



Preamble

The [Global Initiative on Loneliness and Connection \(GILC\)](#) was established on 1 January, 2021, at a time when the prevalence of loneliness, and the value of social connection, was increasingly being recognized as a priority for individual, community, and national action. The GILC is comprised of representatives of national organizations committed to addressing the pressing global issues of loneliness and social isolation.

The GILC member organizations recognize the need to address the negative impacts of loneliness and social isolation on health and wellbeing. As such, GILC itself seeks to help individuals and communities restore, maintain and foster the positive benefits of social connection through broad, equitable, evidence-based systemic strategies and national approaches.

The GILC will release periodic Position Statements that support our three key areas of global partnership: Awareness, Collaboration and National Strategies to end loneliness and promote connection. In keeping with our charter, these Position Statements aim to be grounded in the research evidence, illustrated in the accompanying evidence summaries.

Recommendations will also be offered for public policy, practice and ongoing research with the aim of enhancing social connection and reducing loneliness and social isolation. With a commitment to supporting global health equity, the GILC endeavors to encourage, facilitate, and support the engagement of *all* nations to promote social connection - that is to reduce social isolation and loneliness - and to work together to implement these recommendations.

Position Statements on Addressing Social Isolation, Loneliness, and the Power of Human Connection

OVERVIEW

We are GILC: The Global Initiative on Loneliness and Connection

We are a group of organisations around the world, working to tackle loneliness and social isolation in our respective countries and to support nations around the globe in their existing and/or new systemic efforts to achieve social connection.

This position statement outlines what we believe, and our recommendations on what needs to happen, to reduce loneliness and social isolation and increase social connection.

This Position Statement provides the GILC position on: 1) the nature, importance, and defining features of social connection, and conversely how loneliness, social isolation, and related concepts differ, 2) their consequences for health and wellbeing, and 3) implications and recommendations for developing appropriate solutions.

POSITION STATEMENTS

Position Statement 1 - Social connection Is essential to health and wellbeing

Social connection means having a variety of relationships (from close personal ties such as family and friends through to weaker ties such as acquaintances and strangers); relationships you can rely upon for support; and relationships that are trusted, high quality, and satisfying. These relationships reflect a multitude of influences, including the diversity of our individual cultures and experiences and one's biology. Each of us is somewhere on a continuum of social connection. *Where an individual or population falls on that continuum reflects their degree of social connectedness.* Social connection is vital for our health and wellbeing, while lacking or poor quality social connection is associated with significant risks to health and wellbeing.

Recommendations:

- 1.1 Coordinated strategies to facilitate social connection - that reduces loneliness, social isolation, and social negativity - and that are informed by the diversity of individual cultural and personal experiences - need to be implemented at the individual, community, national and global levels to support social health and wellbeing.
- 1.2 Across all sectors, policymakers need to evaluate and report on the costs and benefits for social health and wellbeing.
- 1.3 Additional research (basic and intervention evaluation) is needed to address existing gaps.

Position Statement 2 - Social isolation, loneliness, and social negativity are distinct and each can compromise wellbeing

Lacking social connection (social disconnection) may result from objective isolation (social isolation), subjective isolation (loneliness), or poor quality social interactions (social negativity). Being socially isolated means having objectively few social relationships or roles and infrequent social contact. Conversely, loneliness is a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships. Social negativity is having poor quality interactions often resulting from conflict or strain. These forms of social disconnection are part of our normal human experience. However, when experienced persistently, they are associated with poorer social, health, and wellbeing outcomes. Importantly, social isolation and loneliness are different concepts. Social isolation and loneliness can co-occur but some individuals may experience loneliness without social isolation, and others may experience social isolation without loneliness. Therefore, meaningful distinctions between these experiences should be made so that effective interventions can be identified and deployed. Furthermore, interventions should consider social negativity given increasing contact could potentially increase conflict and poorer outcomes.

Recommendations:

- 2.1 Awareness campaigns need to provide clear and concise information about (i) social connection and conversely forms of social disconnection including social isolation, loneliness, and social negativity; (ii) how they differ from each other; and (iii) their consequences across many aspects of life, in order to increase public understanding of the benefits of human connection.
- 2.2 Researchers need to examine components of social disconnection (loneliness, social isolation, social negativity) concurrently in order to determine their independent influence on health, work and educational outcomes.
- 2.3 Interventions need to consider social negativity given increasing contact could potentially increase conflict and poorer outcomes.
- 2.4 Increased investment is needed for longitudinal research examining the impact of loneliness, social isolation, and social negativity on health, work, educational attainment and wider community participation.

Position Statement 3 - Social wellbeing is independent from other related concepts

Social connection, social isolation, and loneliness differ from other related mental health (e.g., depression), cognitive-behavioural (e.g., solitude), and personality (e.g., introversion/extroversion) factors, and have independent effects on health and wellbeing. However, these factors may be mechanisms by which social connection, isolation, and loneliness influence health and well-being.

Recommendations:

- 3.1 Awareness campaigns should provide clear and accurate information that allows social isolation and loneliness to be correctly distinguished from other problems.
- 3.2 Researchers need to be precise and explicit about which aspects of social health they are investigating.

Position Statement 4 - A wide range of risk factors leave people vulnerable to loneliness and social isolation

Social disconnection (being isolated or feeling lonely) has multiple risk factors that vary from person to person, and reflect individual experiences and preferences. These risk factors include (but are not limited to) a wide variety of biological (e.g., sensory impairment), psychological (e.g., mental health difficulties), social (e.g., economic disadvantage, low civic engagement and trust), cultural (e.g., membership in a stigmatized group, racial minority) and environmental (e.g., poor transport) issues, as well as a host of significant life changes (e.g., becoming a parent, leaving school). Loneliness and social isolation can affect anyone but disproportionately affect some groups, sectors and places in our communities, placing some people at higher risk of inequalities in health and wellbeing.

