Action Group on Loneliness Policy consultation response Draft Mental Health Strategy 2021-2031 March 2021

AGLP
Action Group on Loneliness Policy in Northern Ireland

The Action Group on Loneliness Policy welcomes the opportunity to respond to the Draft Mental Health Strategy 2021-2031. The Action Group brings together the policy expertise of ten leading organisations calling for urgent action on loneliness - Age NI, Barnardo's NI, British Red Cross, Campaign to End Loneliness, Carers NI, Royal College of GPs, Parenting NI, Marie Curie, MENCAP and Volunteer Now. It is supported by over 70 NI organisations calling for a NI loneliness strategy.

The Draft Mental Health Strategy 2021-2031 is very welcome and presents an opportunity to truly address the shortfalls in mental health services in NI.

Recommendations

While loneliness is not a mental health condition, the two are strongly linked. Given the correlation between loneliness and mental health, both in terms of cause and effect, the Action Group on Loneliness Policy is concerned at the absence of loneliness in the draft Mental Health Strategy - it is a significant gap.

1. Loneliness should be integrated as a core component into the Mental Health Strategy:

It is imperative that loneliness be integrated as a core component into the NI Mental Health Strategy, in order that people have equal access to mental health services, as a means of addressing the causes and consequences of loneliness.

The mental health and wellbeing impacts of chronic loneliness are severe on people of all ages[1]. Action on loneliness needs to be embedded within the 10 year Mental Health Strategy. The current lack of any mention of loneliness in the draft is a significant gap which needs to be addressed. While there are four references to isolation in the draft strategy, they do not touch on the issue of loneliness - although loneliness is often linked to social isolation, it is not the same thing.[2] Tackling both loneliness and mental health is a cross-cutting issue, and requires co-ordinated action across government, statutory bodies, voluntary and community sector and business. Co-design and active partnerships involving experts by experience alongside cross-sectoral stakeholders at all stages, is essential.

Loneliness is relevant to each of the three themes set out in the draft Mental Health Strategy. Prevention and early intervention approaches to tackling loneliness,

alongside targeted interventions to provide the right support at the right time are crucial.[3] In terms of new ways of working, it is important that plans to support our workforce for the future should include loneliness awareness training for all health and social care staff, similar to Dementia awareness training.[4]

2. The Mental Health Strategy should align to the development and implementation of a cross-departmental Northern Ireland Loneliness Strategy

The approaches taken to tackle loneliness in the Mental Health Strategy should align to the development and implementation of a cross-departmental Northern Ireland Loneliness Strategy. The Loneliness Strategy should apply to people of all ages, have committed resources and a clear timeframe for development and delivery; to also include a **Loneliness indicator in the Programme for Government** for all ages to enable effective monitoring of progress.

Due to the severity of the health and wellbeing impacts of chronic loneliness on people of all ages[5], and the range of policy interventions needed across government to tackle loneliness[6], cross-departmental, and cross-government action is needed. The rest of the UK and Ireland have already taken action, with cross-government loneliness strategies in place in Scotland and England since 2018, in Wales from early 2020 and a commitment in the new Irish Programme for Government to develop a plan aimed at tackling loneliness and isolation.

3. The Mental Health Strategy should be fully funded

The Mental Health Strategy should be fully funded: without adequate resourcing, any proposals will be rendered meaningless. However, we are concerned about the ability to fund the strategy. The draft strategy acknowledges that "the investment required is in addition to exist expenditure in mental health services and is dependent on new funding becoming available." In this context, the fact that the Department's 2021-22 budget allocations contain a £10.6m shortfall for the Mental Health Action Plan does not inspire confidence. Given the reality that funding is not currently available to resource existing mental health policy commitments, we are concerned as to whether the Department of Health will be able to meet the cost of a new ten-year strategy.

In addition, financial planning to implement the ten-year strategy, we also believe it will be incredibly difficult to undertake financial planning for a ten-year strategy so long as the Executive is relying on annual budget settlements and non-recurrent in-year monitoring. We are concerned that, like countless other services and strategies in health and social care, the new MHS will fall victim to the counter-strategic short-term budget setting process in Northern Ireland.

4. Establish Loneliness Champions

The Action Group on Loneliness Policy is calling for a regional loneliness champion to be established as part of development of a NI Loneliness Strategy, on a similar footing to the interim Mental Health Champion established by the Minister for Health in 2020[7]. Until this is in place, Loneliness Champions should be established in the

Department of Health and other statutory health and social care agencies, as part of the Mental Health Strategy. This should be duplicated across all government departments.

