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Submitted to **Mental Health and Addiction Long-Term Pathway**
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Introduction

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What is your organisation?
Organisation: Loneliness New Zealand Charitable Trust

Principles

Uphold Te Tiriti o Waitangi – the principles of Te Tiriti underpin all actions in Kia Kaha.

[No answer]

Equity – people have different levels of advantage and experience and require different approaches and resources to get equitable outcomes.

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 (which is our definition of prolonged loneliness).

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 Ministry of Health and the Mental Health and Wellbeing Commission to monitor for equitable outcomes for Māori – and advocating for service improvement.

People and whānau at the centre – whānau are a crucial part of the support network for individuals experiencing challenges. This principle seeks to strengthen the capacity of people and whānau to lead their own pathways to wellbeing.

[No answer]

Community focus – strong communities provide a foundation of support and connection which is vital for mental wellbeing.

Reducing loneliness encourages social cohesion, sense of belonging, manaakitanga and kotahitanga. To explain why, let us begin by understanding the biological and social basis of loneliness (Cacioppo et al. 2006; 2014).

As a species, we have evolved to survive. Some key needs for our survival are so strong that we have evolved emotional motivators to ensure we respond in a timely way to the need. For example, for the needs of: (a) food, (b) water, and (c) acting together as a social species (so we can survive). For each of these survival needs, we have evolved unpleasant aversive signals when our needs are not met. We feel (a) hungry when we need food, (b) thirsty when we need water, and (c) lonely when we lose our meaningful relationships.

These signals provide early warning systems. When we feel these unpleasant aversive signals, we are motivated to overcome them by respectively (a) eating, (b) drinking, and (c) getting connected. Each of these emotional responses are so fundamental, they apply at a biological level across gender, age, ethnicity, culture, and individual circumstance. That is, the aversive signals – which include loneliness (or social pain) – are biologically programmed into all New Zealanders.

Some New Zealanders have prolonged loneliness, where they feel lonely most or all of the time. This is because they are unable to get reconnected. This can sometimes be due to social isolation (e.g. disabled, seniors). However, for others, it can be due to a secondary evolved response where in their desire to reconnect they push people away. This hyper-vigilance response is to protect individuals from reconnecting with anyone - since some people may harm them. Unfortunately, they can have a too strong response leading them to experience prolonged loneliness.

By addressing loneliness (e.g. via the currently unfunded mentoring services provided by Loneliness NZ), more serious mental health problems can be avoided. Reducing loneliness provides a prevention for mental illness and addiction - and a means of encouraging social cohesion, sense of belonging, manaakitanga and kotahitanga.

Uphold human rights – human rights are central to implementing an effective, equitable and balanced future mental health and addiction system.

[No answer]

Collaboration – working together is vital to create stability, efficiency and enhanced support for New Zealanders.

[No answer]

Innovation – innovative and original approaches to mental and social wellbeing support will facilitate transformation of the mental health and addiction system.

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 Mental Health and Wellbeing 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 innovative demand-side initiatives, we believe they will need to fund and monitor services that decrease demand for mental health and addiction services (e.g. services that reduce prolonged loneliness).

Focus areas

What support is most needed to build the ability of communities to initiate and lead mental wellbeing initiatives?

The Loneliness New Zealand Charitable Trust was formed in 2018. Its purpose is to (1) promote public health and social inclusion by supporting those already experiencing loneliness in their lives, (2) advance education by upskilling people in ways to prevent themselves and/or others becoming lonely, and (3) increase wellbeing and life satisfaction of our population by giving New Zealand a focus on conquering loneliness.

Even though (1) 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, (2) Treasury analysis shows a strong association between mental health, wellbeing, and loneliness, and (3) New Zealand research shows 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, the Ministry of Health and mental health community have been slow to recognize the importance of reducing loneliness as a prevention and early intervention for mental illness and addiction issues. As a result, the primary funding of the Loneliness New Zealand Charitable Trust - a national organization - has so far fallen on its founders. So, in order for communities to initiate and lead innovative mental wellbeing initiatives, the Ministry of Health, (just formed) Mental Health and Wellbeing Commission, and mental health community need to be open to new innovative solutions to age-old problems.

What examples of mental health and addiction services are working well, and what makes these successful?

As an example of what is possible to reduce loneliness (and thereby prevent mental illness and addiction), after successful pilots, NHS England is rolling out social prescribing across England – where GPs, rather than prescribing drugs, recognize 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.

Enablers

Workforce – growing and supporting a sustainable, diverse, competent and confident mental health and addiction workforce.

Currently, there is not a dedicated workforce focused on addressing loneliness. One of the founders of the Loneliness New Zealand Charitable Trust (Cathy Comber) is the only person we know who is dedicated to providing specialist mentoring services to those people who experience prolonged loneliness. Clients register via our website and are provided mentoring via Skype or Zoom - which gives the charity coverage over all of New Zealand.

There will be a need to take the expertise of Cathy, and develop a larger trained workforce who are able to provide personal services that address loneliness, before more serious mental illness and addiction issues arise.

Information and data – timely, accurate and comprehensive information and data will be crucial for longer-term success.

GPs are aware of patients who visit them because they are lonely. In the UK it is estimated that up to 10% of GP visits in some demographics are due to patients feeling lonely.

By GPs providing social prescriptions to these patients, the information held by the GP (i.e. that the patient is lonely) can be passed on to a link worker who can help address the patient's social needs.

The financial savings from less GP visits would, we expect, self-fund social prescribing over the medium term.

Policy and regulation – policy decisions and legislative changes set the framework within which on-the-ground services operate.

There needs to be a policy of preventing mental illness and addiction by proactively reducing prolonged loneliness.

Investment – ongoing investments and enhancements to existing funding arrangements will be critical for ensuring people in Aotearoa New Zealand have free and easy access to a range of mental wellbeing support.

There needs to be investment in services to treat prolonged loneliness, such as those provided by the Loneliness New Zealand Charitable Trust.

Technology – ensuring resources reach people with limited access to digital technology is a priority.

The Loneliness New Zealand Charitable Trust currently does not have the resources to extend mentoring services beyond on-line mentoring. However, with greater funding, services could be provided to those with limited access to digital technology.

Leadership – effective communication, collaboration and guidance from leaders will help ensure responses are coordinated, mental wellbeing needs are met, and individuals and whānau feel supported.

There needs to be leadership to move beyond the focus on the supply of mental health services; and also focus on the need for services the reduce the demand for mental health services (such as reducing prolonged loneliness).

What are the key longer-term shifts (ie, in the next 6-10 years) you think are needed to support system transformation?

There needs to be a clear 10-year vision for mental health that is well communicated to all.

Other thoughts

Please share any other thoughts in the text box provided below.

We believe the Mental Health and Wellbeing 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.

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.