# He Ara Āwhina Service-Level Monitoring Framework

## *Submission Form*

## How to have your say

To give us your feedback, you can:

1. email us to set up a time to discuss via Zoom or phone (email jane.carpenter@mhwc.govt.nz to set up a time Monday - Wednesday)
2. complete this submission form and email it to us at kiaora@mhwc.govt.nz
3. take an oline survey on the Initial Commission website – www.mhwc.govt.nz

**We would like to hear from you by Wednesday 9 December 2020.**

## Questions

*You do not have to answer all the questions.*

| | | |
|---|---|---|
| This submission was completed by: | *(name)* | Dr Spencer Scoular |
| Email: | | admin@loneliness.org.nz |
| Organisation (if applicable): | | Loneliness New Zealand Charitable Trust |
| Role (if applicable): | | Trustee |

Are you submitting this as *(tick one box only)*:

- ☐ An individual or individuals (not on behalf of an organisation)
- ☒ On behalf of an organisation(s)

Please indicate which groups of people you identify with or represent *(tick all that apply*

- ☒ People with lived Experience of mental distress Illness and/or addiction
- ☒ Families and whānau with Lived experience of mental distress, illness and/or addiction
- ☒ Māori
- ☒ Pacific Peoples
- ☒ Other
- ☒ Young People
- ☒ Rural Communities
- ☒ Rainbow Communities
- ☒ Disabled People
- ☒ Prisoners
- ☒ Older People
- ☐ Children in state care
- ☐ People who have experienced adverse childhood events
- ☒ Refugees and Migrants

Please indicate which sector(s) your submission represents *(tick all that apply)*:

| | | | |
|---|---|---|---|
| ☐ | Māori | ☐ | Families and whānau |
| ☐ | Pacific | ☐ | Consumer |
| ☐ | District Health Board | ☐ | Government organisation |
| ☒ | Non-governmental organisation | ☐ | Commissioning agency |
| ☒ | Advocacy organisation | ☐ | Professional association |
| ☐ | Academic/research | ☐ | Other service provider |
| ☐ | Addiction | ☐ | Other *(please specify)*: _____ |

**Consent - Individuals**

**How we will use your information**
We will use what you and others tell us to develop the He Ara Āwhina service-level monitoring framework.

We will publish a summary report about the feedback we receive on our website to show how we are working, including what people said.

*Protecting the privacy of individuals*
We will report individual submissions by groups people identify with and represent. We will not publish individual names unless you ask us to. This means when you make a submission, your name will not be included in the list of submitters - unless you ask us to.

*Attributing quotes*
We will not attribute quotes in the summary report to named individuals. Any quotes used in the report from individuals will be de-identified and as the group the individual identifies as and/or represents.

1. Do you consent to the Initial Commission naming you as a submitter in the published summary report (default is you will not be named)?

    ☐ No – I do not want the Initial Commission to list my name
    ☒ Yes – I want the Initial Commission to list my name

**Consent -Groups or Organisations**

**How we will use your information**
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We will publish a summary report about the feedback we receive on our website to show how we are working, including what people said.

*Publishing submitters names*
We will publish a list of submitters in the summary report. This means when you make a submission, we will include your group or organisation name in the list of submitters, unless you ask us not to.

*Attributing quotes*

In the summary report we may quote from responses. We will attribute quotes to groups or organisations unless you ask us not to.

If your group or organisation consents to its name being used, but there are particular areas of the submission you do not wish to be made publicly available, please identify this within the question as being IN CONFIDENCE.

1. Do you consent to the Initial Commission naming your group or organisation as a submitter in the published summary report?

    ☒ Yes – the Initial Commission can name my group or organisation

    ☐ No – I do not want the Initial Commission to name my group or organisation

2. Do you consent to the Initial Commission attributing quotes to your group or organisation in the summary report?

    ☒ Yes – the Initial Commission can attribute quotes to this group or organisation

    ☐ No – We do not want the Initial Commission to attribute quotes to this group or organisation

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The Loneliness New Zealand Charitable Trust advocates for improving the wellbeing and mental health of all New Zealanders by reducing loneliness in New Zealand.

