

“All the lonely people, where do they all belong?”

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Abstract

Loneliness is a distressing experience perceived as isolation and rejection. It has been recognized as a social problem throughout the existence of *Homo sapiens*, and is now considered, in conjunction with social isolation, to be an emergent public health problem affecting all age groups. Mental and physical health are impacted with effects often being negative and long lasting. Various factors contribute to the genesis of loneliness.

‘Third places’, represent places people visit when not at home (first place) or at work or education (second place), are espoused as providing an intervention for loneliness and social isolation. Many of the places proffered lack the credentials needed to address loneliness, notably an environment providing a safe, caring and supportive environment both physically and emotionally, and have commercial imperatives; others require significant financial inputs and commitments by the participant and are neither designed nor equipped nor provide an environment for meaningful loneliness management. The number of third places has been diminishing over recent years.

Third places that can provide the conducive environment for loneliness intervention are few. The Australian Men’s Shed arose out of recognition of depression, loneliness and high suicide rate in males in rural Australia. It is modelled on the concept of the backyard shed where men felt comfortable and maintained their self-esteem and worked on projects. It provides an environment in which men initially, now women, can connect in a safe caring, non-judgmental environment. The model has been emulated in several other countries. The system is not perfect, lacking funding despite providing significant savings to the public purse in the cost of professional mental and physical health care. It functions on the goodwill based on ‘with a little help from my friends’, who also derive benefits from the system.

Introduction

The Beatles, in several songs, present a theme of loneliness including ‘Sergeant Pepper’s Lonely Hearts Club Band’ and several others, but most poignantly in ‘Eleanor Rigby’ with the lyric “all the lonely people, where do they all belong?” [1]. A discussion that needs to happen.

Loneliness has been a social problem likely throughout the existence of *Homo sapiens* and predecessors. Humans, along with other primates, are essentially social animals who possess an innate need to belong to a group and to be accepted by that group [2]: when this need is unmet, the outcome is loneliness. Lonely people feel risk that their relationships are not meaningful and that they are

not understood by others. The World Health Organization [3] declared loneliness to be an emergent health concern worldwide among younger people, although still prevalent in older individuals.

Loneliness is the distressing experience and negative feeling that occurs when one’s social relationships are perceived to be less in quantity, and especially in quality, than desired, and not how they would like it. It is an unpleasant emotional response to perceived isolation and social rejection and can be described as social pain (<https://en.wikipedia.org/wiki/Loneliness>). Loneliness puts people at risk for mental and physical disease and may contribute to a shortened life span [4,5]. It is a pernicious state of mind having a harmful effect especially as it occurs

in a gradual or subtle way. Loneliness is different to feeling alone; we can be surrounded by others but still be lonely, or we can be alone but not feel lonely.

The need to belong was a major source of human motivation [2] and included in the hierarchy of needs along with physiological needs, safety, self-esteem and self-actualization. An inability to meet the need to belong results in loneliness, mental distress and a strong desire to form new relationships [6].

Loneliness and social isolation are commonly used synonymously, although they have distinct applications. Loneliness is considered as the subjective feeling of being alone and reflects an individual's dissatisfaction with the frequency and closeness of their social contact [7]. Whereas, social isolation is an objective measure quantifying social contacts assessed by metrics such as network size [8]. It is challenging to distinguish social isolation and loneliness from one another. Not all who are isolated are lonely and not all who are lonely are alone [9]; in this paper the terms are conjoined for brevity. All age groups can suffer social isolation arising from social disconnect of relations.

Various types of loneliness exist and attempts have been made to define the term to represent the number of visits with family and friends. Some people choose it as a lifestyle, but this is not the case in most people on whom it is imposed. Three types of loneliness are identified [10]:

- situational loneliness which results from environmental factors including unpleasant experiences, interpersonal conflicts and disasters,
- developmental loneliness resulting from personal inadequacies, developmental difficulties poverty and living arrangements, and
- internal loneliness which results from personality factors, mental distress low self-esteem and poor coping strategies and considers that different techniques are required to combat them.

When loneliness persists and becomes entrenched it becomes chronic and has a deleterious influence on many aspects of health.

The problem

Some consider loneliness as a public health problem that requires the engagement and support of the medical community [11], whereas others believe loneliness to be a social issue and that medicalization is ineffective as demonstrated with the obesity pandemic and experience with HIV/AIDS [12].

Influences of loneliness on wellbeing and physical health

The pervasive deleterious impacts of loneliness on physical and psychological health is estimated to chronically afflict about nine million British citizens [13].

Income, education, sex, and ethnicity are not protective, and the condition is contagious. The effects of the condition are not attributable to some peculiarity of the character of a subset of individuals, they are a result of the condition affecting ordinary people [11].

