

Evidence Summary

A review of associations between social isolation, loneliness and poor mental health among five population groups

Report prepared by

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We respectfully acknowledge the traditional custodians of the country in which we work and learn together, and pay our respects to Elders past, present and emerging.

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Glossary

AIHW	Australian Institute for Health and Welfare
CALD	Culturally and Linguistically Diverse
ICT	Information and Communication Technologies
LGBTI	Lesbian, Gay, Bisexual, Transsexual, Intersex
MSV	Mental health, Substance use and Violence
NSSI	Non-Suicidal Self-Injury
QOL	Quality of Life
SSAY	Same-Sex Attracted Youth

Aims of the evidence summary

Physical and social distancing measures aiming to limit the transmission of COVID-19 are likely contributing to, or intensifying, experiences of social isolation in the community. The Murrumbidgee Primary Health Network sought a rapid evidence review to identify relevant evidence to inform regional responses focusing on:

- The implications of loneliness and isolation for risks to mental health and wellbeing
- Factors associated with maintaining and promoting individual wellbeing while physical and social distancing measures are in place
- Insights into the accessibility and benefits of online and other mental health support services and resources
- Generate evidence to inform efforts to ensure that priority vulnerable populations have access to mental health care and resources that can reduce the impacts of mental health distress

The evidence summary focuses on the five social groups whose circumstances present higher risks for experiencing loneliness and isolation as a result of physical and social distancing, than other population groups living in rural areas. They are:

- Older people
- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse communities (CALD)
- People identifying as lesbian, gay, bisexual, transsexual and intersex (LGBTI)
- Farmers and farming families

Key insights

As people age:

- Risks of becoming lonely and isolated are strongly linked to life-course changes and situations
- The 'active lonely' may experience psycho-social barriers to social participation
- Men and women tend to respond to living alone in different ways that have implications for risks of becoming lonely and socially isolated
- Many older people are using information and communication technologies (ICT) to enhance social participation and stay connected with family and friends
- Culturally appropriate community facilities for ageing Aboriginal and Torres Strait Islander people are needed
- Language is a significant barrier to wider social participation among people who have immigrated to Australia as adults.

For Aboriginal and Torres Strait Islander people:

- Loneliness and social isolation are not relevant for understanding factors that impair mental health and wellbeing
- Cultural sensitivity and an Indigenous workforce are foundations for effective services and programs
- There is evidence that mainstream mental health promotion programs can be tailored to meet the needs and circumstances of Aboriginal and Torres Strait Islander peoples
- The involvement of Indigenous Elders in designing and delivering health and wellbeing programs can enhance their effectiveness
- Traditional medicine can have a role in promoting health and wellbeing.

For Australians from culturally and linguistically diverse communities:

- There is evidence for associations between loneliness, social isolation and poor mental health in CALD communities
- Complex and varied contexts for immigration and resettlement influence the ways in which people can become disconnected and understanding these contexts should inform programs and interventions to reduce loneliness and isolation
- Language is a significant barrier to wider social participation for people immigrating as adults
- 'Same-community' social connections are important in reducing loneliness and isolation among older people from CALD communities
- Feeling lonely and isolated can be a source of shame and embarrassment that might discourage people from seeking help.

For people identifying as LGBTI:

- Sexual identity remains an important marker of risk health and wellbeing outcomes in Australia
- Sound understanding of the particular needs of lesbian, gay, bisexual, transsexual and intersex people is required
- LGBTI people and same-sex attracted youth (SSAY) residing in rural areas may have more experiences of victimisation, feel less comfortable in disclosing sexual identity and less likely to be involved in the LGBTI community than people living in urban areas
- Inclusive, culturally competent and responsive healthcare is important
- Strength-based approaches likely to be more effective than focusing on problems
- Parents and guardians need good information for supporting SSAY.

For farmers and farming families:

- Farming can involve social isolation but people may not necessarily feel lonely
- Pressures created as a result of climatic and sector changes are impacting on the mental health of farmers
- It is important to consider gender contexts for understanding and responding to risks for poor mental health and resilience among farmers and farming families
- Women moving onto husbands' farm can experience feelings of loneliness and isolation that persists for many years
- Farming men are more receptive to outreach and community-based services delivered by messengers perceived to have similar lifeworld experiences.

In addition to reviewing relevant evidence for these five populations, the evidence summary opens with a brief explanation of how the COVID-19 pandemic has spotlighted issues of relationships between loneliness and social isolation and mental health and wellbeing. We also provide an overview of how loneliness and social isolation are generally conceptualised in the empirical literature that was surveyed.

Limitations

In efforts to deliver a review of evidence for five population groups who generally have markedly contrasting circumstances, the summary is limited in the breadth and depth of relevant empirical studies that could be reviewed. We limited our initial search to the *Scopus* database, and although it is one of the largest databases providing citations and abstracts for peer-reviewed scientific studies, we are likely to have missed key studies cited in other major databases including *Pubmed*, *Medline*, *Infomit Health Collection*, the *Cochrane Library* and others. Further, we have not searched for 'grey' literature – reports and other

publications – that are produced outside of academic publishing channels and which could provide helpful insights into the focus topics. Selected studies are also restricted to research largely focusing on OECD countries, and papers were not assessed for rigour. The rationale for this was that studies that might be deemed as lacking rigour because they use qualitative methods to explore experiences of small numbers of participants likely reflect the challenges of conducting research with participants who may be socially marginalised, lack proficiency in English, unlikely to participate in surveys or experience other barriers to participating in research. When limited evidence is generally available these studies can offer potentially useful insights into people's situations.

It should be noted that five population groups are identified for the focus of this review, however, they are not meant to be inclusive of groups at risk for experiencing loneliness and isolation. In addition to young people being more likely to report experiences of loneliness (AIWH, 2019), a recent systematic review identified a diversity of other circumstances associated with risks of becoming socially isolated. These included parenting and caregiving, living with chronic disease, living with disabilities and mental health issues, former defence force personnel, parolees, people experiencing bereavement, and survivors of intimate partner violence (Bessaha et al., 2020). It remains important to understand how physical and social distancing measures may be impacting on these community members.

Issues informing the evidence review

The COVID-19 pandemic has put a spotlight on the benefits and risks of social isolation. Social distancing measures have been central in global efforts to curb the transmission of the virus, leaving people spending extended periods of time largely confined to their homes and avoiding face-to-face social interactions. While these measures are effective in curbing the transmission of the COVID-19 virus, there are widespread concerns for the impacts they are having on people's livelihoods, and their physical and mental health and wellbeing. These concerns are informed by strong evidence that social connection and interaction are critical to health (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Sonderlund, Thilsing, & Sondergaard, 2019).

People experiencing loneliness and social isolation prior to the emergence of COVID-19 may be particularly vulnerable to experiencing short- or longer-term mental health problems associated with social lockdown conditions. These concerns map onto general observations of growing problems of loneliness in contemporary, relatively well-off societies, although evidence as to whether loneliness is increasing is mixed. Data compiled by the Australian Institute for Health and Welfare shows younger people more likely to report experiences of loneliness, along with men, and those living alone or with children (AIHW, 2019). A US study exploring the prevalence of loneliness among primary care patients found that 20% of participants were experiencing loneliness and they tended to be younger, single and have poorer health, while factors such as gender, race and living in an urban or rural area were not significant (Mullen et al., 2019).

Adversities such as natural disasters (and pandemics) can profoundly disrupt the routines and rhythms of everyday life, if not in some cases, obliterate its possibility. When social relations are disturbed and unsettled it can increase experiences of loneliness and social isolation and place people at risk for acute and long-term mental health problems. Indeed, studies focusing on the aftermath of disaster events paint a complex picture of the repercussions for

social connection and disconnection among those who are directly affected. In a review of the evidence, Kaniasty (2020) shows that disaster events can provoke experiences of social isolation even among individuals who were not socially isolated prior to being confronted with crisis situations. Further, while disasters can elicit frequently observed pro-social responses and strong experiences of social solidarity, these can coalesce around perceived 'in-groups' and in contrast to 'outgroups' (Kaniasty, 2020). Having close social ties is associated with lower levels of distress, however, over time, extended recovery phases can place immense strains on local social relations and networks with negative impacts for mental health (Bryant et al., 2017; Kaniasty, 2020).