We represent our entire population, as a *whole of life* issue and across all demographic groups. Anyone in New Zealand might experience loneliness at one or more times in their life – at any age. The risk is that transient loneliness becomes prolonged (or chronic) loneliness for some, and that reduces both their physical and mental wellbeing, and may be a pathway to mental illness and/or addiction. Furthermore, the prolonged loneliness can also have an impact upon others through a contagion effect.

The complexity of loneliness is misunderstood. We focus on providing help for individuals (by way of mentoring), educating groups, and influencing Government to address loneliness across the population in New Zealand.

New Zealand research has shown that social connection (e.g. not feeling lonely) is one of the top three drivers of wellbeing (as measured by life satisfaction) in New Zealand. Furthermore, Treasury analysis shows a strong association between mental health, wellbeing, and loneliness. Given the importance of not feeling lonely to wellbeing, we expect that loneliness will be a key measure for the Commission in the He Ara Oranga Wellbeing Outcomes Framework – just as it is a key measure for the Stats NZ Indicators Aotearoa and the Treasury Living Standards Framework Dashboard. In this respect, we believe loneliness – in general – falls under s11(1)(c) of the Mental Health and Wellbeing Commission Act 2020 (the Act).

In this submission, we make an important distinction between loneliness (in general), transient loneliness, and prolonged loneliness. Transient loneliness and prolonged loneliness are subsets of loneliness (in general). As we will explain, prolonged loneliness can be a precursor to mental illness and addiction. We believe the He Āra Awhina Services-Level Monitoring Framework will need to monitor prolonged loneliness, which we define as self-reported feelings of loneliness *most or all the time* over the last four weeks. In this respect, in our view, prolonged loneliness falls under s11(1)(e) of the Act.

## 1. Why monitor services?

The purpose of this question is to ensure that the Mental Health and Wellbeing Commission's function to monitor and advocate for improvement to mental health services and addiction services has the greatest impact. This function is currently carried out by the Mental Health Commissioner under the Health and Disability Commissioner Act 1994 and will be transferred to the Mental Health and Wellbeing Commission in February 2021.

How the Commission best delivers on this function needs to be designed in-light-of its objective, powers and functions, and the broader monitoring and advocacy landscape.

**a. What qualities and attributes would you like to see in the Mental Health and Wellbeing Commission's function to monitor and advocate for improvement to mental health services and addiction services?**

With respect to mental health and addiction services in New Zealand, the challenge is the mismatch between demand and supply of services: the demand far exceeds the supply of mental health and addiction services. There are two generic levers to overcome the supply and demand mismatch:

(a) Increase supply of mental health and addiction services;
(b) Decrease demand for mental health and addiction services.

The current New Zealand mental health paradigm focuses on increasing the supply of mental health and addiction services. This is an important lever to address the problem; however, given the overwhelming demand, this lever by itself cannot in our view resolve the demand-supply mismatch. To match demand and supply, the New Zealand mental health paradigm needs to be extended to also focus on services that decrease demand for mental health and addiction services (i.e. services that provide prevention or early intervention in mental illness and addiction).

As we will explain, services that reduce prolonged loneliness provide an important prevention and early intervention of mental illness and addiction.

For Clinicians prolonged loneliness is not defined as a mental illness or addiction. Instead, prolonged loneliness (and loneliness in general) is considered a symptom (or outcome) of mental illness or addiction. The assumption underlying this view is that mental illness or addiction causes loneliness and not vice versa. However, recent New Zealand research has undermined this assumption. The research found that lack of social connectedness (e.g. loneliness) predicts psychological distress a year later three times more strongly than psychological distress predicts lack of social connectedness (e.g. loneliness) a year later. An implication of this research is that Clinicians, the Ministry of Health, and the Commission should consider poor social health (e.g. loneliness) as a point of early intervention before more serious mental health issues develop. Furthermore, good social health provides a preventative measure for mental health.