Recommendations:

- 4.1 Awareness campaigns should increase public understanding of the broad range of risk factors that increase vulnerability to loneliness and social isolation across the lifespan.
- 4.2 Training in social health and wellbeing, their associated risk factors and management, should be mandatory for health professionals and social care providers.
- 4.3 Consistent policies for robust assessment of risk of loneliness and social isolation at the local level need to be developed, so that resources can be delivered proportionate to need.
- 4.4 Researchers need to gain a better understanding of the mechanisms linking risk factors to the emergence of social isolation and loneliness. Studies examining how these mechanisms vary across culture, race, gender identity, and health status also need prioritizing to advance equality in social wellbeing for all members of the community.

Position Statement 5 - Evidence-based solutions are needed to reduce social isolation and loneliness and to increase social connection

Global research on the consequences of poor social connection, including loneliness and social isolation, is quite robust. However, the evidence is still emerging on how to effectively tackle these issues. While loneliness and social isolation may be challenging to identify, address and resolve, the science shows that there are ways that each can be reduced. In support of addressing health disparities across populations, there may also be various reasons why someone experiences loneliness / social isolation, and therefore any solutions deployed must be responsive to the specific needs of the individual within the context of the communities in which they reside.

Recommendations:

- 5.1 Governments and funding agencies need to increase funding for research designed to improve interventions that prevent or reduce social isolation and loneliness, or increase social connection. The evaluation of existing interventions is

critical to our understanding of what types of interventions work, for whom, and when.

5.2 Guidelines need to be developed for health and social care providers to assist them to implement evidence-informed approaches to identify and support people experiencing social isolation and loneliness across all populations and identities.

5.3 Organizations which provide services and support need to routinely assess, evaluate, and report on the effectiveness of their services to reduce loneliness and social isolation or to increase social connection.

5.4 Governments and organizations should establish standardization of measurement, using validated tools.

Position Statement 6 - Addressing barriers to social connection is central to effective action on reducing social isolation and loneliness

Lonely and/or socially isolated people may need help to identify and overcome a range of practical barriers and societal challenges that limit their ability to develop and maintain satisfying social connections. These barriers can range from broader structural issues, such as inadequate transport and urban design, to poor social policy. The stigma of social disconnection also remains a problem across many countries and may be fuelled by misconceptions and misinformation about social isolation and loneliness.

Recommendations:

6.1 National, local and individual strategies for reducing loneliness and social isolation need to take account of practical and societal barriers that can interfere with making meaningful social connections across the diversity of human experiences.

6.2 Greater attention is needed from all stakeholders to monitor and respond to inaccurate information about social isolation and loneliness.

Evidence in support of these position statements can be found in Appendix A [add hyperlink]

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APPENDIX A: Evidence Summary supporting the Position Statement

This summary provides *selected* examples of the current evidence base supporting the GILC Position on ‘Addressing Social Isolation and Loneliness, and the Power of Human Connection’, along with some implications and recommended courses of action for future research, policy development, and practice.

Position Statement 1 - Social connection is essential to health and wellbeing.

Social connection means having a variety of relationships (from close personal ties such as family and friends through to weaker ties such as acquaintances and strangers); relationships you can rely upon for support; and relationships that are trusted, high quality, and satisfying. These relationships reflect a multitude of influences, including the diversity of our individual cultures and experiences and one’s biology. Each of us is somewhere on a continuum of social connection. Where an individual or population falls on that continuum reflects their degree of social connectedness. Social connection is vital for our health and wellbeing, while lacking or poor quality social connection is associated with significant risks to health and wellbeing.

The influence of social relationships on health and wellbeing has been conceptualized and measured in a variety of ways across different scientific disciplines, but generally captures three important components.

Thus, GILC has adopted the following definition of Social Connection:

Social connection is a term that refers to the (i) structure, (ii) function, and (iii) quality of relationships with others and social connections have been scientifically demonstrated to influence health and wellbeing (see figure 1).^{1,2,3} Social connection includes not only the size and diversity of one’s social network and roles, but the functions these relationships serve, and their positive or negative qualities.

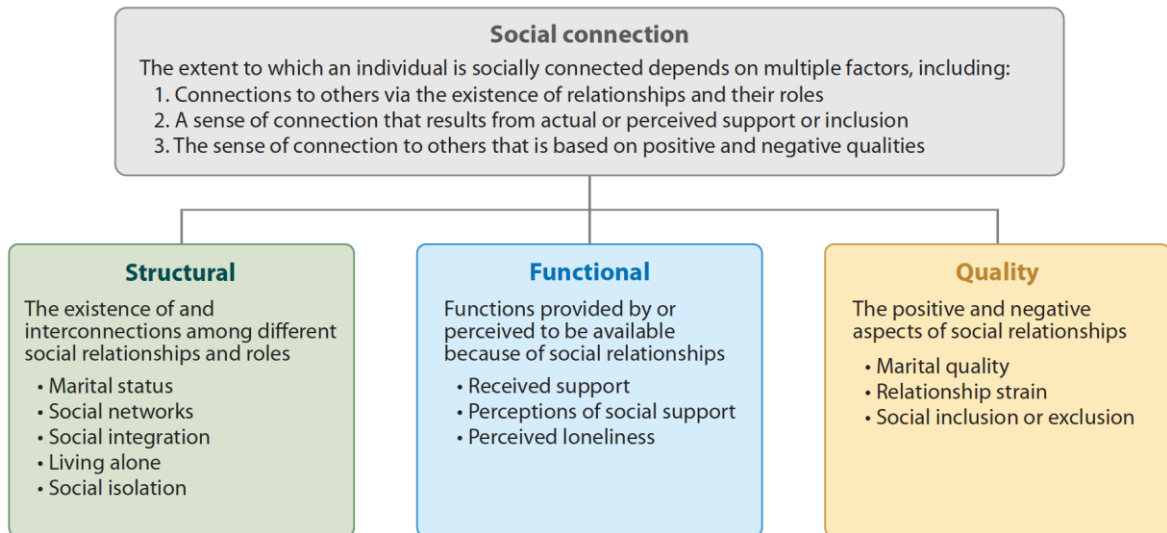


Figure 1: Conceptualization of Social Connection as a multi-factorial umbrella term. Holt-Lunstad, *Annual Review of Psychology*, 2018; and adopted by [NASEM, 2020](#).