During disaster events, socially isolated individuals and households can face additional struggles because they may not be aware of, or fully understand, what is happening, have not had opportunities or support to explore options for contingency plans, have few options for seeking help, or lack the financial resources to stock up on food, medicines and other essentials (Howard, Agllias, Bevis, & Blakemore, 2018). Among some populations, such as people from CALD communities, people may not be aware of, or lack trust in critical, but unfamiliar, sources for important information. This includes the media and emergency services, and they may lack access to historic and community information that can be important in preparing for, and weathering, crisis situations (Howard et al., 2018).

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Mental health effects of quarantine include confusion, anger, frustration, boredom, concerns about supplies, and feelings of stress related to job insecurity and financial losses.

While there is growing evidence exploring how individuals and communities respond to disaster events such as bushfires, floods, cyclones and other extreme weather events, there is less evidence for the psychological impacts of quarantine. A recent systematic review found numerous mild to moderate mental health effects of quarantine including confusion, anger, frustration, boredom, concerns about supplies, and feelings of stress related to job insecurity and financial losses (Brookes et al. 2020). Some studies found that these effects remained evident for extended periods of time. People with pre-existing mental health issues and health workers were at particular risk for experiencing negative psychological impacts (Brooks et al., 2020).

Generally, evidence shows that while there are patterns associated with disaster events, they place distinctive kinds of demands on communities and populations according to complex and interrelated factors. The COVID-19 pandemic is an unprecedented global event and there are few available insights into how people have managed and recovered from similar kinds of crises, or how pressures and strains have differing impacts across individuals, households and communities. Understanding related risks for populations vulnerable to social isolation can offer insights into how social distancing measures may be impacting on mental health, and how individuals can be best supported.

This evidence summary focuses on the five sub-populations in rural communities who are vulnerable to experiencing increased levels of loneliness and isolation and, linked to this, poor mental health, because of circumstances imposed through physical and social distancing measures. They are:

- Older people
- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse communities (CALD)
- People identifying as lesbian, gay, bisexual, transsexual and intersex (LGBTI)
- Farmers and farming families

For some of these groups, their situations may not necessarily be well-recognised or understood in the community and social distancing strategies may have varied and unanticipated emotional, economic and practical consequences.

Method for reviewing the evidence

Although there is little consensus on defining rapid evidence reviews, there is broad agreement that they offer a stream-lined approach for synthesising evidence in a timely, concise and useable format (Khangura, Konnya, Cushman, Grimshaw, & Moher, 2012). Critically, they require a structured approach for identifying and searching evidence that addresses a carefully designed question. There is a range of views on the kinds of evidence that might be included in evidence reviews with some opting for tight criteria of admissible evidence (using established strategies for ranking the rigour of studies) while others argue that inclusive search strategies can be justified (Featherstone et al., 2015).

This evidence summary focused on five populations with differing circumstances and life-world contexts, and so we opted for an approach that combined systematic and exploratory approaches. This was necessary because some populations (for example, aging populations) have been the focus of considerable research exploring the impacts of isolation and loneliness on mental health, while other groups (for example, people from CALD communities) have received less attention from researchers. The key question guiding the review of the evidence is: *What factors are associated with experiences of social isolation and loneliness among key vulnerable populations?* Keywords 'loneliness', 'isolation' and 'mental health' were used to identify relevant articles in the Scopus database. While this combination of key words were effective in identifying relevant articles exploring the situations of older people, people from CALD communities and farmers/farming families, the more general search term 'mental health' was used to identify potentially relevant articles for Aboriginal and Torres Strait Islander peoples and LGBTI populations. The reference lists of relevant articles were also scanned to identify additional papers.

Articles were examined for insights into associations between loneliness and isolation and mental health to identify contextual and causative factors, associations between factors and insights from interventions. We also reviewed a number of articles to understand how concepts of loneliness and isolation were commonly conceptualised and operationalised in empirical studies.

In discussing the situations of Aboriginal and Torres Strait Islander peoples we recognise that different terms are used by different writers to refer to these populations. We recognise that many Aboriginal and Torres Strait Islander peoples prefer this description, however, in discussing the findings we use descriptions from the source texts. This is because we refer to research conducted in different countries and this minimises potential for misinterpretation.

Conceptualising loneliness and isolation

Concepts of loneliness and isolation were frequently used in empirical studies to conceptualise subjective and objective perceptions of forms of mental unease and distress. Loneliness is also used as an indicator for quality of life (QOL) and as a health determinant because of consistent associations with mental and physical health outcomes (Bessaha et al., 2020). Generally, loneliness is considered a subjective experience that conceptualises ‘discrepancy between desired and achieved levels of social participation’ (Bessaha et al., 2020 p.111). Loneliness is also conceptualised as ‘painful isolation’ to distinguish between solitude (which can be desired and relished) and unpleasant and even distressing feelings arising from a lack of social contact and involvement in satisfying interpersonal relationships (<https://ourworldindata.org/social-connections-and-loneliness>). Drawing on these insights, loneliness cannot be assumed from measures of actual social connections and contacts because individuals with relatively few social contacts may not desire more social interaction while individuals who have relatively high numbers of social contacts may still experience feelings of loneliness.

Nonetheless, as a subjective measure, loneliness is frequently associated with objective situations of social isolation, which are usually measured through involvement in social networks and other forms of social connection (Syed et al., 2017). An early study conceptualised experiences of loneliness as consisting of both social and emotional dimensions that should be separated out for analysis (Cattan, Newell, Bond, & White, 2003), although ‘social loneliness’ is likely referring to objective situations of isolation, with ‘emotional loneliness’ describing subjective experiences. Complicating matters, there is some divergence on the meanings of key concepts. For instance, while some researchers use the concept of ‘connection’ as similar to ‘networks’ (Berthold et al., 2019), others understand ‘connection’ as offering a subjective and qualitative assessment of social participation and a sense of belonging in which a lack

of connection is associated with loneliness (Bletscher, 2020). Systematic reviews also work with multiple definitions of key concepts and combine findings from studies drawing on diverse, but related, concepts and measures of loneliness, social isolation, social integration, connectedness, social support and social networks (and the latter might focus on size, content and/or quality). Contexts for network characteristics are frequently overlooked but important because the benefits and demands of social connection can shift across social, economic, cultural and other contexts (Warr, 2006).

There is a considerable body of research exploring specific contexts and circumstances in which individuals have heightened risks for experiencing loneliness and isolation, and the implications for their mental health. Exploring vulnerability to experiencing loneliness and isolation, a recent systematic review identified a diversity of circumstances, including parenting and caregiving, living with chronic disease, living with disabilities and mental health issues, being

‘Painful isolation’ distinguishes between solitude (which can be desired and relished) and unpleasant and even distressing feelings arising from a lack of social contact and involvement in satisfying interpersonal relationships.

elderly, having an immigrant or refugee background, former defence force personnel, parolees, people experiencing bereavement, and survivors of intimate partner violence (Bessaha et al., 2020). Other studies note associations with gender, life course stages (late adolescent/early adulthood and among older people), and in the aftermath of natural disasters (Bryant et al., 2017; Howard et al., 2018; Kaniasty, 2020).

We identified fewer studies that discussed interventions to address loneliness and promote social participation because this would require specific search strategies. Many articles included some general comments about potential strategies. One particular approach is emerging in recent publications suggesting the potential of strategies such as 'social prescribing' and a brief overview is included here.