For Clinicians, the Ministry of Health, and the Commission to be open to these demand-side initiatives, we believe the He Āra Awhina Services-Level Monitoring Framework will also need to monitor services that decrease demand for mental health and addiction services (e.g. services that reduce prolonged loneliness).

**b. How could the Commission best add value and provide the greatest impact to improve wellbeing outcomes for people and whānau accessing those services?**

We believe the Commission can add the most value and provide the greatest impact by focusing and advocating for services that decrease demand for mental health and addiction services (i.e. services that provide prevention and early intervention in mental illness and addiction). This will relieve the pressure on Clinicians and the mental health service, while providing greater wellbeing for New Zealanders.

We believe this can be (at least partially) achieved by tackling prolonged loneliness before more serious mental health issues develop.

As an example of what is possible, after successful pilots, NHS England is rolling out social prescribing across England – where GPs, rather than prescribing drugs, recognise the value of meaningful social connections in mental health and refer patients to a social prescribing link worker. From the patient's perspective they are reducing medicinal intake, and instead of going to the pharmacy, work with the link worker who can facilitate addressing their social needs. The programme is expected to refer at least 900,000 people in England to social prescribing by 2023/24.

More strategies for early intervention and prevention of mental illness are provided in our submission to the He Ara Oranga Government Inquiry into Mental Health and Addiction.

By the Commission advocating for services that decrease demand for mental health and addiction services, like social prescribing, we believe the Commission can add substantial value and impact to addressing the mental health and addiction needs of New Zealanders. With this new way of thinking across the spectrum of care, the voice of the Commission as a watchdog and advocacy function would focus equally on (i) the supply of mental health and addiction services and (ii) reducing demand for mental health and addiction services. Through this balanced approach, the Commission can provide leadership to match the supply of and demand for mental health and addiction services.

**c. How could the Commission provide greatest impact for equitable outcomes for Māori in its monitoring of and advocacy for service improvement?**

Loneliness cuts across all demographics – and has highest incidence in many of our vulnerable communities (e.g. disabled, unemployed, rainbow, youth, sole parents, recent migrants, and Māori). The Stats NZ General Social Survey already provides detailed biannual statistics on loneliness across many demographic groups, including Māori. The statistics provide a measure of prolonged loneliness, since they include the incidence of feeling lonely *most or all the time* in the last four weeks.

In August 2020 we published the first New Zealand report dedicated to reporting prolonged loneliness. Those demographic groups with the highest incidence of prolonged loneliness are, in our view, at higher risk of mental illness and addiction.

Given loneliness impacts all demographics, prolonged loneliness provides a comparable measure across demographics including Māori. Monitoring prolonged loneliness across demographics, including Māori, provides a great way for the Commission to monitor for equitable outcomes for Māori – and advocating for service improvement.

## 2. Monitor what?

The purpose of this question is to define the scope of services that will be monitored as part of the *He Ara Āwhina Service-Level Monitoring Framework.* As there is no common definition of mental health services and addiction services, we are seeking your views on the following proposed draft definition: ***Hauora services that are responsive to the wellbeing aspirations and mental health and/or addiction needs of tangata whai ora and/or their whānau*.**

***Definition of a mental health service and addiction service***

**a. What are your views on the draft definition of mental health services and addiction services?**

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| Our understanding of the draft definition is that Hauora services includes services to reduce prolonged loneliness, since services that reduce prolonged loneliness prevent mental illness and/or addiction and are *responsive* to the wellbeing aspirations and mental health needs of tangata whai ora and/or their whānau.<br><br>Assuming our interpretation is correct, then we support the draft definition. If our interpretation is incorrect, then we ask that the draft definition be broadened to include services to reduce prolonged loneliness. |

**b. Are you aware of any other definitions of mental health and/or addiction services that can be drawn on?**

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| No. |

Even with a definition of mental health services and addiction services there will be grey areas. To help navigate those grey areas, factors could be applied to differentiate whether a service is a 'mental health service and addiction service' as distinct from other health or wellbeing services. These could include whether:

- the primary reason for accessing the service was for a mental health or addiction need
- the service provided responded to a mental health or addiction need
- mental health and addiction workforce training is required to deliver the service
- the intention of the funder is for the delivery of mental health and/addiction support
- the service is provided to individuals (including whānau and group settings) as opposed to the public or populations.