The health impacts of loneliness and social isolation

Loneliness negatively affects our wellbeing – it influences physical health, psychological health and social health [14], however, people who recover from loneliness or who have never felt lonely, appear to be less likely to suffer from dementia and Alzheimer's Disease (AD) later in life. The prevention of loneliness may be protective for dementia and AD.

The health impact of loneliness is manifest in various ways [5,10]. Lonely people show signs of irritability, depression and of being self-centred, become anxious, they lose pride, purpose and self-esteem, which can lead to suicide. Although loneliness does not have the status of a clinical disease it is a contributing factor in the pathogenesis of certain morbidities and mortalities. The physical health status of lonely people can suffer in the long-term with cardiovascular disease and hypertension, type 2 diabetes and increased susceptibility to infectious diseases; a significant connection exists between loneliness and some neoplastic changes. Many of these physical diseases present in older subjects, but aetiological conditions would be initiated in younger people. Sleep disorders, mental health and emotional problems, and substance abuse are seen commonly. More than half of the lonely people were more likely to have poor health [15,16]. The hypothalamic-pituitary-adrenal (HPA) axis is believed to be hyperactive in depressed subjects and is implicated in the pathobiology of a variety of mood and cognitive disorders [17]. The interaction between HPA and gut brain axis is implicated in aspects of depression with changes in the gut biome [18,19], as well as modulating anxiety and depression [20] which likely further impacts nutrition.

Lonely people tend to have a low level of physical activity and seek solace in low nutritional (junk) foods that are high in fat and sugar, which may lead to obesity, thus impacting self-image and creating or worsening depression. Elderly people who have physical illness and disability report a higher prevalence of loneliness compared to elderly without physical illness and or disability [10].

It has long been recognized that loneliness kills [16] with a 26 percent increase in the risk of premature mortality; it has a harmful effect for all-cause mortality and this effect is slightly stronger in males [21]. Among participants who were older than 60 years, loneliness was a predictor of functional decline and death [4,22].

Mental health

An individual can be considered to be suffering from depression if for more than two weeks, he or she has felt sad or miserable most of the time or has lost interest or pleasure in most of his or her usual activities and has experienced several of the signs and symptoms of three of the following four categories, behaviours, thoughts, feelings and physical symptoms.

There are different types of depressive disorders ranging from relatively minor (but still disabling) such as dysthymia through to very severe such as major depression and bipolar disorder.

- Major Depression is characterized by low mood and or loss of interest and pleasure in usual activities as well as other symptoms. Symptoms are experienced most days and usually last for at least two weeks and interfere with all aspects of a person's life including work and social relationships.

- Bipolar disorder is characterized by periods of severe depression and periods of mania, and with periods of normal mood in between. Mania is considered the opposite of depression with periods of feeling great, having lots of energy, little need for sleep, talking quickly and having difficulty focusing on tasks. It can cause a loss of reality and even episodes of psychosis including hallucinations and delusions.

- Dysthymic disorder, also known as persistent depressive disorder, has similar symptoms to major depression and whilst they are less severe symptoms last longer. For a diagnosis of dysthymia, symptoms of depression must have persisted for more than two years.

Some of the more pervasive symptoms of depression are loss of pride, self-esteem, thoughts of failure, indecisiveness, social isolation, reliance on alcohol and sedatives, negative thoughts ('I'm worthless') and a general lack of purpose.

It is important to recognize loneliness and identify those most at risk. But how do we recognize it – what are the signs and symptoms? One of the problems in diagnosing loneliness is the social stigma that is attached to it. Loneliness is more likely to be recognized in the older population being more often in contact with health care

professionals, be they living at home or in care. The British Geriatric Society [23] have developed a Comprehensive Geriatric Assessment (CGA) which focuses on diagnosing an older persons medical, psychological and functional capacity which not only facilitates the identification of loneliness but also ways of supporting people.

Once recognized how can help be suggested and provided? Once diagnosed, provision of programs to alleviate loneliness should not just involve healthcare professionals, but other government agencies and voluntary organizations. However, the link between these various agencies can at best be described as tenuous in the UK and nascent within Australia.

Factors Contributing to Loneliness

Age profile

Loneliness is often considered and represented as occurring in later life, however it can occur any time throughout life [24]. In a recent survey [25], younger people reported more loneliness than those in middle age, and people in their middle age reported more loneliness than older people. A survey revealed that:

- 1 in 4 Australians feel lonely, especially younger Australians, report anxiety about socializing,
- thirty per cent do not feel part of a group of friends, and
- lonely Australians have worse physical and mental health, and are more likely to be depressed.