Social prescribing

There is an emerging area of work exploring the potential of 'social prescribing', also known as 'community referral', as an approach for linking individuals living in the community to existing local non-clinical health, welfare, and social support services (Drinkwater, Wildman, & Moffatt, 2019). Social prescribing can include a variety of activities linked with voluntary and community sector organizations (walking groups, nature-based interventions and community gardening). Social prescriptions are designed to provide a holistic approach to a patient's care by working in concert with their existing clinical treatments. Although relatively new in Australia, international evidence has demonstrated these social prescribing programs to be linked with improvements in quality of life (including loneliness) and health status (Aggar, Thomas, Gordon, Bloomfield, & Baker, 2020).

In recent years, the positive impact of nature-based social prescribing (i.e. referral to nature-based community services and resources) on strengthening social networks, facilitating social connectedness and reducing stress has received much attention (Cartwright, White, & Clitherow, 2018; Leavell et al.,

2019). Importantly, in urban settings the presence of accessible natural environments and green spaces such as parks or golf courses within a 500m zone has been found to increase a sense of community belonging which, in turn, can reduce the likelihood of psychological distress (Rugel, Carpiano, Henderson, & Brauer, 2019). Social prescribing programs have been found appropriate for reaching a range of high-risk populations including recent immigrants, older adults, economically and linguistically isolated populations (Leavell et al., 2019). These kinds of programs could be difficult to establish in rural settings, however, because access to resources remains dependent on what is available in local environments. Physical and social distancing measures also limit available options, although it could be worthwhile to explore the potential of online alternatives to meet some needs.

The following sections summarise insights from studies exploring the situations of the key vulnerable populations that are focus of this rapid evidence review.

Accessible natural environments and green spaces have been found to increase a sense of community belonging which, in turn, can reduce the likelihood of psychological distress.

Loneliness and isolation among aged populations

Issues of loneliness and isolation among the elderly is a focus for a considerable amount of international research addressing heterogeneous circumstances, including ethnicity, socioeconomic status, and living in community and residential settings. In these studies loneliness is consistently identified as an important influence on quality of life in older age and lower levels of reported loneliness have been identified as a strong predictor of perceived wellness (Santini et al., 2020). Although, among the general population, younger people are more likely to report being lonely (AIHW, 2019), risks of becoming lonely and socially isolated are strongly linked to life-course changes. Loss of mobility and increasing frailty as people age means they increasingly rely on others coming to visit, including them in social occasions, and providing other forms of support and assistance. Studies have found that 'living alone' and 'feelings of loneliness' are independently associated with higher risk of mortality in older men (Henriksen, Larsen, Mattisson, & Andersson, 2019; Holwerda et al., 2012). These indicators may be useful as readily available psychosocial measures to identify vulnerability in community-dwelling older adults.

In addition to physical changes associated with aging that heighten risks of becoming lonely, older people experience loneliness and social isolation through bereavement at the loss of spouses and friends. Contexts of contemporary life can also mean that older people may be living some distance from adult children and their families, who themselves may have limited time for caring due to pressures and demands they are experiencing in their own lives (Beutel et al., 2017; Cohen-Mansfield, Hazan, Lerman, & Shalom, 2016; De Koning, Stathi, & Richards, 2017). Spotlighting issues of associations between declining mobility and risks of loneliness as people age, a large Irish study of over 8000 people examined associations between transport mode and driving status with depressive symptoms, quality of life, loneliness, monthly involvement in active social leisure activities and volunteering and social network strength (Donoghue, McGarrigle, & Kenny, 2019). Logistic regression analysis found that the ability to travel independently (i.e.

Loneliness is consistently identified as an important influence on quality of life in older age and lower levels of reported loneliness have been identified as a strong predictor of perceived wellness.

driving, being driven by a spouse/partner or taking public transport) was associated with better indicators of social participation and psychosocial wellbeing versus relying on lifts from family/friends.

There is also some evidence that while the prevalence of mental health problems among older people is difficult to assess, informal social support available to older rural people may have some protective effects. This was suggested in findings that noted lower rates of mental health problems among older residents of rural areas compared to those living in urban areas (Beere, Keeling, & Jamieson, 2019; Henderson, Crotty, Fuller, & Martinez, 2014; Henning-Smith, Moscovice, & Kazhimannil, 2019), although this is likely to vary for sub-populations (Henning-Smith et al., 2019). There is also evidence that social network structures and function (how networks operate to create and circulate social support and other resources) vary and different structures can be strongly intertwined with anxiety and depression symptoms in the general population of older adults. The presence of social capital, as measured by social network size, and the degree of community participation are also strongly linked to mental wellbeing (Nyqvist, Forsman, Giuntoli, & Cattani, 2013) and perceived wellness (Hodgkin, Warburton, & Hancock, 2018).

Research has found lower rates of mental health problems among older residents of rural areas compared to those living in urban areas.

Cattan et al. (2003) argue that there are tendencies for programs and activities addressing loneliness and isolation among older people to evolve out of the needs of current participants and this generates risks of overlooking the needs and situations of older people in other situations. These authors recommend that when developing services intended for isolated and lonely older people, it is helpful to distinguish between those who are 'active lonely' and those who are isolated because of their frailty. Program design and community engagement should seek to understand these different contexts for becoming lonely and potential barriers they present in accessing available support.

Promoting social connections through digital technologies

Information and communication technology (ICT) can enhance social connections, reduce loneliness, provide mental stimulation and transform how older people engage in social activities (Berg, Winterton, Petersen, & Warburton, 2017; Kim, Lee, Christensen, & Merighi, 2017). Over recent years, the use of ICTs including e-mail, the Internet, chatrooms, voice technology (on Smart phones, PCs and tablets) by older adults has steadily increased. Research indicates, however, that in contrast to younger adults there are notable gender differences in the access and use of ICT in the aged population (Gell, Rosenberg, Demiris, LaCroix, & Patel,

2015). For example, men are more likely to access ICT than women and more likely to use the Internet for dealing with health matters, compared to women. Conversely, ICT access is associated with an increased likelihood of women visiting with family or friends.

Residential aged care

Studies find associations between mental health problems and living in residential aged care/nursing homes, however, the picture is complex. Drawing on general population data, research from NZ shows that associations between aging, loneliness and living in residential care vary across socioeconomic status, ethnicity and geographic location (Beere et al., 2019). A key finding from this study are lower rates of loneliness among people living in rural areas (both in residential care and community-dwelling). Other research from NZ found that the prevalence of 'death wishes' – suicide ideation and suicide attempts – and 'weariness of life' was found to be almost 10 percent among older people being assessed for long-term residential care. These feelings were associated with poorer physical and mental health, loneliness, diminishing involvement in social activities and impaired cognitive functioning (Cheung, Edwards, & Sundram, 2017). More specifically, people expressing death wishes experienced a higher incidence of falls, fatigue, struggles with pain and other stressors. In addition to strongly indicating poor quality of life for many aged people, the study noted that previous research found associations between death wishes and higher mortality from all causes, suggesting that there can be varied benefits in supporting people as they age to be generally well, safe and free from pain as far as this is achievable (Cheung et al., 2017).

Otherwise, much of the evidence that we located focused on older adults in non-OECD countries and findings may not be directly applicable to Australian contexts. These studies found that older adults living in residential aged care are more likely to develop mental health disorders, particularly depression (Seddigh et al., 2020), compared with older adults living at

home (Ibrahim, Al-Lami, Al-Rudainy, & Khader, 2017). Increased levels of perceived support have been linked with improved physical health and reduction in suicidal thoughts (Zhang et al., 2018). Art therapy activities have been found to be beneficial for increasing happiness (Barfarazi, Pourghaznein, Mohajer, Mazlom, & Asgharinekah, 2018) and reducing depression (Ching-Teng, Ya-Ping, & Yu-Chia, 2019) of older adults in residential care. Incorporation of art therapy activities in social support programs may help maximise the positive effects of these programs.

