff satisfaction and performance management processes to improve staff retention and performance.

## PRACTICE

- Develop person-centred and tailored loneliness interventions which are designed for the specific needs of the targeted population and type of loneliness.
- Develop local resources and referral pathways that include options across the range of possible loneliness intervention types.
- Routinely train all health organisation staff in screening for and supporting consumers who are at risk of developing loneliness or who report loneliness.

## ADVOCACY

- Conduct health awareness campaigns that include the three key messages (in this guide) to help reduce the stigma of reporting loneliness and seeking support.
- Advocate for better evaluations and local research on loneliness including the measurement of costs (economic and health).

# References


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