Although social connection and social connectedness may be used interchangeably, social connectedness may reflect where an individual or population falls along the continuum of social connection.

GILC has adopted the following definition of Social Connectedness:

The degree to which one has a variety of relationships and roles, relationships that can be relied on and are high quality.

Having greater social connection has been shown to positively influence a range of mental, physical, and cognitive health outcomes², with the strongest evidence showing that being more socially connected reduces risk for premature all-cause mortality. For example, those who are more socially connected have a longer lifespan, are at reduced risk for chronic illnesses such as cardiovascular disease and stroke, reduced risk for acute illnesses including susceptibility to viruses and upper respiratory infections, are more likely to mount an effective immune response to a vaccine, and faster wound healing. Those who are more socially connected are also more likely to engage in healthier behaviours (e.g., engaging in, and sticking with, an exercise regimen), are more likely to have better sleep quality and quantity, and have better adherence to medical advice. Furthermore, those who are more socially connected are at reduced risk for mild cognitive impairment and Alzheimer's disease. Similarly, those who are more socially connected are at reduced risk for depression and anxiety and have greater satisfaction with life. Thus, social connection is associated with significant resiliency against a host of health and wellbeing outcomes.

The extent to which one is socially connected also influences opportunities to access support and resources when needed (including at times of stress, illness or disaster³), facilitates sharing of information⁴, and contributes to a broader sense that our life has meaning.⁵ Furthermore, the benefits of social connection are gained across our social network. For example, evidence shows that interactions with acquaintances and even strangers (referred to as ‘weak social ties’) also have a positive effect on psychological health and wellbeing.⁶

Being socially connected is recognized as a fundamental human need,⁷ and is important at every stage of life. For every increase in measured social connection across the lifespan, there are reductions in biomarkers of health risk across the lifespan, suggesting a continuum of risk (when low) and protection when the level of social connection is high. When social connection is lacking, people may experience either subjective social isolation (i.e., loneliness), objective social isolation, or both.

Recommendations

- 1.1 Coordinated strategies to facilitate social connection - that reduces loneliness, social isolation, and social negativity - and that are informed by the diversity of individual cultural and personal experiences - need to be implemented at the individual, community, national and global levels to support social health and wellbeing.
- 1.2 Across all sectors, policymakers need to evaluate and report on the costs and benefits for social health and wellbeing.
- 1.3 Additional research (basic and intervention evaluation) is needed to address existing gaps.

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Position Statement 2 - Social isolation, loneliness, and social negativity are distinct and can each compromise wellbeing

Lacking social connection (social disconnection) may result from objective isolation (social isolation), subjective isolation (loneliness), or poor quality social interactions (social negativity). Being socially isolated means having objectively few social relationships or roles and infrequent social contact. Conversely, loneliness is a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships. Social negativity is having poor quality interactions often resulting from conflict or strain. These forms of social disconnection are part of our normal human experience. However, when experienced persistently, they are associated with poorer social, health, and wellbeing outcomes. Importantly, social isolation and loneliness are different concepts. Social

isolation and loneliness can co-occur but some individuals may experience loneliness without social isolation, and others may experience social isolation without loneliness. Therefore, meaningful distinctions between these experiences should be made so that effective interventions can be identified and deployed. Furthermore, interventions should consider social negativity given increasing contact could potentially increase conflict and poorer outcomes.

GILC has adopted the following definition of social disconnection:

Objective or subjective deficits in social connection, including deficits in relationships and roles, their functions and/or quality.

Social isolation, loneliness, and social negativity are defined and experienced differently. In everyday conversation the words ‘loneliness’ and ‘social isolation’ are often used interchangeably; however, these constructs are distinct. While loneliness and social isolation or loneliness and social negativity sometimes co-occur, these experiences typically refer to different kinds of social disconnection. To avoid confusion, it is important to distinguish clearly between them.

Formal definitions of loneliness vary but typically share two common elements: an emotional component (i.e., the feeling is unpleasant, unwelcome, distressing) and a social cognition component (i.e., the perception of being disconnected from other people along with a desire to be more connected).

GILC has adopted the following definition of loneliness:

A subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships.

Loneliness is a common, subjective experience that is described in many ways. Although loneliness is an aversive experience, it also has some adaptive functions that motivate us to reconnect socially, much in the same way that hunger and thirst motivate us to seek out food and water.¹ For example, recent evidence suggests that acute bouts of loneliness are accompanied by a neural signal to connect with others, which fits the intuitive idea that brief periods of loneliness motivate people to repair their social connections. In short, feeling lonely is a natural signal that our social connections are lacking (not functioning in the way that we need them to be), and that action is needed to repair the problem.

GILC has adopted the following definition of social isolation:

Social isolation refers to having objectively having few social relationships, social roles, group memberships, and infrequent social interaction.