Many of the studies exploring associations between loneliness, mental health and aging focused on particular sub-populations and these insights are incorporated into relevant sections below. Critically, these findings show that in addition to circumstances associated with aging, social environments are important for understanding how older people become lonely and isolated, and should be considered when developing effective responses to such situations.

There are varied benefits in supporting people as they age to be generally well, safe and free from pain as far as this is achievable.

Key points

- Risks of becoming lonely and isolated are strongly linked to life-course changes and situations
- The 'active lonely' may experience psycho-social barriers to social participation
- Men and women can respond to living alone and social isolation in different ways
- Older people are using ICT to enhance social participation and stay connected with family and friends.

Conceptualising poor mental health for Aboriginal and Torres Strait Islander peoples

The concept of loneliness and social isolation was not relevant for understanding poor mental health among Aboriginal and Torres Strait Islander/ First Nations people and the search term did not identify any articles. The evidence unanimously underlined that physical, mental, social and emotional health and wellbeing (SEWB) for Indigenous people sits within a holistic and whole-of-life view of health, which recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and the significance of these connections for individuals (Butler & al., 2019). Mental health risks are linked to separation from family and community, historical trauma, racism, quality of social relationships, community processes and generalised community wellbeing. Consistent across the literature are calls for sustainable, and culturally appropriate services, that understand the cultural and social contexts and histories of Aboriginal and Torres Strait Islander peoples, apply models of trauma-informed care and focus particular attention on the needs of young Indigenous Australians (Balaratnasingam et al., 2019).

A large body of research focuses on elevated suicide rates among Indigenous youth. Insights broadly suggest risks for suicide are associated with exposure to severe childhood adversity and challenges faced by young people navigating rapid culture change and socio-cultural dislocation (Gone & Kirmayer, 2020). Healing from trauma, including intergenerational trauma are viewed as key to enhancing wellbeing. Studies note the importance of recognising the effects of stress arising from external conflicts and life problems on the mental health of Indigenous Australians, while avoiding attributing these issues to personality or Indigenous identity. Approaches for improving social and emotional wellbeing include processes of “meaning making”, a narrative-based approach to fostering resilience, exploring cultural strengths and harnessing cultural constructs through interactive techniques such as yarning circles, art, music or dance’ (Balaratnasingam et al., 2019:349). A review of promising strategies for promoting mental health among Indigenous children identified six enabling

factors: involvement of wider community; easy to access (including cost); collaborative involvement of multidisciplinary health services; strong relationships between partners and community; cultural sensitivity, and organisational and staff capacity (Lopez-Carmen et al., 2019). A Canadian review of models to address cultural diversity in mental healthcare identified key areas in which policy innovation is urgently needed: 1. Cultural competence, safety and anti-racism training and accreditation standards for practitioners and for healthcare education, service systems and institutions; 2. National regulations and quality assurance standards to ensure use of language interpreters; 3. Development of a cadre of culture brokers to improve clinical communication; and 4. Integration of attention to culture in service systems design, as well as clinical practice (Kirmayer & Jarvis 2019).

While there is strong emphasis on developing cultural sensitivity for understanding and responding to mental health issues among Aboriginal and Torres Strait Islander and First Nations peoples, insights suggest that generic training is not necessarily effective. A study exploring the impacts of promoting cultural safety among staff of public mental health services can be found to contribute to further stereotyping and limit clinicians’ ability to integrate cultural knowledge in their assessments and interventions (Gone and Kirmayer, 2020). Other researchers also found that generic training related to the broad area of Indigenous health

Consistent across the literature are calls for sustainable, and culturally appropriate services, that understand the cultural and social contexts and histories of Aboriginal and Torres Strait Islander peoples.

and health service needs did not appear to evolve into informed specialist mental health nursing practice for Indigenous Australian service users (Molloy & al., 2019). Rather, promoting cultural sensitivity requires 'more nuanced, multidimensional, and interactional views of culture' and broader institutional commitments to addressing cultural issues (Gone and Kirmayer, 2020). There are also concerns that trauma-related psychotherapies seeking to assist patients move from the position of victims to survivors and, ultimately, to resilient thrivers may reinforce an individualistic 'egocentric' self and may be at odds with traditional cultural values and self-orientations (Gone and Kirmayer, 2020, 244).

Other research explores how current social support might buffer the effects of historical trauma and associated mental dis-ease, depression and anxiety. A secondary analysis of survey data collected in two First Nation communities in Ontario, found that among women, there was a significant interaction between low social support, experiences of childhood adversities and experiences of depression and/or anxiety, and insignificant associations among women with high social support, although similar associations were not evident among men (Bernards et al., 2019).

Promoting mental health and wellbeing

Drawing on these insights, there were many studies examining programs and interventions to improve mental health and wellbeing for Aboriginal and First Nations people. For example, Morton et al. (2020) present a protocol for a research-to-action program – Mental Wellness Program (MWP) – which aims to increase community capacity, promote relationship-building among communities, and close gaps in services through processes that place value on and support Indigenous communities' rights to self-determination and control. Critically, MWP will use local community data to address (sometimes interrelated) mental health, substance use and violence (MSV) challenges by building on community supports and resilience factors. The MWP program also aims to

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share exemplary knowledge-to-action models and wellness strategies developed by and for First Nations people. To develop this knowledge the proposed study has four key phases: intensive data collection at the individual; service provider and community levels to provide comprehensive understanding of MSV – related issues and data synthesis to identify a priority area for strategic development based on local strengths and need; participatory action research to develop, implement, and evaluate the MWP addressing the selected priority area; and then developing and implementing effective knowledge-sharing initiatives. Guidelines and models for building the MWP are shared regionally and provincially through forums, webinars, and social media, as well as cross-community mentoring.

A study by Tu (2019) found that encounters with Indigenous Elders as part of routine primary care were associated with a clinically and statistically significant reduction among Indigenous patients in presentations at hospital emergency departments, depressive symptoms and suicide risk. They conclude that further expansion and evaluation of the role of Indigenous Elders as part of routine primary care is warranted. Other studies have examined the effectiveness of widely available programs such as Mindspot, Mental Health First Aid (MHFA) for assisting Indigenous Australians to manage mental dis-ease. One study examining outcomes of individuals accessing Mindspot, an online assessment and treatment program for treating anxiety and depression, found that although Indigenous Australians had higher symptom scores at

initial assessments and reported more psychosocial difficulties, there were similar outcomes for Indigenous and non-Indigenous Australians among those who completed the treatment course (Titov, Schofield, Staples, Dear, & Nielssen, 2019). The number of Indigenous men who completed the treatment course was too small to be able to draw firm conclusions about its efficacy in this population, and indicates the need for a further evaluation with a larger sample (Titov et al. 2019, 253 & 255).

A culturally-relevant version of the Mental Health First Aid program called Mental Health First Aid First Nations (MHFAFN), have been developed in Canada and acknowledges the significance of cultural safety and collective trauma (Auger, 2019). A MHFA course focusing on Aboriginal and Torres Strait Islander Australians has also been developed (<https://mhfa.com.au/courses/public/types/aboriginal>). Participants and facilitators have identified a range of factors that promote cultural safety, including the knowledge and skills of the facilitators and the cultural components of the course. A panel of Aboriginal and Torres Strait Islander people with expertise in non-suicidal self-injury (NSSI) were able to reach consensus on appropriate strategies for providing mental health first aid to an Aboriginal and Torres Strait Islander engaging in NSSI. The re-development of the guidelines has resulted in more comprehensive guidance than the earlier version. The re-developed guidelines were envisaged to inform the basis of an Aboriginal mental health first aid short course on NSSI for Indigenous community members and non-Indigenous frontline workers (Armstrong et al., 2017).