***Factors to help apply the definition in practice***

**c. Are factors needed to further define mental health services and addiction services in practice?**

Yes, factors are needed to further define mental health services and addiction services (see next response).

**d. What are your views of the listed factors? Are any missing? Are some more important than others?**

The listed factors address the supply of mental health and addiction services, i.e. diagnosis, treatment, and rehabilitation of mental illness and addiction. The factors do not decrease demand for mental health and addiction services (i.e. preventions and early interventions that decrease demand for mental illness and addiction services).

In order to decrease demand for mental health and addiction services, we believe the first factor needs to be changed from: “the primary reason for accessing the service was for a mental health or addiction need” (a supply factor) to: “the primary reason for accessing the service was for (or to prevent) a mental health or addiction need” (a supply and demand factor).

In our view this proposed factor is the most important factor, since it captures both demand and supply of mental health and addiction services.

### 3. How to monitor?

The purpose of this question is to test whether the existing Mental Health Commissioner's framework for monitoring mental health and addiction services is 'fit for purpose' for the permanent Commission and what other models, frameworks and approaches we should consider.

The Mental Health Commissioner's framework draws on four information streams to support monitoring and advocacy: complaints to the Health and Disability Commissioner about mental health and addiction services; consumer and whānau feedback; sector engagement; and service performance information. From these information streams a set of annual quantitative measures are derived to track trends over time. At the heart of the framework are six monitoring questions:

- Can I get help for my needs?
- Am I helped to be well?
- Am I a partner in my care?
- Am I safe in services?
- Do services work well together for me?
- Do services work well together for everyone?

***Mental Health Commissioner's Monitoring and Advocacy Framework***

**a. What are your views on the Mental Health Commissioner's framework for monitoring mental health services and addiction services and advocating for improvements? Do the monitoring questions resonate with you?**

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| The questions monitor the supply of mental health and addiction services (i.e. diagnosis, treatment, and rehabilitation of mental illness and addiction). The questions do not monitor services that decrease the demand for mental health and addiction services (i.e. prevention and early intervention of mental illness and addiction). The questions would resonate with us much more if they also monitored for the reduction of demand for mental health and addiction services (i.e. prevention and early intervention of mental illness and addiction). |

**b. Would you change any of the monitoring questions? How?**

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| No. They are fine for monitoring the supply of mental health and addiction services. |

**c. Are any monitoring questions missing?**

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| Yes. The monitoring questions do not monitor services that decrease demand for mental health and addiction services. We recommend the following question(s):<br><br>"Do some services decrease the demand for mental health and addiction services?"<br><br>Alternatively (on a personal level), "Do some services prevent me from becoming mentally ill and/or addicted?" and: "Do some services provide early intervention in my mental illness and/or addiction?" |

### *Other models, approaches and frameworks*

**What other models, approaches and frameworks should we consider for the Mental Health and Wellbeing Commission's framework?**

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| Supply and demand models that not only capture supply of mental health and addiction services (i.e. diagnosis, treatment, and rehabilitation); but also capture services that decrease demand for mental health and addiction services (i.e. prevention and early intervention). |

### *Te Tiriti o Waitangi*

**d. What could a Te Tiriti o Waitangi partnership approach look like in relation to the Commission's function to monitor mental health services and addiction services and advocate for improvement? Can you provide examples of successful Te Tiriti partnership approaches for the Commission to consider?**

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| We do not have the expertise to answer this question. |

**Ngā mihi nui. Thank you for your feedback – it is much appreciated.**