Social isolation encompasses objective (observable) indicators of deficits in social connection, and can indicate an inadequate structural social foundation. The existence of social relationships and roles, and frequency of contact with others, provides the foundation for how relationships can potentially influence health and wellbeing². Having others in our life can affect our health and wellbeing because our relationships fulfill a variety of physical, emotional, and cognitive needs. Social isolation reduces the opportunity for these needs to

be met. When this foundation has gaps, is weak, or absent, this leads to increased social vulnerability.

GILC has adopted the following definition of social negativity:

Social negativity is characterized by the presence of aversive interactions or relationships, rather than the absence of desired social interactions or relationships.

Social negativity can occur within specific social interactions, relationships, or networks. Social negativity can be experienced as interpersonal conflict or strain and may be characterized by hostile, insensitive, or demanding social exchanges. Social negativity can be a source of stress and undermines trust in others as reliable sources of support. Severe abuse, violence, and neglect go beyond the scope of social negativity, given their severity and often pathological nature.

Social isolation, loneliness, and social negativity are common and if left unaddressed can lead to negative consequences.

Social isolation, loneliness, and social negativity are part of a normal human experience that many people will experience at some point in their lives. However, severe levels of loneliness are estimated to affect around 10-50% of adults³, and social negativity is estimated to co-occur in roughly half of relationships. While there are several indicators of social isolation, trends suggest that social capital is decreasing⁴, with more people living alone, fewer people engaging in social groups including participation in religion, and household size shrinking. The prevalence rates and trends across these indicators vary somewhat from country to country. Furthermore, the COVID-19 pandemic also led to decreases in social contact globally, due to “social distancing” recommendations and subsequent increases in loneliness, particularly among at-risk groups. Never or rarely leaving the home, also has exacerbated risk associated with living alone and social negativity.

Transient social isolation, loneliness, or social negativity may be normal, but for some individuals these experiences become prolonged, lasting over weeks, months, or years. Recent reviews of the literature show that social isolation, loneliness, and social negativity, when frequent, intense or enduring, are associated with poorer social, health and economic outcomes,⁵ though there are far more studies examining isolation and loneliness. Adverse outcomes for mental health and wellbeing, including increased risk of depression, anxiety and suicidal behaviour, have been documented for both social isolation and loneliness, though more longitudinal evidence is needed for mental health outcomes. Social negativity has been linked to poorer health-relevant physiology, self-rated health, morbidity and mortality. Some studies suggest a link between social disconnection (limited social ties or loneliness) and poorer cognitive development in children as well as increased risk of dementia in older adults - though this remains an area of debate. In addition, high levels of loneliness have sometimes, though not consistently, been associated with higher use of health and social care services which may, in part, be related to the complex physical and mental healthcare needs that occur in people who are lonely.⁶ Emerging literature also suggests that lack of social connection is associated with other undesirable outcomes, including increased economic costs in the health sector, lost productivity and absenteeism in the workplace, and lower academic achievement.⁷ However, more research is needed in this area.

Social isolation and loneliness can co-occur or be experienced independently.

Social isolation and loneliness are related (i.e., weakly correlated⁸) but separable experiences. Importantly, while social isolation and loneliness can co-occur, some individuals may experience loneliness without social isolation, and others may experience isolation without loneliness. Therefore, there may be meaningful distinctions between these experiences.

The evidence points to significantly poorer outcomes among those who are either socially isolated or lonely relative to those who are not; however, most studies only examine isolation or loneliness but not both experiences within the same sample. Among those that do, it appears that social isolation may have independent associations with mortality, while the effect of loneliness on mortality may be carried by the intermediary effects on isolation. Nonetheless, there is less evidence of the independent effects of each, as well as potential interactive effects of being both isolated *and* lonely, on health and other outcomes.

Social isolation and loneliness are both multifaceted constructs⁹ that are common across all cultures.¹⁰ Evidence points to different dimensions of social isolation (e.g., network size, network diversity, social roles, living arrangements, social engagement) and loneliness (e.g., intimate, relational, collective) or types (e.g., emotional isolation, social isolation) of loneliness. However, the extent to which these distinctions map onto each other, and their separate roles in producing negative outcomes is an ongoing area of investigation.

Recommendations

2.1 Awareness campaigns need to provide clear and concise information about (i) social connection and conversely forms of social disconnection including social isolation, loneliness, and social negativity; (ii) how they differ from each other; and (iii) their consequences across many aspects of life, in order to increase public understanding of the benefits of human connection.

2.2 Researchers need to examine components of social disconnection (loneliness, social isolation, social negativity) concurrently in order to determine their independent influence on health, work and educational outcomes.

2.3 Interventions need to consider social negativity given increasing contact could potentially increase conflict and poorer outcomes.

2.4 Increased investment is needed for longitudinal research examining the impact of loneliness, social isolation, and social negativity on health, work, educational attainment and wider community participation.

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⁹ *Studies exploring the multifaceted nature of loneliness:*

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¹⁰Heu, L. C., Hansen, N., van Zomeren, M., Levy, A., Ivanova, T. T., Gangadhar, A., & Radwan, M. (2021). Loneliness across cultures with different levels of social embeddedness: A qualitative study. *Personal Relationships*, 28(2), 379-405. <https://doi.org/10.1111/per.12367>

Position Statement 3 - Social wellbeing is independent from other related concepts

Social connection, social isolation, and loneliness differ from other related mental health (e.g., depression), cognitive-behavioural (e.g., solitude), and personality (e.g., introversion/extroversion) factors, and have independent effects on health and wellbeing.

Loneliness and social isolation are sometimes confused with other concepts; therefore, it is important to understand how they differ from various psychological experiences and traits.