A number of studies identified the value of sport in promoting mental health, wellbeing and healing (Dalton, Wilson, Evans, & Cochrane, 2015; Dockery & Gorman, 2017; Stronach, Maxwell, & Pearce, 2019). Based on interviews and findings from a recent Australian Parliamentary inquiry into Indigenous health and wellbeing Stronach et al. (2019) concluded that Indigenous women can become empowered to improve

their mental and physical health through participation in sport. Indigenous women-only opportunities, partnerships with health agencies and sports organisations, culturally safe spaces and Indigenous women acting as role models were identified as factors that may augment Indigenous women's agency, and thus empowerment (Stronach et al. 2019). Analysis of the 2012 Mission Australia Youth Survey (MAYS) found that among Indigenous youth aged 15–19 years there was a positive relationship between self-reported participation in sport and rating of overall health and risk of mental health disorder (Dalton et al. 2015). Using a single question to rate their general health on a scale of 1–5 and the Kessler 6 non-specific psychological distress scale it was clear that the proportion of Indigenous youth with negative outcomes was greater for both general and mental health measures. Among youth who participate in sport there are substantially smaller proportions who are in poor health or at risk of serious mental illness.

Developing Aboriginal-specific measures of mental health and wellbeing

Alongside research focusing on mental distress/health and wellbeing is a strand of work exploring culturally relevant ways of conceptualising and measuring health and wellbeing. These efforts respond to critiques of Western atomistic frameworks, which can imply that Native identities are themselves risk factors for poor health, rather than historical and systematic

Expansion and evaluation of the role of Elders as part of routine primary care is warranted.

factors which frame people's lives and opportunities. Further, domains of wellbeing relevant to and valued by Indigenous Australians may not be included in existing QOL and wellbeing instruments. A synthesis of literature relating to QOL and wellbeing of Indigenous Australians revealed nine broad interconnected wellbeing dimensions: autonomy, empowerment and recognition; family and community; culture, spirituality and identity; Country; basic needs; work, roles and responsibilities; education; physical health; and mental health (Butler et al. 2019).

Mental health issues for older Aboriginal people

Many studies noted the need to consider the services available to Indigenous people over 50 living in the community and the possibilities for culturally developed community facilities for the ageing; see Broe (2019) for an overview of some key contexts and issues.

Key points

- Cultural sensitivity and an Indigenous workforce are foundations for effective services and programs
- Some evidence that mainstream mental health promotion programs can be tailored to meet the needs and circumstances of Aboriginal and Torres Strait Islander peoples
- The involvement of Indigenous Elders in designing and delivering health and wellbeing programs can enhance their effectiveness
- Traditional medicine can have a role in promoting health and wellbeing.

Loneliness and isolation among culturally and linguistically diverse (CALD) populations

The selected studies focused on immigrant groups in mostly English-speaking settler nations, including Australia, Canada, New Zealand, United Kingdom (UK), United States (US) and some European countries. These countries have relatively high proportions of CALD populations and some shared contexts for migration. These include: forced migration (humanitarian resettlement programs and asylum seekers), voluntary migration (relocating as skilled migrants, international students, joining spouses), children accompanying their families and adults migrating through family reunification schemes. Studies conducted in populous countries such as the US, where there can be relatively high numbers of immigrants frequently focus on specific ethno-cultural groups (particularly immigrants identifying as Chinese, Korean and Latinx) and have relatively large sample.

Studies from other countries, including Australia, usually have smaller, and culturally diverse, samples of participants. An early review article focusing on older people from CALD communities in Australia noted that most of the available evidence is generated largely through small scale, localised studies (Rao, Warbarton, & Bartlett, 2006), and this appears to remain largely the case. Despite being gathered together, it is important to understand that CALD populations are highly heterogeneous and have diverse histories and socio-political contexts for resettlement that influence settlement experiences, opportunities and capacities for adaption and integration with host societies and other circumstances that contribute to experiences of loneliness and social isolation.

Connections to local (host) communities are particularly important for experiencing a sense of belonging in adopted countries.

While the prevalence of mental health issues among CALD community in Australia remains poorly understood (Wohler & Dantas, 2017), available evidence suggests strong associations between loneliness and social isolation and poor mental health in these populations. Studies focusing on immigrant populations emphasise the social environmental factors that present significant challenges to social integration, belongingness, and self-sufficiency (Bletscher, 2020). Lee et al. (2020) note that people with immigrant backgrounds can encounter significant barriers to being socially connected with wider (majority) populations. These include language barriers in establishing new networks, disrupted and fragmented family and friendship networks following immigration, discrimination and the cyclical effects of poor mental health that is the legacy of experiences of trauma and depression (Berthold et al., 2019). Some studies use a social exclusion lens to show how CALD communities can be cut off from some resources and supports (Salma & Salami, 2019).

Among CALD communities, the concept of social isolation is used to understand the impacts of individual-level connection and disconnection from co-ethnic networks and the community-level contact and interaction with majority populations, although they can have different contributing factors and implications. While co-ethnic connections with family, friends and community are important sources of everyday social support that enable people to 'get by' (Lee et al., 2020), being connected in wider community networks can provide access to social and economic and other opportunities that enable people to 'get ahead' (Warr, 2006). Connections to local (host) communities are particularly important for experiencing a sense of belonging in adopted countries (Klok, van Tilburg, Suanet, Fokkema, & Huisman, 2017), even as many people with immigrant-backgrounds sustain strong transnational networks.

Many factors influence the implications of connection and disconnection following resettlement for mental health and wellbeing. A US study of a

Risks for loneliness and isolation generally shift across stages of post-migration and socio-demographic circumstances.

regional population of Cambodian immigrants found associations between limited community engagement, high levels of social isolation and poor mental health (Berthold et al., 2019). At the same time, social disconnection from the community was observed to also have some protective effects for mental health. These seemingly contradictory findings were attributed to adaptive strategies associated with surviving the brutality of the Khmer Rouge regime (which inculcated distrust towards neighbours) and because this population was relatively small compared to other enclave communities of Cambodian refugees in other parts of the US. The advantages of community connection are increased in larger communities with stronger institutional capacities. This study was unusual in examining social connections among people with immigrant-backgrounds over an extended post-settlement period. Findings suggested that being disconnected from the community may have had some short term benefits but these diminished over time because they inhibited access to community-based resources. Risks for loneliness and isolation generally shift across stages of post-migration and socio-demographic circumstances (Lee et al., 2020).

A study conducted in Netherlands found that even residents with migrant backgrounds who had multiple and frequent same-ethnic community network contacts and strong family relationships reported degrees of loneliness (ten Kate, Bilecen, & Steverink, 2020). This was attributed to feelings of homesickness and a lack of a sense of belonging to the host community. Pressures associated with resettlement, high expectations of members to succeed in their adopted country, role disruptions, and adult children

perceived as neglecting parents because of work and household commitments (reported in a number of papers focusing on immigration through family reunification schemes), can strain family relationships and contribute to feelings of loneliness and social isolation. People from immigrant backgrounds can also experience 'cultural loneliness' because they miss familiar ways of being and interacting, or often feel misunderstood in their host culture. A narrative review conducted by Calati et al. (2019) found that living alone and feeling alone was associated with increased risk for suicide, although these risks differed across ethnic groups and host countries.

Contexts for migration also explain factors associated with loneliness and social isolation. Humanitarian refugees, for example, can experience high levels of PTSD, depression and anxiety that may interfere with capacities to interact in unfamiliar social settings and learning new things, including a language. An analysis of longitudinal data shows that following resettlement in Australia, humanitarian refugees initially experienced improved mental and physical health but these then worsened over time. They attributed this to loneliness and other integration stressors (Chen, Wu, Shuxian, & Renzaho, 2019), although the authors conceded a potential bias in the study's findings in that healthier participants may have tended to drop out of the study.