Despite commonly regarded as affecting older members of the community, especially males, it affects all age groups [24] and is particularly prevalent in modern Britain among young adults [26]. One study found that 70 percent of teenagers to be lonely and carried on through the life span [27] and the lowest incidence was within older adults. In India 80 percent of people aged below 18 and 40 percent above 65 had reported loneliness at some stage in their life [10]. No one is immune, with some populations appearing more affected. Loneliness gradually diminishes through the middle adult years, and then again increases in older age (≥ 70 years) [28].

Retirement

Transition to retirement imparts significant changes in both routine and social environment and requires self-directed efforts to maintain social engagements. Those lonely people who are unable to transition can develop depressive symptoms which can exacerbate loneliness, and these can benefit from interventions increasing social interactions [29].

Gender differences

Men reported more loneliness than women [25]. Women talk 'face-to-face', whereas men tend to hide emotion and are secretive. Men are reluctant to disclose experiencing what is socially stigmatized [30]. Compared with women, Australian men suffer poorer health outcomes on almost every measure of health status. This disparity increases with remoteness and is particularly evident with indigenous males. Men are at least three times more likely to commit suicide than women and experience 70 per cent of the burden of disease related to injury [31].

In terms of health service utilisation, men are less likely than women to access health services and more likely to delay seeking health services or health advice; they spend less time with doctors than women and receive less health advice as a group. When they do access health care services, they focus on physical problems and are less likely to discuss mental and emotional problems [31]. In some ways men are their own worst enemies with regard to socialisation, due to the prevalence of the stereotype of the 'strong male', where terms such as 'take a teaspoon of cement' or 'toughen up princess' can lead to a feeling of rejection.

Veterans and families

The transition from military to civilian life can be confronting, and the third place is essential both for transition and upskilling in preparation for employment. Public opinion and the numbers of veteran suicides has caused the Australian Government to provide counselling services for veterans and significantly the recent establishment of a Royal Commission into Veteran Suicides.

Connections between loneliness and trauma have been studied in veteran populations, where difficulties in sharing traumatic experiences can potentially lead to feelings of alienation and loneliness [32,33]. PTSD specifically is associated with loneliness in various veterans' populations, an association consistently observed even many years after the traumatic experience [34]. Loneliness plays a major role in the development of complex PTSD and the continuation of its symptoms [35], suggesting that therapies for complex PTSD should include interventions that address loneliness. One of the pervasive symptoms of PTSD is negative self-concept which can lead to self-isolation which impacts the development and preservation of meaningful relationships leading towards loneliness.

Bereavement

Loneliness is expected when people grieve the loss of someone to whom they were closely attached. Social support is essential mainly by friends and family but

loneliness cannot be remedied solely by social support [36] and in some 'third places' the newly bereaved needs an opportunity to express themselves. Loneliness in bereavement is in itself a risk factor for the development of depression, is an emotional health concern following bereavement [37], and requires specialist grief management. Support interventions promote positive affect and diminish loneliness of widowed seniors [38], however the role of 'third places' in bereavement is poorly studied.

People with disabilities

Physical disability has a profound effect on one's quality of life, social intercourse and emotional well-being. Loneliness has been found to be a frequent companion of those afflicted with chronic illnesses that result in physical disabilities [39,40]; a double stigma of loneliness and disability affects the lives of people with disabilities in many societies.

Sense, a UK online magazine (<https://www.sense.org.uk>) identifies that half of disabled people report feeling lonely, with one in four feeling lonely every day. Whilst most of the population will feel lonely at some time in their lives, having a disability means that loneliness is more likely to be chronic. Whilst making connections has been identified as a good counter to loneliness, a lack of awareness and understanding of disability is a significant obstacle to making connections and forming friendships. Sense identified that 49 percent of non-disabled people consider that they have nothing in common with disabled people and 26 percent reported avoiding contact with a disabled person.

In Australia the Australian Federation of Disabled Organisations (<https://afdo.org.au>) identified that discrimination affects a disabled person's participation in everyday activities, resulting in avoidance which in turn increases the likelihood that they will experience social isolation which impacts overall health and wellbeing. Social isolation is exacerbated for those who are immobile and are reliant on others for access; this situation was made worse by the recent COVID-19 pandemic where some were forced to physically isolate.

People moving to unfamiliar areas

People who move to a new setting, an unfamiliar city, a rural area, across states and migrants moving to a new culture, are at risk of becoming lonely and isolated. Many strategies exist with employment and education and in most cases the feeling of loneliness and social isolation is transient. For these people the range of 'third places' [41] has value. Any association with networks in the region, through Rotary, Lions and Men's Sheds provides a valuable resource.

Marital status

Australians who are married are the least lonely, compared to those who are single, separated or divorced. Australians in a de facto relationship are also less lonely than those who are single or divorced [42].

Although marriage is believed to protect against loneliness, this is not so in all cases, and effects of poor marital quality on loneliness were not ameliorated by good relationships with friends and relatives [43]. For some, stuck in a loveless marriage or a marriage of convenience, loneliness is an ever-present possibility particularly if the partner has his or her own social agenda.