Depression: Loneliness shares some characteristics with depression, and as a consequence these experiences are sometimes conflated. But, people can be lonely without being depressed, or they can be depressed but not lonely, which means that these are similar but separate constructs. Whilst loneliness is a negative feeling, depression refers to a more global disturbance in mood. Several lines of evidence indicate that loneliness and depression are reciprocally related. For example, recent studies show that adults in the general population with higher levels of loneliness are at more than twice the risk of developing depression over time. In addition, higher levels of depression may also lead to increased feelings of loneliness.¹

Solitude: Loneliness and social isolation also differ from solitude. Solitude is a state in which an individual spends time alone with themselves, rather than with a deliberate focus on an external activity or with the (potentially influential) presence of other people.² Solitude can be described as a state of being alone, without feeling lonely. Whilst loneliness and social isolation are negative experiences, solitude is often a desired and savoured state that can be used for relaxation and personal growth.² In addition, though spending time in solitude involves a temporary lack of contact with people it does not necessarily indicate a lack of social connection in general.

Shyness: Shyness is the tendency to feel awkward, worried or tense during social encounters.³ Shyness is related to loneliness, in that both involve negative emotional experiences and unsatisfactory social relationships. A number of studies show that shyness is one of the potential causes of loneliness.³ Similarly, people who are shy are more likely to withdraw from social interactions, due to their excessive self-consciousness, negative self-evaluation and perceived lack of social skills, which puts them at increased risk of social isolation.

Introversion-extraversion: Introversion and extraversion are considered a central dimension of human personality. In social situations introverts and extraverts exhibit very different behaviours. Extraverts have a strong preference to seek out social engagement and generally experience less loneliness than introverts. However, though extraverts have larger networks of social connections, they do not necessarily *feel* closer to individuals in those networks, meaning they can still be vulnerable to loneliness.⁴ Similarly, introverts sometimes prefer more solitary activities and may avoid social interaction as a result. However, introverts are not immune from feeling lonely, if the quality or quantity of their social connections is less than they desire.⁴ In sum, it's important to recognize that both extraverts and introverts can experience social disconnection.

Most studies of social connection, isolation, and loneliness, adjust for related mental health factors (e.g., depression) and show independent effects on physical or mental health. However, fewer studies control for (or take account of) a broad range of behavioural, emotional and personality factors when studying the consequences of loneliness and isolation. In general, it is helpful to understand the similarities and differences between loneliness and social isolation and related concepts, since the best ways of dealing with these experiences may differ.

Relevance to other Social Factors: While the term “loneliness” is often used as a catch-all term to refer to a variety forms of social deficits, there are important distinctions. There are several important social factors (such as social network size and diversity, social support, belonging, living alone, etc⁵) that are all conceptually distinct but relevant to health and well-being. Deficits across all of these social experiences are forms of social disconnection. Thus, social disconnection includes, but is not limited to, social isolation and loneliness.

Recommendations

3.1 Awareness campaigns should provide clear and accurate information that allows social isolation and loneliness to be correctly distinguished from other problems.

3.2 Researchers need to be precise and explicit about which aspects of social health they are investigating.

Data Sources

¹Examples of evidence linking loneliness and depression:

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Position Statement 4 - A wide range of risk factors leave people vulnerable to loneliness and social isolation

Social disconnection (being isolated or feeling lonely) has multiple risk factors that vary from person to person, and reflect individual experiences and preferences. These risk factors include (but are not limited to) a wide variety of biological (e.g., sensory impairment), psychological (e.g., mental health difficulties), social (e.g., economic disadvantage, low civic engagement and trust), cultural (e.g., member of a stigmatized group, racial minority) and environmental (e.g., poor transport) issues, as well as a host of significant life changes (e.g., becoming a parent, leaving school). Loneliness and social isolation can affect anyone, but disproportionately affect some groups, sectors and places in our communities placing some people at higher risk of inequalities in health and wellbeing.

Loneliness and social isolation are associated with a wide range of risk factors and triggers that increase the likelihood of social disconnection arising, or provoke the onset of new episodes of these experiences, respectively.¹ Understanding the diversity of these factors and how they increase risk for different types of social disconnection is essential in developing and implementing effective intervention and prevention strategies. Common examples include: 1) biological factors (e.g., sensory decline/loss; physical health impairment or disability); 2) socio-cultural factors (e.g., unemployment, retirement, intimate partner violence, migration, social marginalization, racial and gender minority, workplace culture); 3) psychological and cognitive factors (e.g., mental health problems, neurodevelopmental disorders, cognitive difficulties); and 4) social environmental factors (e.g., transportation, housing, urban design). In addition, significant life changes (e.g., leaving home, transitioning to university study, becoming a parent, becoming homeless, suffering illness and trauma) are often triggers for experiencing loneliness and social isolation. Precisely how these factors increase risk of social isolation and loneliness is not well understood. In addition, the relationship between risk factors and social isolation or loneliness is often (though not always) bidirectional in nature. For example, longitudinal studies show that the presence of common mental health problems (e.g., depression, anxiety) increases the risk for developing

loneliness at follow-up, whilst high levels of loneliness increase the risk for subsequent onset of these mental health disorders.²

Prevalence rates obtained through surveys can provide insight into potential risk factors. Recent survey evidence suggests that those aged 16-25 years are the group most likely to report feeling lonely.³ However, the estimated prevalence of loneliness varies across studies, age-groups⁴ and countries. For example, see Figure 1 below illustrating the prevalence of loneliness in older adults in different nations. Prevalence estimates are influenced by a large range of factors, including the type and quality of the measure used, the timeframe assessed, the characteristics of the people included (or excluded from) the estimates and the year the data were collected.