Some studies have considered how CALD communities are able to prepare for, and recover from disasters and these findings offer some insights into capacities for CALD communities to manage in crisis situations associated with COVID-19 pandemic. This includes evidence that CALD groups may be less prepared for disaster events because of language barriers, a lack of appropriate educational materials, and a limited understanding of local geography and associated hazards (Eisenman, Glik, Maranon, Gonzales, & Asch, 2009; Hansen et al., 2013; Howard et al., 2018). People from CALD communities may also have additional risks associated with low household incomes and limited purchasing capacity to prepare for disasters, housing-related issues such as small, over-crowded or sub-

standard housing that impact on capacities to stay safe or cope in the aftermath of disaster events, and find information sharing strategies such as community meetings less helpful (Howard et al., 2018; O'Neill, Zanobetti, & Schwartz, 2003).

Language barriers contributing to loneliness and disconnection

Language barriers are consistently noted as an impediment for people who have immigrated from non-English-speaking backgrounds in accessing social support and other resources and establishing diverse social connections. In a longitudinal study that explored associations between language and interaction with majority populations, Tip et al. (2019) found that proficiency in the language of host societies was associated with increased wellbeing. Suggesting the complexity of understanding how language facilitates different kinds of social interaction and connection, another study focusing on Latinx (a gender-neutral term referring to people of Latin American descent) communities in the US found that speaking better English than Spanish is associated with increased feelings of loneliness (Lee et al., 2020). The researchers speculated that this could be related to feeling not quite part of either community.

Aging members of CALD communities

Many studies focus on aging members of CALD communities. A longitudinal study focusing on older Hispanic Americans found high levels of depression among older members of the community, although this was mediated by factors such as having positive spousal support, or a history of experiencing depression or chronic disease (Muruthi, Zalla, & Lewis, 2020). Risks of loneliness and social isolation in older age are related to the specific kinds of challenges that people with migrant backgrounds experience in forging and maintaining social connections, particularly if individuals were not proficient in speaking the language of the host society. People with migrant-backgrounds in these situations are often referred to in the

literature as being 'unincorporated' or 'unintegrated'. Despite this, older immigrants nonetheless are able to participate in, and contribute to, civic society through experiences of 'co-ethnic incorporation' into closely connected older immigrant communities that offer valued forms of social connection and belonging (Wright-St Clair & Nayar, 2017). This suggests that promoting opportunities for 'same culture' social interaction can have positive benefits for older people.

People who immigrate at older ages, often through family reunion schemes where middle-aged and elderly adults move to be with adult children, are particularly vulnerable to experiencing loneliness and social isolation. This is because, for different reasons, it is more difficult to learn a new language and establish new networks at older ages (Caidi, Du, Li, Shen, & Sun, 2020). As people age and become increasingly reliant on health and social services, the challenges of language and navigating unfamiliar health service systems can have cascading effects for everyday life. It's a period of life that can also involve changes in family dynamics and migrants might experience dissonance between their dreams of joining children in their new lives and the reality of coming to grips with a strange language, customs and the loss of friends and familiar neighbourhoods (Caidi et al., 2020). These researchers also found that migrants who had moved through family reunification schemes tended to be more satisfied with independent living arrangements, however, financial constraints frequently limited their options. Family-centric cultures can mean that being lonely is experienced as a source of shame and embarrassment leaving people reluctant to admit they are feeling this way (Park, Morgan, Wiles, & Gott, 2019).

Responding to loneliness and social isolation in CALD communities

Some studies identify strategies for addressing loneliness and isolation among people from CALD communities. These are generally multi-faceted and involve improving social skills among individuals, increasing social support, increasing occasions for

social contact and, where appropriate, providing some individuals with more intensive support for mental health issues (Calati et al., 2019). A review of interventions to reduce loneliness, found five studies focusing on the experiences of people with immigrants and refugee backgrounds and all described face-to-face interventions that aimed to increase access to social support (Bessaha et al., 2020). The review also showed that while group interventions can in themselves provide social support and reduce loneliness, on-line programs have increased potential to be tailored to specific sets of circumstances and needs (Bessaha et al., 2020). Stewart et al. (2012) discuss an initiative using peer support workers in face-to-face sessions to increase social support for African women with refugee backgrounds living in Canada. In Denmark, women's clubs have been used to address loneliness among women with immigrant backgrounds (Povlsen, 2012). The clubs offered opportunities to socialise with others with similar ethnic backgrounds and become acquainted with aspects of Danish society, although they required considerable time to organise and proved difficult to sustain over the longer-term.

Studies also focused on the challenges that people in CALD communities might experience in seeking treatment and support for mental health illness. Most studies focus on the general community, although one study examines the challenges for women that are associated with language and communication, logistical (transport, cost, accessing specialist care, childcare), fear of losing children, stigma from own community, and cultural dissonance with health service providers who may have limited understanding of culturally-specific ways of understanding mental illness and its symptoms (Stewart et al., 2012). There is also poor understanding of the needs of CALD communities among many health professionals (Rao et al., 2006). Longstanding challenges associated with lack of ethnic specialist services in country areas, as well as a lack of culturally competent local health workers and limited translated health information may explain the low utilisation of available services by CALD communities

(Rao et al., 2006). People coming from countries where there is strong stigma towards psychiatric conditions can be reluctant to disclose problems to community members or to seek professional help (Rao et al. 2006). Generally, studies point to the need for more research to understand culturally-sensitive practices to support CALD communities to get through or live with mental illness, and how to better translate policies into practice.

Key points

- Evidence for associations between loneliness, social isolation and poor mental health in CALD communities
- Complex and varied contexts for immigration and resettlement influence the ways in which people can become disconnected and understanding these contexts should inform programs and interventions to reduce loneliness and isolation
- Language is a significant barrier to wider social participation for people immigrating as adults
- 'Same-community' social connections are particularly important for older people from CALD communities
- Feeling lonely and isolated can be a source of shame and embarrassment that might discourage people from seeking help.

People who immigrate at older ages, often through family reunion schemes where middle-aged and elderly adults move to be with adult children, are particularly vulnerable to experiencing loneliness and social isolation.

Exploring associations between loneliness, social isolation and mental health among LGBTI populations

While different acronyms are used to refer to people who identify as same-sex attracted and/or whose sexual identity and orientation does not conform to heterosexual norm – the ‘rainbow umbrella’ – we follow the National LGBTI Health Alliance and use the acronym ‘LGTBI’ (see their website for a discussion of these identities: https://www.lgbtihealth.org.au/lgbti_people_and_communities). While the studies we refer to use a range of acronyms, for the sake of consistency we stick with LGBTI because it is more inclusive with exceptions for studies involving only men or women. Following others, we also use the acronym ‘SSAY’ (same-sex attracted youth) when discussing research involving young people because it best reflects situations where they are attracted to others of the same sex but are yet to identify with LGBTI communities. Many studies note that LGBTI people have poorer mental health than the general population and specific medical and mental health needs (Carman, Corboz, & Dowsett, 2012; Perales & Todd, 2018).

Historically and in contemporary times, people identifying as LGBTI have been subjected to considerable stigma, discrimination, ridicule and abuse in educational settings, workplaces and personal life that contributes to emotional distress, depression and anxiety. There is widespread agreement that disapproving and demeaning attitudes and behaviour towards LGBTI people are shifting, although the pace of change is uneven. In Australia, a turning point was the Australian Marriage Law Postal Survey conducted in 2017 where citizens voted to legalise same-sex marriage. Nonetheless, research found that the postal survey served as a significant stressor to Australia’s LGBTI community (Casey, Wooton, & McAloon, 2020), and despite the growing acceptance of diversity within the wider community, many people continue to bear the burdens of stigma and discrimination. There is also varying levels of support and acceptance across the diversity of sexual identities that are important to recognise.