5. Deliver COVID-19 response to loneliness

The COVID-19 pandemic has seen a huge surge in loneliness, which has led to entrenched feelings of loneliness, poor mental health and growing concerns about what the future holds.[8]

The Mental Health Strategy should include clear actions to address the critical needs which have emerged from the COVID-19 crisis, including:

- Emotional support, including psychological interventions to proactively reach those who have been - and remain - particularly isolated, such as people who are living alone, clinically vulnerable/clinically extremely vulnerable and shielding, or bereaved.
- Continued investment in the social infrastructure that community responses to loneliness depend on, including the community and voluntary sector.
- Support to address digital exclusion, access to technology, access to broadband, data poverty, and digital skills and confidence.
- Offer psychosocial and emotional support, including one to one support, by default alongside financial support.[9]
- Ensure everybody has the advice and information they need in order to overcome loneliness and support friends and family members that may be struggling emotionally, maximising accessibility for all ages on NI Direct and Covid-19 Wellbeing Hub.

6. Community Mental Health should be fully resourced

Appropriate resourcing and commissioning of services will be required to deliver appropriate mental health services in the community. This includes community and voluntary sector organisations that will be providing services and in GP Federations to enable the necessary restructuring of GP-led services.

Community responses to tackling loneliness can be very effective and help prevent a downward spiral to chronic loneliness, which we know can have consequences that are severe in terms of mental health and wellbeing outcomes.[10] We also know that GPs are often a first point of contact with three in four GPs seeing between 1 and 5 lonely people every day.[11]

A range of support models have been developed in Northern Ireland to specifically address loneliness, for example, social prescribing and link workers/community connectors/community navigators, as well as mental health workers and social workers as part of multi-disciplinary teams in primary care. These should continue to be supported and consistently provided across all areas to ensure good access to loneliness/mental health services, supported by a strong, sustainable community and voluntary sector, acknowledging role of volunteering.

The multi-disciplinary team model, which sees mental health workers, social workers and physiotherapists embedded into GP practices, is an important element of HSC transformation and an effective intervention to tackle health inequalities and support people within their own community, including those who are lonely or isolated. To date, the model has only been funded and rolled out in six out of 17 GP Federation areas. It is essential that this is rolled out to all areas as soon as possible. This will help avoid inequity of service provision for patients based on their postcode, as well as inequity in workforce/workload support in busy GP practices. It is important that MDTs work as partners with their local voluntary and community sector to develop the strong relationships that will make MDTs a success. There will also need to be appropriate funding to support extra referrals to services.

The proposal to reorganise secondary and community mental health services around GP Federations, is also recognised as a fundamental change. As such it will require restructuring and sufficient resource to become a reality.

7. Extend transitions support to all people at risk of chronic loneliness

The risks of loneliness increase during times of major life transitions, and this is relevant to people accessing mental health services, who reach a transition point, either from child to adult or adult to older people's mental health services. Often people may struggle to access services after they have reached milestone ages triggering a transition. Consideration should be given to easing this process and developing extensions or additional support for particularly vulnerable people. This includes, for example young people with complex needs, or young people leaving care, older people and children with learning disabilities. There is also a requirement for provision in the Mental Health Strategy for reasonable adjustments to be made for people living with a physical or learning disability.[12][13]

8. Gaps:

a. People living with dementia

Loneliness can be a particular problem for people with dementia. It both increases the risk of someone being lonely while loneliness and social isolation significantly increase the speed of cognitive decline.[14] Given the growing challenges presented by rising numbers of people living with dementia, the Mental Health Strategy should include clear reference and commitments to address this issue. A clear outcome and actions relating to people living with dementia and their carers, across each of the three themes, is required.

b. Carers

Specific actions to address the mental health and loneliness needs of family carers is required.