A confusing pattern is reported of a gender difference in loneliness in marriage [44], and often results in coping behaviours such as watching television, compulsive reading or online games, which from the outside can be seen as a highly successful relationship, but where in reality only one of the partners is engaging in a fulfilling social agenda.

Culture

People in individualistic countries place high value on self-reliance and are associated with loose social networks, primarily dominated by chosen relationships, whereas collectivist cultures encourage interdependence and are patterned by tighter social networks, dominated by family and other ingroup members reported more loneliness [25]. Cultural variations in the meaning and concept of loneliness influences (and confuses) the meaning of loneliness [45].

COVID-19

Prior to the COVID-19 pandemic, many Australians were struggling with loneliness. Recent research conducted by Swinburn University (<https://www.swinburne.edu.au/news/2020/07/lonely-in-lockdown-youre-not-alone/>) reveals that one in two Australians reported feeling more lonely since COVID-19. The effect is reflected worldwide [46].

Composite factors

Loneliness represents a composite of contributing factors with age, gender and culture interacting in its genesis [25]. It is likely to be a greater problem for individuals suffering psychiatric disorders, many of which are associated with poor interpersonal relationships, both prior to and consequent to the onset of specific disorders [35].

Mental and physical health

Mental and physical factors can contribute to loneliness and conversely loneliness can contribute to mental and

physical conditions. Social isolation and loneliness are considered as being more destructive than obesity and tobacco [47].

Sensory and functional factors potentially contributing to loneliness:

The impact of sensory decline is rarely considered in relation to social isolation and loneliness. If an individual is unable to effectively relate socially due to some sensory decline (sight, speech, touch) then they are more likely to engage in social avoidance to compensate for their perceived failures and become socially isolated and as a result experience loneliness.

Auditory decline is commonly recognized as contributing to social isolation [48] and contributes to loss of cognitive function. Regular suboptimal social interactions due to poor audition can lead to social avoidance which can lead to loneliness. Whilst hearing aids are available and improve such social interactions, they are expensive and may incur a cost benefit analysis where social isolation is the inevitable consequence.

Although not considered in studies are declines in olfaction and audition. Only in recent years has the true value of olfaction been appreciated. As well as contributing to the pleasure of the consumption of food and beverages, olfaction has a significant under recognized contribution to social bonding [49]. Anything that impacts social bonding can lead toward social isolation and possibly even loneliness: an area ripe for research.

Depression is often accompanied by alterations in olfactory function [50] with the outcome for the subject to lose connectivity in all 'places' of life.

Poor oral status significantly influences nutrition, and can be a contributing factor leading to social isolation in veterans [51] and older subjects [52].

Recognition and Interventions

This review considers interventions relating to the roles and benefits of 'third places'. Various forms of loneliness would be expected to influence the style of intervention. Several types of intervention are recognized [10], with development of social skills, provision of social support, the provision of opportunity for social interaction and the recognition of maladaptive social cognition. Some of these strategies can be achieved through development of skills – be they physical or communication, provision of a caring and supportive environment, and providing a suitable environment for social interactions. The appropriate approach depends on the factors contributing to the loneliness. Once physiological and safety needs are met then an individual can work on the need to belong and

once that need is satisfied then they can then move onto self-esteem and eventually self-actualization [5].

Many of the papers and reports reviewed failed to consider the role of the 'third place' in relation to either addressing social isolation and loneliness or in combination.

Third places

The term 'third place' describes the public spaces used for informal social interaction outside of the home and workplace. Oldenburg [53] presents a far-reaching and enlightening sociology of diverse scenarios of 'Third Places', their social context and their values, as a 'home away from home'; a 'replacement home', or even a place in which to escape the loneliness of an imperfect marriage. *The Great Good Place; Cafés, Coffee Shops, Bookstores, Bars, Hair Salons, and other Hangouts at the heart of community.* However, the role of third places as interventions for people who are lonely and socially isolated is not addressed despite the role of a third place being recognized as providing value in countering social isolation. The third place is the social surroundings separate from the two usual social environments of home being the first place, and the workplace representing the second place. Examples of third places would be environments such as churches, cafes, clubs, public libraries, bookstores or parks; Jeffres et al. [41] expanded the list of places.

They help people feel part of their community and contribute to the overall social health of residents and urban areas. A third place is especially important because the modern home in developed countries has effectively become a place of social isolation, particularly outside of major cities. Homes have become a place of total retreat from the world, in which to 'zone out' and exist in a personal bubble. Work, through a variety of reasons, can become a highly stressful environment where employees seek a 'third place' to get away from the problems of an unpleasant environment. Alternatively, work could be considered as a 'third place' where one goes to seek interpersonal relationships if home has become a place of social isolation.