The Minority Stress Model is a key theoretical framework for understanding mental health risks for LGBTI people. The model postulates that we

live in a hetero-centric, gender-normative society that stigmatises and discriminates against LGBTI people and subjects them to chronic stress (Carmel & Erickson-Schroth, 2016). Consistent with minority stress theory, Australian research conducted after Marriage Law Postal Survey found that that LGBTI people living in constituencies with higher numbers of ‘No’ votes reported comparatively worse life satisfaction, mental health and overall health than those living in other areas (Perales & Todd, 2018). Another Australian study found notable disparities in the health and wellbeing profiles of different sexual minority populations in Australia. Among other findings, individuals identifying as bisexual had worse scores across a range of indicators, as did lesbian women compared to gay men (Perales, 2019). Perales (2019) argues that sexual identity remains an important marker of risk for health and wellbeing outcomes within Australia and underscores the importance of fully integrating sexual identity in health policy and practice.

Findings from international studies support these insights. In the US, the Behavioral Risk Factor Surveillance System surveys one of the largest samples of LGBTI adults across 10 states and finds marked health inequalities, including that bisexual women bear particularly high burdens of health disparities (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014). Another study found that people identifying as LGBTI have higher rates of depression than the general population and unique medical and mental health needs (Carman et al., 2012). A Canadian study found substantial differences in depression scores across (non-heterosexual) identities with transgender

There is widespread agreement that disapproving and demeaning attitudes and behaviour towards LGBTI people are shifting, although the pace of change is uneven.

and non-binary (identifying as neither male or female) individuals reporting higher scores for depression (Ferlatte et al., 2019). These identities have less acceptance in the wider community and this may be contributing to higher mental health burdens. Insights from an Australian study involving an online survey of 572 SSAY young men and women aged between 18–25 years offered support for the minority stress theory by showing that experiences of chronic social stress that was associated with poorer mental health (Lea, de Wit, & Reynolds, 2014). The study found high rates of psychological distress, suicidality, and substance use problems among respondents and moderate associations between the minority stress indicators and mental health outcomes. The authors argue that these associations suggest that SSAY should be a priority population for mental health and substance use intervention and prevention. SSAY residing in rural areas were found to be more likely to have strong religious beliefs, feel less comfort in disclosing their sexual identity to others, more experiences of victimization and discrimination, less likely to identify with or be involved in the LGBTI community, and report less perceived social support when compared to their non-rural counterparts (Rickard & Yancey, 2018). In these situations, SSAY can have increased exposure to minority stress and less access support to cope with these situations.

Poor mental health of LGTBI people, including depression, anxiety, substance abuse, suicidality, and risk behaviours, is associated with exposure to stigma, internalised homophobia, rejection from family and religious attitudes (for those growing up in religious households and communities). There is also some evidence that LGBTI women may be at increased risk for mental health concerns and disordered eating that may be related to issues of body image (Burnette, Kwitowski, Trujillo, & Perrin, 2019). A study by Al-Khouja et al. (2019) examined a subset of data from Understanding Society: the UK Household Longitudinal Study (UKHLS) where data was collected every year for a period of six years from adults aged 16 years and older from almost 40,000 households across the

UK. The subset of 882 respondents reported being lesbian/gay or bisexual in wave three, the first year in which sexual orientation was assessed. There is almost equal number of male and female respondents and 54% reported being 'gay/lesbian' and 406 (46%) reported being 'bisexual'. Their responses identified that being able to rely on others, feeling understood, and support for self-expression, in their relationships with parents, friends and intimate partners is related to long-term mental health. Support for self-expression was particularly important.

While a number of studies note risks for suicide ideation, associations between stressors placed on LGBTI people and attempted or completed suicide remain unclear. A paper published by Skerrett (2014) noted that sexual orientation is seldom recorded at death in Australia, and to date there have been no studies on the relationship between those that have died by suicide and sexuality or minority gender identity in Australia.

Inclusive services

There is growing evidence that services that are perceived to be LGBTI friendly are highly trusted, better utilised and more effective in meeting the needs of this population. With the increasing visibility of sexual minority groups there is a need to ensure that health service providers offer culturally competent and responsive healthcare that meets the needs of these diverse groups. A large study of health providers in the US identified implicit prejudices and bias among healthcare, including mental health care, professionals (Sabin, Riskind, & Nosek, 2015). A meta-narrative synthesis of 13 studies found that many LGBTI people feel that mental health practitioners displayed poor cultural awareness of sexual minorities, appear uncomfortable discussing sexuality, and were unhelpful or even harmful in their interactions with service users (McNair et al., 2018). This included experiences of discrimination and a pathologising of their sexual identity (McNair et al., 2018). Conversely, disclosing sexual identity to a regular, trusted GP is correlated

with improved utilisation of alcohol and mental health treatment among same sex attracted women. A review conducted by McNamara and Wilson (2020) calls for mental health professionals to receive education and training in LGBTI diversity, and for this to be ongoing. Further, it is important for mental health professionals to demonstrate LGBTI awareness and use affirmative approaches, including competence, openness, respect and not assuming someone's sexual identity. Services should actively demonstrate sexual identity inclusiveness by, for example, using posters in waiting areas, the way in which information is presented on websites, having practitioners who feel safe in being open about their sexuality, using open language on forms and having practitioners asking about sexual identity rather than making assumptions.

While there are many shared experiences, there are also concerns that grouping 'LGBTI' populations together under the inclusive 'rainbow umbrella' risks overlooking the specific needs of sub-populations. Given evidence of the extent of the psychosocial needs of people identifying as lesbian and bisexual, there is an opportunity to ensure that policy initiatives, such as public health, primary care, sexual health, and mental health, integrate and reflect their specific needs and issues (McCann & Brown, 2020). More generally, integrating the needs of LGBTI people within nursing and other health education programmes will contribute to raising the awareness of their distinct needs and concerns within mental health services (McCann and Brown 2020, 8).

It is important for mental health professionals to demonstrate LGBTI awareness and use affirmative approaches, including competence, openness, respect and not assuming someone's sexual identity.

Same-sex attracted youth (SSAY)

Meeting the needs of SSAY remains important. Baams et al. (2015) explored levels of coming-out stress, sexual orientation victimisation, perceived burdensomeness, thwarted belongingness, depression, and suicidal ideation and feelings of being a burden to family and friends. They considered that this may explain higher levels of depression and suicidal ideation among young people. The authors argued that these insights have implications for community and social support groups targeting SSAY, many of which base their interventions on decreasing social isolation rather than addressing youths' beliefs of burdensomeness. An online study of women aged between 18 and 28 who are mainly attracted to other women found that protective factors of trait acceptance, avoidance coping, and perceived lesbian, gay, and bisexual social support partially mediated the relationship between minority stress and depressive symptoms (Bergfeld & Chui, 2017).

Older LGBTI people

Sometimes referred to as the 'silver rainbow umbrella', studies also explored issues for LGBTI people as they aged. Despite the stresses, victimization and exposure to various forms of prejudice experienced by people identifying as LGBTI, a review of international studies found that people seem to have developed adaptive capacities and resilience that are helpful for managing the challenges of aging (Beauchamp & Chamberland, 2015). Protective factors, include involvement in supportive social networks and social support while other issues, including ongoing needs to conceal sexual orientation, internalised homophobia, and loneliness can impair mental health. Many of the mental health problems associated with advancing age among gay and lesbian seniors, remain similar to those observed in adulthood although feelings of loneliness may be an added burden (Fredrikson-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015; McCann & Brown, 2020). A US study found that physical and mental health Quality of Life (QOL) measures were negatively associated with discrimination and chronic conditions and positively with social support, social network size,

physical and leisure activities, substance non-use, employment, income, and being male when controlling for age and other covariates (Fredriksen-Goldsen et al., 2015).

Sexual minorities in CALD communities

We identified a few papers focusing on issues for people with immigrant background identifying as LGBTI. Carr (2010) discusses areas for awareness-raising and practice development, specifically those concerning the recognition of and provision for LGBTI people who are from black and minority ethnic (BME, an acronym most commonly used in the UK) backgrounds or who are seeking asylum in the UK. Bhugra, Gupta, Kalra, & Turner (2010) also explore specific problems related to migration, adjustment and acculturation among LGBTI individuals.

