# Addressing loneliness in general practice

**Brooke Ah Shay**

**LONELINESS** has been a public health concern in Australia for many years,[1] but the COVID-19 pandemic arguably brought the issue to the forefront. There is no standardised definition of loneliness,[2] but it can be broadly described as the subjective feeling of inadequate meaningful connection to others,[3] occurring when there is a mismatch between the relationships a person has and those that they want.[4]

Importantly, although the terms are often used interchangeably, and they are often researched simultaneously, loneliness is not the same as social isolation. Loneliness and social isolation are distinct psychosocial constructs with weak-to-moderate correlation with each other and are mechanistically associated with different health outcomes.[5] Simply increasing social connection, therefore, is not a holistic solution.[6]

Loneliness is a highly individual experience, and complex in causality, which contributes to the many challenges related to addressing it. The relative paucity of research on the topic is another limitation. It remains poorly understood within the community and health sector.[7]

It is difficult to obtain precise estimates on prevalence because of the variation across the life course, cultural and gender differences, and the use of differing measurement scales.[8] Furthermore, lack of comparable data in Australia precludes reliable international comparisons.[1] Nonetheless, Australian initiative, *Ending Loneliness Together*, estimates that 32% of Australians feel lonely, with 17.5% feeling severely lonely.[9] In Australia, young people (aged 18–24 years) and middle-aged people (aged 45–54 years) report the highest levels of loneliness.[9]

Loneliness is recognised as an important psychosocial risk factor for numerous physical and mental health conditions. It is associated with an increased risk of Alzheimer's disease and related dementias,[10] as well as poor mental health outcomes, including increased depression, anxiety and psychotic symptoms.[11] In Australia, those who are lonely are more than four-fold as likely to have depression and twice as likely to have chronic disease.[9]

A public health approach to addressing the issue requires interventions that exist across the so-called 'upstream–downstream' spectrum, addressing both the upstream factors (the wider structural and societal forces) and downstream factors (individual behaviours). Loneliness is strongly mediated by the social and structural determinants of health,[12] and so upstream action underpinned by policy changes and government investment to address these determinants is crucial.

However, general practitioners (GPs) play a crucial role. GPs are often the first point of contact within the Australian healthcare system,[13] and one recent meta-analysis found that people who experience loneliness and feelings of social isolation make a greater number of visits to their physician or GP, finding a small but statistically significant average effect size between loneliness and use of primary care.[14]

GPs can identify at-risk patients and screen for loneliness using validated loneliness scales where appropriate (refer to Table 1), bearing in mind their limitations, particularly in culturally diverse groups. Based on this assessment, GPs can work with patients to develop personalised management plans, which might include referral to other providers. A meta-analytic review concluded that psychological treatment and social and emotional skills training are the most promising interventions for loneliness, with a moderate magnitude of effect.[15] Although less studied, occupational therapists might also have a role in mitigating loneliness by way of helping people to engage in meaningful social participation.[16] GPs are central to the coordination of multidisciplinary care.

Social prescribing is another potential management option. Australian initiatives such as Neighbourhood Connect[17] and Friendline[18] offer accessible, non-clinical options that GPs might wish to consider. A recent systematic review found that nature prescribing can help to combat loneliness.[19] Research has also found that volunteering can alleviate and reduce the risk of loneliness.[20] Although there is currently no national framework in place for this, GPs can create social prescriptions informed by their knowledge of the local community programs and services and their assessment of a patient's interests and needs.

Given the importance of removing the stigma around loneliness,[21] GPs have a role to play in educating their patients on the issue and working to dismantle the associated stereotypes, though this is not necessarily a simple task. Educational material can also be displayed in practice waiting rooms, which might include pamphlets, posters, booklets and digital displays for practices with screens. This can encourage patients to seek or accept help.

**Table 1. Examples of loneliness scales**

| Scale | Description | No. items | Scoring | Strengths | Limitations |
|---|---|---|---|---|---|
| UCLA Loneliness Scale (version 3) | Assesses 20 dimensions of loneliness | 20 | 4-point rating scale; higher scores indicate greater loneliness | Well validated, widely used | Lengthy for routine GP use; might not distinguish well between acute and chronic loneliness |
| Three-item Loneliness Scale (Modified UCLA) | A shortened version of the UCLA scale | 3 | 3-point rating scale; higher scores indicate greater loneliness | Quick to administer, correlates strongly with the 20-item UCLA scale | Might not capture nuanced aspects of loneliness |
| De Jong Gierveld Loneliness Scale | Measures both emotional and social loneliness | 6 (shortened version) or 11 | Dichotomous (Yes/No) or scale scoring; higher scores indicate greater loneliness | Distinguishes between emotional and social loneliness, useful for different interventions | 11-item version might be too long for GP consultations |
| Single-item Loneliness Measure | A single direct question: 'How often do you feel lonely?' | 1 | 3-point or 5-point scale | Very quick and easy to use | Lacks depth; might result in under-reporting, might not capture different dimensions of loneliness or changes over time |
| Lubben Social Network Scale (LSNS-6) | Assesses social isolation by measuring social network size and engagement | 6 | Scores below a threshold indicate risk of social isolation | Identifies at-risk individuals, useful in older populations | Measures social isolation rather than loneliness specifically |

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Although GPs face increasing patient complexity and rising demand,[22] which restricts time and resources, their ongoing community-based patient relationships and primary care expertise uniquely position them to identify and manage loneliness. There is no 'one-size-fits-all' approach that can be taken, but tailored and even modest interventions – ranging from screening and counselling to social prescribing – can have a meaningful impact on patient health and wellbeing.

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