Loneliness among carers can be chronic and severe, with one in three carers reporting that they are 'always or often lonely', a rate six times higher than the general population.[15] Almost three quarters of carers in Northern Ireland feel isolated or lonely because of their caring role.[16][17]

c. Advocacy/support service

The 'no wrong door' approach should be extended to all ages, and an independent advocacy/support service should be established to help people experiencing loneliness/mental health issues to step through the system and get the best care. This should be provided by a third sector organisation(s) to ensure its independence.

d. Infant Mental Health

While we welcome the focus on prevention in respect of children and young people's mental health, this needs to begin earlier than pre-school in recognition of the importance of early years and the first 1001 days. Parents/carers need support to develop secure attachment to promote infant mental health and healthy social, emotional and cognitive development.[18][19]

e. Loneliness and learning disability

Specific actions to address the mental health and loneliness issues which arise for people with a learning disability are required, and absent from the current draft. People with learning disability are a group at particular risk of loneliness, and one in seven children with a diagnosable mental health condition has a learning disability.[20] Recent research has found that 24% of adults with a learning disability reported feeling lonely 'a lot'.[21] Older people with a learning disability are at particu-

lar risk of isolation and loneliness, while 1 in 3 of 18-35 year olds with a learning disability spend less than 1 hour outside their home on a typical Saturday.[22]

f. Human Rights

The strategy should be underpinned by a human rights framework which offers a structure for addressing the broad range of social determinants of mental health and health inequalities[23], including loneliness.[24]

Supporting evidence

Most of us will experience loneliness at some point in our lives. Loneliness is 'a subjective and unwelcome feeling which results from a mismatch in the quality and quantity of social relationships we have and those we desire.'[25] Loneliness is often linked to social isolation, but it is not the same thing. Social isolation describes the quantity of social connections and relationships that a person has at individual, group, community or societal level.[26]

In Northern Ireland one in five people say they feel lonely[27]. Whilst loneliness is a normal human emotion, **chronic loneliness** – when people always or often feel this way – seriously impacts on people's health and wellbeing, and increases the risk of death by 26 per cent[28]. Chronic loneliness affects one in 20 people[29] in Northern Ireland.

Loneliness and Mental Health

While loneliness is not a mental health issue in itself, the two are strongly linked. Loneliness can lead to poor mental health - it is a risk factor for depression in later life[30] - or can be caused by mental ill-health. Loneliness with severe depression is associated with early mortality[31] and puts individuals at greater risk of cognitive decline and dementia.[32][33] Loneliness and low social interaction are predictive of suicide in older age.[34] The stigma associated with mental health problems can cause people to withdraw, increasing social isolation and loneliness.[35] Anxiety, particularly social anxiety, can inhibit the ability to engage in everyday activities, leading to a lack of meaningful social contact and feelings of loneliness.[36]

Loneliness also affects children's emotional health and wellbeing, impacting the way they understand and respond to others, and how well they cope with events which are beyond their control.[37]

How loneliness affects our health

The pathways to explain how loneliness affects health are not fully understood. Three main pathways have been suggested: behavioural (life-style), psychological and physiological.[38] For example, loneliness and isolation are associated with health-risk behaviours including physical inactivity and smoking,[39] [40] and older people who are lonely are at risk of malnutrition.[41] Isolation and loneliness adversely influence a person's ability to perform daily activities - like washing and dressing - to meet basic needs, fulfil usual roles, and maintain health and well-being.[42] Loneliness is also associated with poorer quality of sleep[43], a range of psychological risk factors[44] and limited use of active coping mechanisms.[45] Loneliness and isolation can have a direct influence on health-related physiology such as blood pressure and reduced immune functioning.[46]

The downward spiral to chronic loneliness model[47] explains how the experience of loneliness can make it hard to reach out to old friends or make new connections. This is why we cannot presume that people will always find their own way out of loneliness. Both strategic policy interventions and community-based support are needed to make a real difference.

Given the seriousness of these effects on our wellbeing it is not a surprise that loneliness leads to people using health services more. Three in four GPs say that they see between 1 and 5 lonely people every day.[48] In addition to the consequences of loneliness on people's health and wellbeing, there are significant implications and costs to communities, wider society, public health and the economy. A recent report released by the UK Government calculates that the overall monetary impact of severe loneliness is at least £9,530 per person per year.[49]

Causes - and who is most at risk of loneliness

Loneliness can be experienced by anyone, anywhere and at any age. Indeed chronic loneliness can often begin in childhood.[50] However, particular groups are more vulnerable to loneliness and life events or circumstances can trigger feelings of loneliness at any stage in life. For example; the onset of a health condition, becoming a carer, becoming a parent, becoming unemployed, retirement, experiencing family breakdown and bereavement.[51]

Loneliness also affects children's emotional health and wellbeing, impacting the way they understand and respond to others, and how well they cope with events which are beyond their control.[52]

Loneliness among carers can be chronic and severe, with one in three carers reporting they are "always or often" lonely, up to 7 times more likely than the general pop-

ulation.[53] Almost three quarters of carers in Northern Ireland feel isolated or lonely because of their caring role.[54] That's almost a quarter of a million people in Northern Ireland.[55]