Many of these third places have commercial imperatives, some reflect social and economic status, others are outdoor areas and more have educational and cultural functions. The person who is lonely needs an environment which is caring, not threatening, is sincere and above all in which they can feel safe and at ease. Some commercial third places have taken a Relationship Marketing approach which benefits not only the organization but also the patrons; Raciti [54] found that highlighting the value of creating a social and emotionally supportive service experience led to sustainable consumer patronage – "a win-win situation". Whilst many of these third places were

established for a specific often commercial reason, Men's Sheds were inceptioned to fulfil a specific social need.

Virtual 'third places'

Oldenburg's conceptualization has been used consistently to describe the communication of computer-mediated contexts such as chatrooms and multi-user environments [55].

Virtual third places lack the full value of body language and not generally considered is the social communication through olfaction. Loss of smell is well recognized in association with depression [50]. The impact of 'social communication' provided by the olfactory system in humans [56] and its lack in virtual reality needs considering. Also, body language is difficult to interpret over an on-line system such as Zoom, especially as body language is a very important factor as it can provide both positive and negative reinforcement in an interpersonal relationship.

Wexler [57], in making the point that third places have been treated as unified concepts, identifies three types of places, communitarian, commercial and virtual, and applies a *cui bono* (who benefits) approach to 'third places'.

Social prescribing

This is the practice where health professionals, including general medical practitioners, have the resources and infrastructure to link patients with social services and social groups, in a bid to address the social determinants contributing to poor health and stave off the epidemic of social isolation and loneliness (<https://chf.org.au/social-prescribing>).

Helen Stokes-Lampard, the chair of the Royal College of General Practitioners in the United Kingdom, described social prescribing as '*a fancy name for what good doctors have always done, which is navigate our patients towards other resources outside of the health care sector that can help them*'. Social prescription can have a downside with '*buffing and turfing*' to an organization to circumvent needing to manage the problem at stake.

The Military provides social prescription in some forms through referral to supportive organizations such as Soldier On Australia, Vietnam Veterans Federation Inc and Open Arms.

Global recognition of loneliness

In the UK, a minister for loneliness was first appointed in response to a Commission on Loneliness, more recently in response to an increase in suicides amid the COVID-19 pandemic the Japanese Government has followed suit.

Loss of 'Third Places'

Third places are being lost in America, and many other countries, and the impact on health and quality of life and as a buffer against loneliness is of concern and under-researched [58].

'Third Places' for "The Lonely People"

A sense of belonging or 'belongingness' is the human emotional need to be an accepted member of a group and to be an important part of something greater than themselves. There needs to be acknowledged acceptance by the group (both giving and receiving attention) for a true sense of belonging. All human beings need a certain minimum quantity of regular, satisfying social interactions, and an inability to meet this need results in loneliness, mental distress and the seeking of new relationships. The strength of the need to belong differs between individuals, with those having a strong need can be less satisfied with their relationships and tend to be relatively lonely [6].

Not belonging to a group can be a powerful negative factor leading towards loneliness, especially for those moving to a new environment involving new work and it may take a while to develop new connections. In cases such as this, the 'third place' can be very important such as Men's Sheds of which there are over 1000 in Australia, all having the same general focus of providing a safe caring and supportive third place for people to enjoy and enhance their health and well-being by sharing experiences, participating in a range of pleasurable, meaningful activities in the medium of wood and other materials and giving back to the community. It is relevant to note that the negative impact of not belonging to a group is culturally exclusive.

The concept of "Third Places" espoused by Oldenburg presents places available to people when not at home ('First Place') and not at work or educational facility ('Second Place'). In reality amongst these 'third places' there is a significant paucity of those providing an environment in which loneliness can be addressed caringly and sensitively. Many of the venues listed have overarching commercial imperatives, others although providing gatherings are not conducive for socializing, others may have political, religious or other ministering objectives. These are largely reflected in Wexler, Mark & Oberlander's [57] observation of third places which do not have a context with loneliness.

For loneliness to be addressed the third place must create a sense of community on a smaller more personal scale. They should encourage conversation and warmth in a homely (non-combative, relaxed, comfortable) atmosphere. They should enable people to come and go freely and without judgement or obligation. The status and backgrounds of users are of no relevance. (Rosefield Community Website,

2021 - <https://www.rosefieldcs.org.au/>).

For a third place to be of value to counter, not entrench, loneliness, they need to be safe environments both physically and emotionally, practice egalitarian principles and be non-judgmental. The provisioning of third places does not, by itself, guarantee a remedy to strengthen communities. Commercial establishments are run by private citizens and thus subject to implicit and explicit biases and exclusions can be deliberate [58,60].