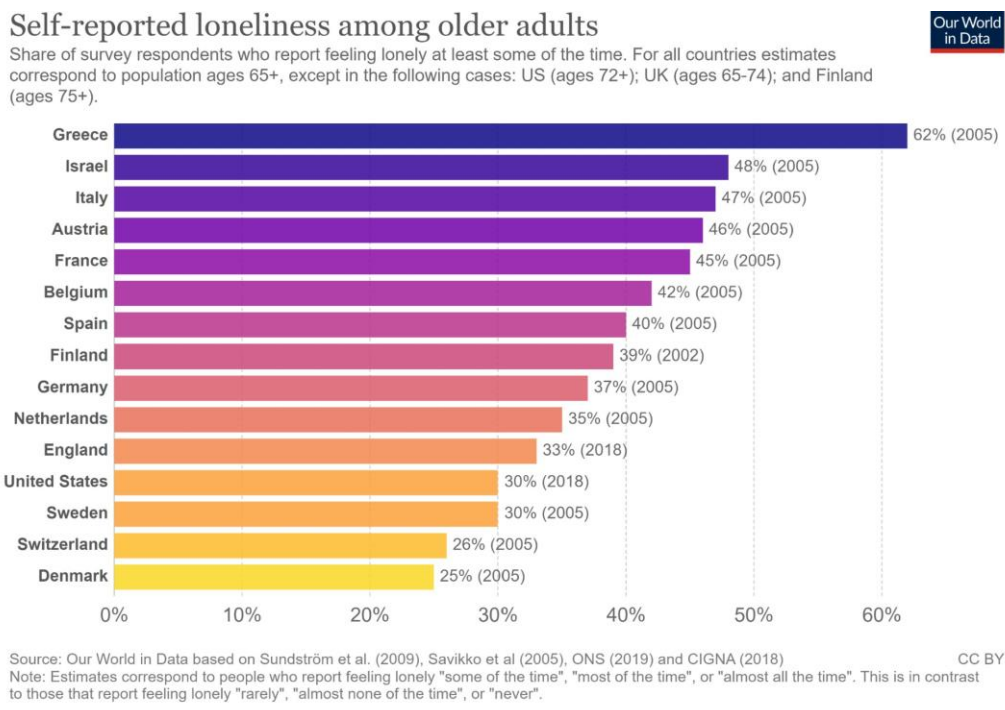


Figure 2. Estimated prevalence of loneliness in older adults across several countries: [Esteban Ortiz-Ospina and Max Roser (2020) - "Loneliness and Social Connections". Published online at OurWorldInData.org. <https://ourworldindata.org/social-connections-and-loneliness>]

Some risk factors appear to influence both social isolation and loneliness, whilst others are more selective in their effects.⁵ For example, hearing loss has been associated with both social isolation *and* loneliness, whilst bereavement is a consistent predictor of loneliness but not social isolation. The presence of common cause factors, as well as comorbid social and health problems, makes it difficult to conclusively identify unique predictors of social isolation and loneliness. Complicating matters further, both synergistic effects (i.e., interactions) between multiple risk factors⁶ and generational differences in predictors of loneliness have been described⁷, which means that solutions for managing social disconnection need to be sensitive to the complex and individualized risk factors involved.

Individuals also differ in the type, number and combination of risk factors for social disconnection; consequently, loneliness and social isolation do not occur equally across the

community. Factors such as green space (e.g., parks, woodlands) influences the odds of becoming lonely, and the benefits of nearby green space appear to be much stronger for those who live alone.⁸ Similarly, some sectors of society experience higher rates of loneliness and social isolations than others. For example, lack of employment, being in receipt of income support, and engagement in the gig economy (flexible, short-term contract or freelance work) are associated with a higher risk of loneliness.⁹ Other studies show that some groups are at higher risk of loneliness than others. For example, age is a particularly important risk factor for loneliness⁴. However, whilst loneliness clearly occurs across all age groups, rates of loneliness are unevenly distributed across the life-course with peaks in prevalence often found in both older and younger adults. Many other groups are vulnerable to loneliness or social isolation, often in the context of multiple risk factors, including (but not limited to) migrants, people with a disability, individuals with a psychotic disorder, long-term care home residents, and carers.¹⁰ Marginalization and discrimination may contribute to risk for poorer social connection, further contributing to health and economic disparities. Conversely, emerging evidence indicates that different types of social capital - that is, the diverse types of social connections in our lives (from personal relationships to family engagement and community participation) convey a broad range of benefits that buffer against loneliness and social isolation. Consequently, enhancing social capital may be a useful strategy to protect against social disconnection.

Recommendations

4.1 Awareness campaigns should increase public understanding of the broad range of risk factors that increase vulnerability to loneliness and social isolation across the lifespan.

4.2 Training in social health and wellbeing, their associated risk factors and management, should be mandatory for health professionals and social care providers.

4.3 Consistent policies for robust assessment of risk of loneliness and social isolation at the local level need to be developed, so that resources can be delivered proportionate to need.

4.4 Researchers need to gain a better understanding of the mechanisms linking risk factors to the emergence of social isolation and loneliness. Studies examining how these mechanisms vary across culture, race, gender identity, and health status also need prioritizing to advance equality in social wellbeing for all members of the community.

Data Sources

¹ *Studies illustrating the multiple risk factors for loneliness and social isolation*

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³Lim MH, Eres, R. & Peck, Cl. (2019). The Young Australian Loneliness Survey: understanding loneliness in adolescents and young adults. Victoria: VicHealth. <https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Social-connection/The-young-Australian-loneliness-survey-Report.pdf?la=en&hash=94F3B07524F419C67901C4E5741F2DF9D29BF2A>

⁴*Studies showing age as a risk factor for loneliness*

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⁵ *Common and separate predictors of loneliness and social isolation:*

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⁶Beller, J. & Wagner, A. (2018). Loneliness, social isolation, their synergistic interaction, and mortality. *Health Psychology*, 37 (9), 808-813. <https://psycnet.apa.org/doi/10.1037/hea0000605>

⁷Altschul, D., Iveson, M., & Deary, I. (2021). Generational differences in loneliness and its psychological and sociodemographic predictors: An exploratory and confirmatory machine learning study. *Psychological Medicine*, 51 (6), 991-1000. <https://doi.org/10.1017/s0033291719003933>

⁸Astell-Burt, T., Hartig, T., Eckermann, S., Nieuwenhuijsen, M., McMunn, A., Frumkin, H., & Feng, X. (2021). More green, less lonely? A longitudinal cohort study, *International Journal of Epidemiology*, dyab089, <https://doi.org/10.1093/ije/dyab089>

⁹*Evidence of employment and income as risk factors for loneliness:*

Relationships Australia 2018. [Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey](#). Canberra: Relationships Australia.