Promoting mental health and inclusion

Studies offered a range of insights for sustaining and improving mental health for LGBTI individuals. This includes reducing stigma, enhancing young people's safety, and supporting practitioners through training and resources. Adams, Dixkinson, & Asiasiga (2013) note the importance of involving LGBTI people in co-designing services and resources. A study by Allen, Hammack, & Himes (2012) identified the importance of services offering safe environments and access to social support and referral to critical services for LGBTI youth. Drop-in centres where youth can interact with peers are also valued, although could be difficult to sustain in rural areas with smaller populations. It is also important to be mindful of potential variation in the qualifications of peer support program facilitators and/or supervisors, suggesting that identifying critical skills may be helpful for this workforce (Allen et al., 2012).

Building self-esteem appears to have strong effects in negating the effects of stigma and discrimination suggesting that strengths-based approaches for working with LGBTI clients may be more effective than problem-focused approaches (Douglass, Conlin, Duffy, & Allan, 2017). There is also evidence that SSAY can struggle to locate support and services and there

are varied views about how online services should be delivered (Bowman, Easpaig, & Fox, 2020). It is clear that parents/guardians have critical roles in facilitating access to services so ensuring they have good information is helpful. Mental health promotion should be tailored for diverse sub-groups to build mental health literacy and resilience in the face of ongoing discrimination (McNair & Bush, 2016). This includes meeting the needs of SSAY in rural areas, which may not be met by mainstream internet resources. Dürrbaum and Sattler (2020) suggest interventions specifically targeting SSAY to support capacities to cope with minority-stress factors, such as support groups, family interventions and, in some cases, psychotherapy. Sexual identity and specific experiences associated with it (for example, victimisation, family rejection, and internalised homonegativity/binegativity) need to be accounted for in psychotherapy with adolescents and other supportive interventions. Edwards, Britton, Jenkins, Rickwood, & Gillham (2014) discuss the *Headspace* model which includes a client sexual health pathway.

Key points

- Sexual identity remains an important marker of risk health and wellbeing outcomes in Australia
- Need sound understanding of the particular needs of lesbian, gay, bisexual, transsexual and intersex people
- LGBTI people and same-sex attracted youth residing in rural areas may have more experiences of victimisation, feel less comfortable in disclosing sexual identity and less likely to be involved in the LGBTI community than people living in urban areas
- Inclusive, culturally competent and responsive healthcare is important
- Strength-based approaches likely to be more effective than focusing on problems
- Parents and guardians need good information on supporting SSAY.

Loneliness and isolation among farmers and farming families

For farmers and farming families, remoteness and isolation is frequently an aspect of everyday life. While remoteness and poor mental health are not necessarily linked, there are concerns that the former can negatively impact the mental health and wellbeing of farmers. Remoteness, however, should be distinguished from social isolation in this population. There is a general consensus in the literature that farmers (and particularly male farmers) are financially strained, time poor and have a strong culture of stoicism (Vayro, Brownlow, Ireland, & March, 2020). An Australian study by McPhedran and de Leo (2013), however, found no significant difference between levels of perceived social support among male farm workers compared with men in other occupations. Although much of the isolation literature focusses on male farmers, the impact of loneliness for women on the land should also be noted. Women who move onto their husband's farms, in particular, are likely to report ongoing feelings of isolation and a sense of not truly belonging, even after having lived in that community for years, even decades (Judd et al., 2006).

The evidence also notes strong preferences among rural workers to manage issues themselves rather than seeking advice and support from health or mental health services. Analysis of data from a longitudinal cohort, the Australian Rural Mental Health Study, showed that farmers were half as likely to access services compared to non-farmers, regardless of the service accessibility within the community (Brew, Inder, Allen, Thomas, & Kelly, 2016). The authors discussed the importance of tailoring services to farmers to enhance trust and increase service use and this may require gaining better understanding of the barriers to help-seeking. There is evidence from clinicians that when male farmers present at health services it is often at the prompting or insistence of wives and partners, rather than of their own volitions (Cole & Bondy, 2020). They also note that conversations with farmers around mental health are frequently difficult and most often occurred indirectly, when the farmer was being seen for an alternative health issue, or opportunistically

in community settings. Farmers may also be open to health promotion messaging delivered by people perceived to be similar and have some understanding of rural life-worlds.

Although a number of papers recognise farmers' unique circumstances in the development and delivery of mental health promotion and prevention initiatives, there are surprisingly few published formal evaluations of mental health interventions services responding to these needs. Women are more likely to seek help for mental health issues (Brumby & Smith, 2009) so gender-specific initiatives may be important in mental health promotion activities. Some promising strategies for reaching male farmers include reaching out face-to-face through home-farm visits by GPs/ Nurse Practitioners, and using complementary health promotion information that is co-developed with farming-related and community organisations. These approaches emphasise the importance of engaging with farmers 'where they are' (Cole & Bondy, 2020). A soon-to-be published paper describes a promising initiative for delivering health promotion to rural men at agricultural events (Seaman, Green, & Smith, In press).

There is also evidence to suggest a significant association between men, depression and subsequent unintentional injury (Inder et al., 2017). With this in mind, it has been suggested that campaigns to reduce the impact of mental illness should consider unintentional injuries as a contributor. Given positive association between resilience and mental health, future mental health promotion initiatives could benefit from inclusion of education on enhancement of positive mental health outcomes such as resilience.

Remoteness should
be distinguished from
social isolation.

Suicide risk

There are widespread concerns for associations between rural men and risk of suicide. Across the Australian population, suicide deaths rates for males is consistently higher than for females. Data from the Australian Bureau of Statistics shows that, in 2018, over half of all suicide deaths (54.8%) occurred between the ages 30 and 59 (ABS, 2018). Globally, suicide rates in rural populations are consistently higher than that in the general population (Hirsch, 2006). In Australia, male farmers have the highest suicide rates of any rural or urban group (Alston, 2012; Page & Fragar, 2002), and a more recent analysis showed that farmers, along with labourers, machine operators, technical and trade workers have the highest suicide rates by occupational category (Milner, Niven, & LaMontagne, 2015). Judd (2006) cited a number of factors which may contribute to suicidal ideation including social isolation, genetic influences, mental health problems and access to means of inflicting self-harm. A more detailed analysis of completed suicides in the Australian farming sector from 1988–1997 (Page & Fragar, 2002) found that over half of these suicides were in male farm managers, predominantly over the age of 55. By contrast, suicides in the ‘agricultural labourers’ group occur predominantly in the younger age groups.

There is little doubt that recent periods of prolonged drought, trends of younger generations leaving the family farm and financial pressures created as a result of climatic and sector changes are having negative impacts on the mental health of farmers. An understanding of these combined social, psychological and health impacts of these circumstances and resulting pressures, alongside acknowledgement of the cultural factors which influence health-seeking behaviours, need to be taken into consideration in the design and development of any mental health and wellbeing initiative. For instance, qualitative research exploring attitudes among members of three rural communities in Australia found that risks were associated with one’s sense of identity, isolation,

loneliness and lifestyle factors, however there remain challenges in identifying specific individuals at risk of suicide (Perceval, Kölves, Reddy, & De Leo, 2017).

Key points

- Important to consider gender for understanding and responding to risks for poor mental health and resilience among farmers
- Women moving onto husbands’ farm can experience feelings of loneliness and isolation that can persist for many years
- Farming men are more receptive to outreach and community-based services delivered by messengers perceived to have similar lifeworld experiences
- Individual factors and social and environmental stressors are important for understanding risk of suicide and reduced help-seeking in Australian farmers.

Farmers were half as likely to access services compared to non-farmers, regardless of the service accessibility within the community.

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