Few of the third places listed have a significant role to address the problem of loneliness and social isolation by providing 'connectiveness'. For a third place to provide an environment that addresses loneliness it needs to be caring, non-judgmental, and non-evangelical and not be governed by business concerns. Few places represent and fulfill these social needs. An overview of values, shortcoming and appropriateness for loneliness intervention based on Wexler et al., and Wexler [57,59] is presented in Table 1.

An overview of the three categories of 'third places' based on that of Wexler [59] of social context, focus of the place, 'cui bono' (who stands to gain), key problems, ideological implications and appropriateness in the context of loneliness intervention.

Unlike most 'third places' 'The Men's Shed' is an example of a 'third place' designed and developed for the specific purpose of connectivity (close to the heart of the authors).

The Australian Men's shed - Background, history and evolution

In Australia the Men's shed system arose from the National Rural Health Conference held in 1997 to address the high rate of male suicides in rural communities. Precursors to the movement include a group of miners in Broken Hill in the 1980s and the Albury Manual Activities Centre which opened in 1978 [31].

Men's Sheds developed, often quite spontaneously, in many areas of Australia over a number of years before the inception of The Australian Men's Shed Association (AMSA). A major achievement for the Association was formal recognition by the Federal Government of the role that Men's Shed play in addressing social isolation, health and well-being. Its inclusion in the National Male Health Policy launched in 2010 lead to funding through the Federal Department of Health with a major proportion of this one-off funding quarantined specifically for the direct financial assistance to Men's Sheds.

A 'Men's Shed' represents a community-based, non-commercial organization that is open to men which provide a place where men can feel included and safe. Men's sheds aim to improve the health and wellbeing of

Table 1: Third places adapted from Wexler 2009 & 2017 [57,59].

Third Place Variation	Societal Context	Focus of the place	<i>cui bono</i> who stands to gain	Key Problem	Ideological Implications	Appropriateness in the context of loneliness intervention.
Communitarian	Civil society	Mission/cause Wicked problems	User/volunteers society at large	Resourced poorly (can enable saving in cost of mental and physical health)	Stresses the role of the good citizen	Effective when sincere, safe and welcome
Commercial	Neoliberal society	Business/ commercial Enhancing profitability	Owners, investors	Balancing the commercial and social responsibilities	Stresses the compassionate potential of the private sector	Can be gratuitous
Digital	Sharing Society	Technology/ cyberspace online sharing	Owners; participants; advertisers	Governance and community control	Stresses the humanizing potential of connectivity via augmented technologies	Research is needed to determine if in value as a safe and effective intervention.

"Third places". They are informal public gathering places where people can interact and socialize – not all third places are equal

Australian men, and to address social isolation and boost men’s mental health in terms of: feeling safe, and making friends (<https://www.health.gov.au/initiatives-and-programs/mens-sheds/about-mens-sheds>).

Since its inception around one thousand formal sheds have been founded throughout Australia along with some others in outback and aboriginal settlements.

Men’s health has figured prominently with an emphasis on mental health and wellbeing at the fore and with physical health as well. Men’s Sheds challenged the acceptance of the gender agnostic approach to service provision at that time which only saw a need for services for women. The slogan adopted by AMSA reflected this from the concept that women speak face to face whereas men talk shoulder-to-shoulder, truncated to ‘shoulder-to-shoulder’: this manner of interaction misses eye contact so important in establishing lasting connections. The Australian Men’s Shed Association was founded in 2007.

The concept of the modern-day ‘Men’s Shed’ movement in Australia is based on the culture of the backyard shed. Traditionally, these backyard sheds have always been places where men can spend time on activities that they love (<https://www.entegra.com.au/understanding-the-mens-shed-movement-in-australia/>).

Although the original focus of the shed was on men, recent years has seen a metamorphosis with some incorporating female membership becoming designated as ‘Community Sheds’, others focussed on veterans, aboriginal communities, migrant groups and with recent

establishment of ‘female sheds’. Young and unemployed people are encouraged in some sheds.

A characteristic of all sheds is the focus on the meeting area for communication and conjoined is some form of work area; some members just drop in for the social interaction. Projects undertaken are various, most are based on some form of woodwork – making or repairing items. An important ‘tenet’ is in the promotion of pride, self-esteem conjoined with purpose and appropriate upskilling.

Recently computer numeric control systems (CNC) are being installed in sheds which have enabled disabled members and those with limited motor skills to accomplish high quality projects, away from previous mundane tasks.

The demography of members tends to reflect the community in which the shed is situated but wide ranges often occur.

The shed concept has been emulated in Ireland, Scotland [61], US, Finland, Greece, Canada, and New Zealand. It enables the global membership visiting around Australia and overseas opportunities to visit likeminded individuals and groups.