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¹⁰ *Selected examples of specific groups at risk of loneliness.*

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Position Statement 5 - Evidence-based solutions are needed to reduce social isolation and loneliness and to increase social connection

Global research on the consequences of poor social connection, including loneliness and social isolation, is quite robust. However, the evidence is still emerging on how to effectively tackle these issues. While loneliness and social isolation are difficult to identify, address and resolve, the science shows that there are ways that each can be reduced. In support of addressing health disparities across populations, there may also be various reasons why someone experiences loneliness / social isolation, and therefore any solutions deployed must be responsive to the specific needs of the individual within the context of the communities in which they reside.

Addressing social isolation and, or loneliness is likely to differ from person-to-person, as social needs and resources are dependent on the individual's health, social, economic, and environmental context. Current evidence suggests that social isolation and loneliness may involve different pathways to poorer health outcomes, but solutions that can reduce *both* social isolation and loneliness are likely to lead to better health outcomes. Equally, the evidence suggests that solutions for reducing loneliness and social isolation may need to be nuanced. In particular, reducing social isolation may not lead to reductions in loneliness and reductions in loneliness may not lead to reductions in social isolation. Furthermore, not all solutions that increase social contact or engagement may be helpful if solutions are not

responsive to needs or inadvertently increase social negativity. Solutions should include strategies that reach individuals, communities, institutions, and the larger society.

Evidence is currently mixed in terms of the types of approaches that are most effective for reducing social isolation or loneliness and many different types of solutions, strategies, and frameworks may be needed to meet the diversity of needs of different individuals¹. Solutions for loneliness and social isolation which differ in intensity are currently lacking, but should also be available, as individuals express clear preferences about what they feel would work for them. Similarly, solutions that are co-designed to increase consumer engagement and relevancy and that adopt evidence-based approaches are viewed as best practice. More research is therefore needed, as a priority, to fill these gaps in knowledge.

There are currently consensus guidelines for addressing social isolation and loneliness within the health sector (NASEM, 2020); however, consensus guidelines are also needed for other sectors. One useful framework to consider is the Centre for Disease Control's Socioecological Framework² which articulates opportunities to intervene at the individual, interpersonal, organizational, community, and societal level. Lim and colleagues (2020)³ integrate this framework into a Conceptual Model of Loneliness for the general community (See Figure 2). This model is intended to be tailored and adapted to the person's situation including the resources accessible to them. Other targeted frameworks for people with mental health problems⁴ such as psychotic disorders⁵, medical and chronic health conditions and public health⁶ have also been proposed.

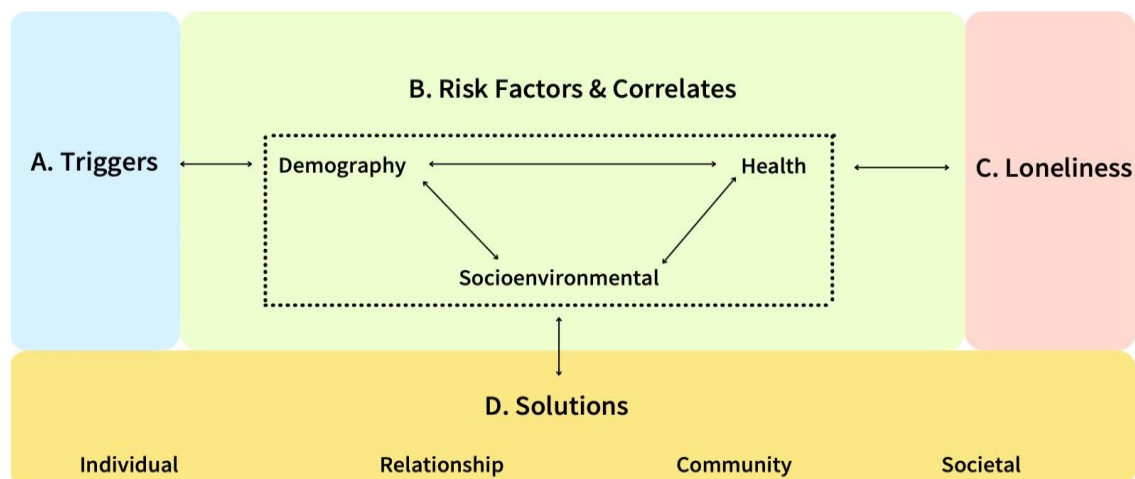


Figure 3. Example of how to tailor solutions to the individual's context taking into account triggers, risk factors and correlates, and loneliness severity and chronicity. Conceptual Model of Loneliness modified from Loneliness in the 21st century: an update on correlates, risk factors, and potential solutions. Lim, M.H., Eres. R., & Vasan, S (2020).