Structural inequalities also play a part in exacerbating loneliness across society. People are more likely to be lonely if they are have low incomes, live in rented accommodation or lack internet access. Meanwhile, those who are living with a disability, come from an ethnic minority background or the LGBTQ+ community can face particular challenges in developing the relationships they need.[56]

Loneliness and Covid-19

It has never been so important to tackle loneliness across society, with cross-government action. Recent research highlights that the pandemic has made loneliness worse, people who are lonely feel less able to cope now and feel three times less confident about their recovery from the pandemic than the general population.[57] Among those most at risk include people who are living alone, people who are clinically vulnerable, clinically extremely vulnerable and those caring for others.[58] At the same time, people are struggling with the stigma of loneliness, are reluctant to reach out to others and have limited coping mechanisms to overcome loneliness.[59]

Unpaid carers, already six times more likely to experience loneliness 'always or often', have been seriously impacted by the pandemic. Due to lockdowns and shielding, their support systems dramatically fell away, through closure of day centres, schools, short break provision, face to fade support groups as well as a reduction in care packages, leaving many to manage with less support from outside the home and who were unable to access both formal and informal respite.[60] The majority of carers have had to provide more care, many have experienced increased loneliness and isolation, and have seen a decline in their health and wellbeing.[61]

The impact of shielding over the course of the pandemic, has had significant impact on people's mental health and wellbeing, and must be addressed in the Mental Health Strategy.[62] ONS statistics published in June 2020, found that 35% of clinically extremely vulnerable (CEV) people reported their mental health and wellbeing as worsening. [63] The report also found that of CEV people aged under 50 years and aged between 50 and 59 years, almost half report worsening mental health (46% and 45% respectively)'. In addition, a Public Health Scotland survey of just over 12,800 people who had been advised to shield showed that 72% reported it having negatively impacted their mental health. This rose to 88% among socio-economically vulnerable respondents, including those with a disability.[64]

Current responses to loneliness

A range of services across the public, voluntary and community sectors, faith-based organisations and sporting bodies and private sector, are working to tackle loneliness in Northern Ireland. These connector services[65] do not always explicitly describe their work as reducing loneliness.

Often they are framed as services which support health and wellbeing, active ageing, building resilience or independence. These may be age sector network events or activities, keep active clubs, walking groups, knit and natter, story telling groups, luncheon groups, befriending, volunteering and day services. For younger people, services which address loneliness may be delivered in a wider context of capacity building programmes providing life skills, social skills, and employability training and support. Some services also have an intergenerational component.

While these connector services are effective ways of addressing loneliness, they generally support wider outcomes too. However, evidence shows that the most effective loneliness interventions are 'explicitly designed with tackling loneliness in mind.'[66]

A range of models have been developed in Northern Ireland to specifically address loneliness, for example, social prescribing and link workers/community connectors/community navigators, as well as the model for multi-disciplinary teams in primary care that include social workers and mental health practitioners.

A Loneliness Strategy

The Campaign to End Loneliness, supported by the Action Group on Loneliness Policy published 'Loneliness in Northern Ireland: A Call to Action' which outlines the key evidence and considerations for a future Northern Ireland strategy. The policy interventions needed to tackle loneliness are cross-cutting across government and society; health and social care, communities and neighbourhoods, community infrastructure, built environment, transport, accessibility and connectivity.[67]

Tackling loneliness deliberately across government means that a whole range of existing policies can be seen through a 'loneliness lens' that can unleash the power of supporting relationships in ever more areas. Drawing on available research, good practice and existing strategies and approaches across these islands, we have set out a template of what must happen next in Northern Ireland to tackle loneliness, from planning all the way through to spending and service delivery.[68]

As the devastating impacts of chronic loneliness begin to be understood, government and cross-sectoral partners have responded to support key demographics, particularly older people through a range of initiatives including volunteering and

Age Friendly approaches.[69] Whilst valuable work has been happening in Northern Ireland to help people who are lonely in both the public and community and voluntary sectors, nevertheless, a step change in efforts to tackle loneliness is required. An overarching strategy for tackling loneliness in Northern Ireland is required, co-produced with people and communities, rather than individual policy interventions, to make sure people get the support and information they need throughout their lives and that promotes human connection.[70]

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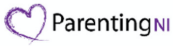

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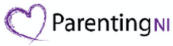

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