Value of mentoring and supervising

Rarely considered in volunteering is the significant emotional value that is gained by volunteers in supervising and mentoring; however, a degree of burden exists in the bureaucracy of the management of a shed which could

be alleviated by appropriate government support. It is important that the shed system does not become a 'drop-off ground' for 'carers' to divest their charges as has been seen at times. Carers need to be involved in the activities of their charges to enable their charges to become fully immersed in the shed environment and for sheds to actively support the function of the carer in providing activities for the disabled.

Programmes for living

All sheds have an emphasis on mental and physical health, and some sheds have evolved programmes for living by addressing specific factors arising from loneliness and social isolation. An example being culinary literacy, cooking classes, and recipe books. Although the shed system is largely based around woodwork and the medium of wood, some sheds have developed additional programmes, some are making musical instruments and involving members in music, others are repairing electric and electronic equipment, others in metal work and blacksmithing.

Nutrition and Culinary literacy

Living alone can influence food intake [62-64] resulting in poor nutrition and inappropriate eating. Many people trying to cope with social isolation resort to fast or highly processed energy dense foods.

Malnutrition is a risk factor commonly recognized in older subjects and is commonly related to loneliness along with factors comprising social isolation, economic and educational status, and place of residence, with those most at risk being single, widowed and divorced [65]. Men living alone are more at risk than women of undesirable nutrient intakes [62]. Organizations such as Meals on Wheels (MoW) provide not only the nutritional aspect but also a friendly face to reduce social isolation. In many cases the visit from the MoW may be the only social contact that the person has for considerable periods of time, helping to stave off the loneliness.

Dysnutrition, considered to be a new health problem in which there is severe imbalance in nutrients resulting in malnutrition despite adequate calorific intake can occur in those with poor food choices with highly processed foods and confounding factors such as drug addiction, alcoholism, and lack of funds as a consequence of these addictions, needs to be considered in loneliness.

Culinary literacy should also consider the development of commensality (the practice of eating together). As many members are older and living alone and socially isolated from family members malnutrition is a concern [66]. The provision of culinary literacy comprising cooking skills

along with marketing and promotion of eating skills is an area of significant value. One would hope that such a line would encourage commensality, recognized as a means of intervention. Social isolation and loneliness have emerged as central drivers for participating in food sharing initiatives [67].

Discussion

"The whole conviction of my life now rests upon the belief that loneliness far from being a rare and curious phenomenon is the central and inevitable fact of human existence."

– THOMAS WOLFE

Prolonged social isolation has harmful social, health and economic consequences [68]. Currently minimal financial support is provided to institutions and groups who provide a 'not-for-profit' service. These services rely on volunteers and despite goodwill they need a degree of financial security to cover costs, repairs and enable development and execution of programmes, and not expend member's time and resources on chasing funds from charities and granting bodies, or undertaking mundane production line projects.

Do the majority of third places as depicted by Oldenburg accommodate or act as interventions or to reduce loneliness and social isolation? Most of these 'third places' available to communities are businesses and are thus commercially based such as cafes and restaurants, shopping malls or have significant recurrent costs and outlays demanding remuneration such as gymnasias, golf clubs, theatres and concerts, whereas others have specific functions such as libraries, schools and universities. Finlay [58] expressed a concern that the number of 'third places' lost to the community during 2008 to 2015 is a likely continuing trend.

Few of the listed third places can be considered to be 'designed third places' to address loneliness, most serve consumer, religious, or other primary functions but fail to provide the characteristics needed to address loneliness. Open spaces provide some aspects but tend to be for people to seek solace and solitude away from hustle and bustle. For a third place to be effective in addressing loneliness and social isolation it must promote connection.

As populations increase in urban areas loneliness increases. It is not for the lack of people but from the lack of socialization between people, based in part due to a lack of community care, consideration and services. New suburbs are being developed without due consideration by planners for the necessary services to address loneliness: many of these suburbs are in the urban fringe and attract

new migrants due to the affordable housing but lack transport links and social hubs. Such environments foster social isolation and loneliness.

The third place, the place where people have available when neither at home nor at work, is looked at as a place to 'chill out' but when examined in detail they afford little for the person who is lonely. Most have dominant commercial overtures precluding a meaningful welcoming environment, many other places, clubs etc. develop cliques, require significant financial input, other third places with entertainment, concerts, theatre, etc., represent limited social involvement. A truly caring third place must be welcoming, nonjudgement, and safe (physical and emotionally). Many religious institutions provide such care but with the promotion of evangelism.

Despite much having been written on loneliness and social isolation, there is a need to call on researchers to investigate how 'third places' contribute to wellbeing [58] What features of a 'third place' have the potential to enrich social interaction's sense of community and belonging. This can only be achieved by considering the diverse range of venues currently espoused to be 'third places' and consider if they provide a conducive environment in which the intervention of both loneliness and social isolation are the various reasons and causes contributing to these conditions; 'One size does not fit all!' [68].