The Conceptual Model of Loneliness is just one example of how to select an appropriate solution within the person's context: A) what are their triggers?; B) what are their risk factors?; C) how severe and chronic are these lonely feelings?; D) what types of solutions

(i.e., individual, relationship, community, or societal) can be applied in this individual's circumstance and context? Solutions can be applied at A, B, or C, which assumes that solutions can be adopted either to prevent loneliness, to address it, or both. While this model does not explicitly apply to social isolation, it is assumed that objective social isolation is both a trigger (A) and a risk factor for loneliness (B). As noted above, risk factors may include demographic characteristics (e.g., age, gender, marital status, migration status, living status, socioeconomic status), health (e.g., physical, mental, cognitive health, brain, biology, and genetics), and socio-environmental variables (e.g., digital, workplace), and may also work synergistically - in that they interact with each other.

In the process of selecting the most appropriate solutions for reducing social disconnection, it is important to note many interventions are time-limited due to resource or funding constraints. The NASEM report⁷ noted that most interventions were not sustained for long enough and/or not evaluated over the longer term, to determine whether benefits endured beyond the intervention period itself. What remains unclear is whether the cessation of an intervention leads to a rebound in risk of social isolation and, or loneliness. It is important that we gain a better understanding of the implications of current solutions and whether they can maintain their effectiveness over the long term.

Current evidence-based interventions need to be scaled up and widely implemented and, in order to progress, promising interventions need to be evaluated rigorously including using psychometrically-validated assessment tools for loneliness and social isolation⁸. However, the impact of many community-based initiatives (from group-based activities to social prescribing) are often under-evaluated, often because of poor resources; consequently, the gap between scientific evidence and practice remains.

Recommendations

5.1 Governments and funding agencies need to increase funding for research designed to improve interventions that prevent or reduce social isolation and loneliness, or increase social connection. The evaluation of existing interventions is critical to our understanding of what types of interventions work, for whom, and when.

5.2 Guidelines need to be developed for health and social care providers to assist them to implement evidence-informed approaches to identify and support people experiencing social isolation and loneliness across all populations and identities.

5.3 Organizations which provide services and support need to routinely assess, evaluate, and report on the effectiveness of their services to reduce loneliness and social isolation or to increase social connection.

5.4 Governments and organizations should establish standardization of measurement, using validated tools.

Data Sources

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Position Statement 6 - Addressing Barriers to Social Connection is Central to Effective Action on Reducing Social Isolation and Loneliness

Lonely and/or socially isolated people may need help to identify and overcome a range of practical barriers and societal challenges that limit their ability to develop and maintain satisfying social connections. These barriers can range from broader structural issues, such as inadequate transport and urban design, to poor social policy. The stigma of social disconnection also remains a problem across many countries and may be fuelled by misconceptions and misinformation about social isolation and loneliness.

There are many structural and practical barriers in a person's environment that can limit social connection and contribute to loneliness and social isolation in daily life, such as poor or inaccessible transport, low digital literacy or digital inequity, and financial constraints. Furthermore, access to some types of interventions for loneliness may not always be feasible, due to inadequate training or supply of qualified practitioners, or lack of availability of technological devices. Consequently, a diverse array of practical strategies - from provision of affordable and appropriate public transport, to well-designed public places and spaces in which to connect, to better training and availability of health and social care providers - may be vital components in reducing social disconnection.¹

Negative attitudes about loneliness and social isolation (e.g., fear of negative evaluation, shame associated with living alone) can also be a serious barrier to connection. For example, the stigma of loneliness can mean that people feel uncomfortable talking about their feelings of disconnection from others and may stop them from reaching out for help. In addition, biased thinking about loneliness or social isolation can make it difficult for service providers to identify, engage with, and support people experiencing loneliness. Challenging the stigma of loneliness is therefore considered an important component of many national campaigns tackling loneliness, though more attention is needed on evaluating the effectiveness of these efforts. Previous research has identified three broad types of stigma: public, self, and structural stigma.

Public stigma

Early studies on the public (or social) stigma of loneliness found that people view lonely individuals as being unlikeable and less competent than their less lonely counterparts, implying that the cause (and blame) for loneliness rests within the lonely person. However,

more recent studies, with better research methods and larger, more diverse samples of adults, suggest that there is much less evidence of public stigma of loneliness than previously thought.² Similar conclusions were drawn from the BBC Loneliness Experiment, which surveyed 55,000 adults worldwide. The findings of this study suggest that the general public may not hold strongly stigmatizing attitudes towards other people who are lonely.³ However, research in this area remains limited and requires further investigation.

Self-stigma

Research consistently indicates that loneliness is felt by many, though few admit. For example, 2017 survey data from the Campaign to End Loneliness showed that just over half (56%) of UK adults say that admitting to loneliness is difficult, with around three-quarters of older adults (aged 65+yr) reported that they would not admit to feeling lonely in order to avoid being perceived as a burden others. Until recently, research has largely overlooked the experience of loneliness in young adults. One reason for lonely people being unwilling to open up about their experiences is that they judge themselves harshly for being lonely. This self-stigmatization is associated with feelings of shame, which is often higher in women than men, and in younger than older adults.³

Structural stigma

Structural stigma refers to societal conditions, cultural norms and institutional policies or practices that limit opportunities and create social or health inequalities for stigmatized groups.⁴ This form of stigma has been much less examined in relation to loneliness and social connection. The widely reported tendency to underestimate, ignore or downplay the importance of loneliness, and the need for social connection, may provide indirect evidence of the structural stigma of loneliness that deserves more attention.

The current evidence shows that a range of factors within the environment and stigmatizing attitudes towards social isolation and loneliness can act as barriers to forming meaningful social connections. These findings serve as an important reminder of the need to take a 'person-in-context' approach when developing and implementing individual, local and national solutions for alleviating social isolation and loneliness.

Recommendations

6.1 National, local and individual strategies for reducing loneliness and social isolation need to take account of practical and societal barriers that can interfere with making meaningful social connections across the diversity of human experiences.

6.2 Greater attention is needed from all stakeholders to monitor and respond to inaccurate information about social isolation and loneliness.

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