A caring environment is a starting point but without impetus for meaningful endeavours it would not likely achieve very much. The development of purpose and reestablishment of pride and self-esteem must be achieved through mental stimulation and involvement. Achievements are diverse from physical activities such as belonging to a walking group, maintaining skill and upskilling with woodwork, making and repairing furniture, or with a knitting group often referred to as '*stitch and bitch*'.

Loneliness can no longer be ignored [42], it is as bad as smoking 15 cigarettes a day. Technology is increasingly to blame for our lack of true social interaction and that increased use of social media results in emotion being often mute. By improving the quality of relationships, specifically by building intimacy with those around us, is a promising way to tackle loneliness.

Loneliness needs to be considered as a public health threat, [4] and that social connectedness as a health factor; part of medical evaluations and screenings ought routinely include variables of social well-being. Medical care could promote enhanced social connection, however the challenge we face now is what can be done about it.

Cotterell et al. [68] also highlighted the need for a

cultural change from 'cure' to 'prevent' social isolation and loneliness. What is obvious through preventing, and managing loneliness at an early stage, investment in meaningful 'third places' and services would enable valuable 'health dollars' to be saved. It is time for a full study of the benefits of third places in management of mental disorders.

When people retire, the quality of their social connections is a much more important predictor of their physical and mental health than how wealthy they are.

Funding is needed – most importantly in the case of sheds bureaucratic interference must be avoided to enable the function of mental capacities of members to control their own destinies. Although heralded as being funded by the Federal Government, the funding has been inadequate and does not recognize the savings in public health expenditure. Across Australia the response to funding by individual states is disparate. Some states funding through a state lottery, others receiving startup funding, but at the other end no state funding. A limited annual federal granting pool is competed by the 1,000 sheds with those with recognized social disadvantage obtaining a significant share, but paradoxically urban areas perceived as 'well healed' have hidden pockets of loneliness, poor physical health and cases of malnutrition.

Limited funding through competitive grants is available and directed to mental health projects, seeding funding for new sheds and for sheds with needs in lower socioeconomic situations. Paradoxically less funding has encouraged sheds to develop their own economic bases which tends to encourage cohesion within the membership, but at the expense of the development of self-esteem through exploration and 'upskilling'.

Recent years has seen a decrease in the number or clubs managed by charities, such as Returned Service Men's clubs, working men's clubs, related to the penalties imposed for drink driving (driving under the influence), the improvement of television services, television streaming and the extended use of the internet. Technology provides people the ability to speak face-to-face through video applications such as Zoom, however, such video applications are not the panacea, as they rely on the speed of the servicing internet and poor internet speeds can lead to distortions and delays which can make you feel isolated, anxious and disconnected, and above all lack the 'intimacy' of proximity or contact.

Where do all the lonely people belong? Not as a burden on the health services. We need to reevaluate the concepts of third places and get people to acknowledge one another, to look up [69].

The Australian Men's Shed system, along with related sheds throughout the world, is providing a system, despite some faults, which is worthy of emulation in other contexts. The prime benefit is to provide a comfortable environment for social interaction which is independent of cultural, socioeconomic and other factors in which a lonely person can become reconnected with others. Often not realized and reported is the value to those who provide mentoring and derive pride, social benefits and skills.

Returning to The Beatles, amelioration of the pandemic of loneliness should be represented by their tune from Sgt Pepper's Lonely Hearts Club Band "With a little help from my friends" [70].

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Author Contribution Statement

Both authors – concept, research, drafting and editing.

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Supplementary Information - About the Authors

Graham is dentally qualified, has a master's degree in dental science and a PhD in experimental pathology. As well as being an academic for almost three decades has practiced in rural Australia and been a winemaker relates to the 'trials and tribulations' of many rural residents and the value of the innovation of sheds. Now living in an urban environment recognizes that loneliness is not restricted to rural environments.

Michael has a master's degree in Ergonomics as well as degrees in zoology and psychology. He is an Army veteran of twenty-one year's standing rising to the rank of Lieutenant Colonel. During most of his service he worked as an organizational psychologist including an operational deployment to Cambodia with the United Nations in 1993. As a result of that deployment, he was discharged medically unfit due to psychological illness including PTSD and Major Depression. He has since spent 16 years as a research psychologist working in the field of human factors and human computer interaction, for the British Ministry of Defence and the Australian Defence Force. Having departed the research world nearly a decade ago due to a resurgence of his medical conditions he is well versed in the concepts of loneliness and social isolation.

Graham Ellender and Michael Bonner - Both are members of the Rosefield Community Shed in Adelaide and have firsthand experience of the benefits and deficits in the 'Men's Shed' system.