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FOREWORD

Our proposed *Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand* builds on the Government's Rural Mental Health Initiative launched in June 2015. This joint initiative between the Ministry of Health and the Ministry for Primary Industries was born out of increased concern about the rates of mental distress, anxiety and suicide in rural communities, especially for those involved with the business of farming.

Improving mental health and addiction outcomes is highlighted as a priority across Government. Rural Health Alliance Aotearoa New Zealand (RHĀNZ) has been contracted by the Ministry of Health to lead the development of this cross-agency framework to guide future policy and funding decisions across government and non-government sectors including District Health Boards, Primary Health Organisations, agri-business organisations, local communities and other service providers.

We have been overwhelmed with the level of support given so freely by so many for this important piece of work.

To our colleagues at the Ministry of Health and the Ministry for Primary Industries; to the great group of people who came together as our Expert Advisory Group; to those sector specialists who gave us their best advice; to the many people who made time to join us in one of the regional workshops with a special note to the group in Kaikohe who met with us twice; to our amazing network of Clinical Champions and Rural Support Trust colleagues; to the hundreds of people who took a few minutes out of their day to complete the online survey, and to our own RHĀNZ board, thank you!

We are hopeful we have told your stories well and look forward to working together to achieve our goal of *'Mentally Healthy Rural New Zealand'*.

Marie Daly

RHĀNZ Programme Manager

Michelle Thompson

RHĀNZ Chief Executive

EXECUTIVE SUMMARY

The Rural Health Alliance Aotearoa New Zealand (RHĀNZ) is privileged to have this opportunity to develop a *Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand* (the Framework). The proposed Framework provides advice and guidance to the Ministry of Health and the Ministry for Primary Industries on how we can work together to achieve mentally healthy rural communities.

Government has set an ambitious goal of doubling the value of New Zealand's primary industry exports by 2025. For this goal to be achieved people living and working in rural New Zealand must be productive. Good mental health and wellbeing is inextricably linked to productivity.

Just as good mental health cannot be separated out from good physical health the Framework cannot be seen in isolation of the wider social and economic environment. Over many years, the gradual reduction in rural health, social, education services and agribusiness activities has eroded the social and commercial structure of rural NZ. This has negatively impacted on the day to day life of rural communities.

The success of our Framework requires a whole of Government and multi-agency approach if sustainable improvements to the mental wellbeing of rural communities are to be made.

Ultimately, the *Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand* is an investment in the future prosperity of New Zealand.

A co-design approach

We adopted a co-design approach to developing the Framework by working closely with rural mental health and addiction specialists, agribusiness and rural community experts, facilitating regional workshops, undertaking an online survey targeting rural people, reviewing the evaluation of our suicide prevention workshops, applying findings from our farm-related suicide research and the ongoing advice from our network of clinical champions.

This helped us understand the unique features that underpin mentally healthy rural communities but can equally be linked to inequalities in health outcomes. Understanding these factors led to the Framework putting greatest focus on building resiliency, enhancing responsiveness and placing rural communities at the centre of all endeavours.

Mentally Healthy Rural Communities sets out five key themes

Caring communities

People Powered

Rural people are connected to their communities, know how to take care of themselves and each other.

Reachable services

Closer to Home

Rural communities have equitable access to self-management therapies, health and social services and timely access to specialist and emergency services when needed.

Accountability for rural outcomes

Value and high performance

Rural people have equitable access to and utilisation of Vote Health funded services.

Our circle of care

One team

Rural health and social service professionals are well resourced and supported to provide the highest possible quality of care for people experiencing mental distress, illness or addictions.

Understanding rural New Zealanders

Smart System

Mental Health & Addiction outcomes data informs research priorities, community and service development, resource allocation, and health and social service provision.

What rural people told us

New Zealand's rural primary care services are overstretched, often propped up with locum doctors from overseas who may have limited knowledge of our health system or the reality of rural life. When this is combined with a transient workforce created by the evolving nature of our primary industries, the ability and sometimes willingness to access a health professional can be more difficult. It can also diminish the ability of health professionals to pick up on when "things are not right".

Wherever we went, rural New Zealanders told us they have a growing sense of being 'left behind' and that the challenges of rural living are both changing and increasing. They told us that while they accept that geographic and social isolation is a reality of the life and work they have chosen, they do expect access to essential services and when there is a crisis, need to know that help is on its way.

We saw much evidence that rural people are passionate about their communities and proud of their No. 8 wire approach to life. They are willing to step up and be part of the solution as their experiences show that having urban health care models imposed on rural communities is seldom effective.

They see the Framework as being the mechanism for mobilising and upskilling both themselves and their health and social service professionals to deal with increased mental health and addiction needs. They also see the Framework as a catalyst for capturing baseline data which could in turn be applied to increasing District Health Board (DHB) and Primary Health Organisation (PHO) accountability for the equitable delivery of non-urban health and social services. It could also inform future health policy and research priorities.

The basis of the Framework

At the heart of our Framework is the call for equitable access to health and social services as a vital foundation of equitable health outcomes.

Funding and contracting arrangements, and the integrity with which these are applied, can ensure that rural communities receive their fair share of Vote Health. They must encourage collaboration and flexibility in the context of rural service provision.

The Framework sets out five key themes, each an application of the themes of the New Zealand Health Strategy (2016). Outcomes for each theme will contribute to the overall goal of *Mentally Healthy Rural Communities*.

Defining 'Rural NZ'

From the outset of this work, we were unable to clearly define 'rural NZ' as it pertains to health outcomes, and more specifically, to the population group targeted in this Framework.

Key groups including the National Rural Advisory Group facilitated by the Ministry of Health and the New Zealand Rural General Practice Network frequently discuss the inconsistency in definitions of 'rural' used by researchers, rural general practices, rural alliances, NZ Police, St Johns and NZ Statistics.

These groups agree that the urban/rural classification used by NZ Statistics underestimates the rural population (and by implication those accessing rural health services). Furthermore, as the current NZ Statistic population data is dated 2006 it may no longer accurately report rural population numbers.

Sector leaders are working on a definition of 'rural' that once agreed, can be consistently applied across the health sector. This will enable greater analysis of health outcomes and quantify the extent of the disparities in health outcomes between rural and urban populations.

Such analysis is likely to reveal greater disparities in mental health and addiction outcomes, and suicide between rural Māori and non-Māori, and between urban Māori and rural Māori populations.

Each theme has a set of proposed actions of which the key components include:

- Developing community resiliency and capacity to respond to mental health and addiction needs.
- Establishing rural psychiatric clinical leadership.
- Developing a rural mental health and addiction community development plan that reflects Māori models of practice.
- Instigating culturally relevant peer support programmes.
- Expanding telehealth services and greater use of text, email, e-therapy and online programmes that augment face to face service provision in rural communities.

The Framework is cognisant of a constrained financial environment, and while some new investment is required, a large component of the Framework utilises and builds upon community initiatives, the extensive RHĀNZ network and increased utilisation of health and wellbeing programmes that are already in place.

Moving forward together

It is important to take the momentum and goodwill created by this work into the next phase of implementation. Approaches that are inclusive of a broad range of stakeholders, across both rural agri-business and the health and social service sector, are required if the advice in the Framework is to be successfully translated into outcomes.

“Learning to be Māori saved me; it’s about peer support and Māori models of care.”

Kaikohe workshop participant

Applying this principle to the establishment of a governance structure to oversee a Framework Implementation Plan and associated programme of activity would enable us to move forward together.

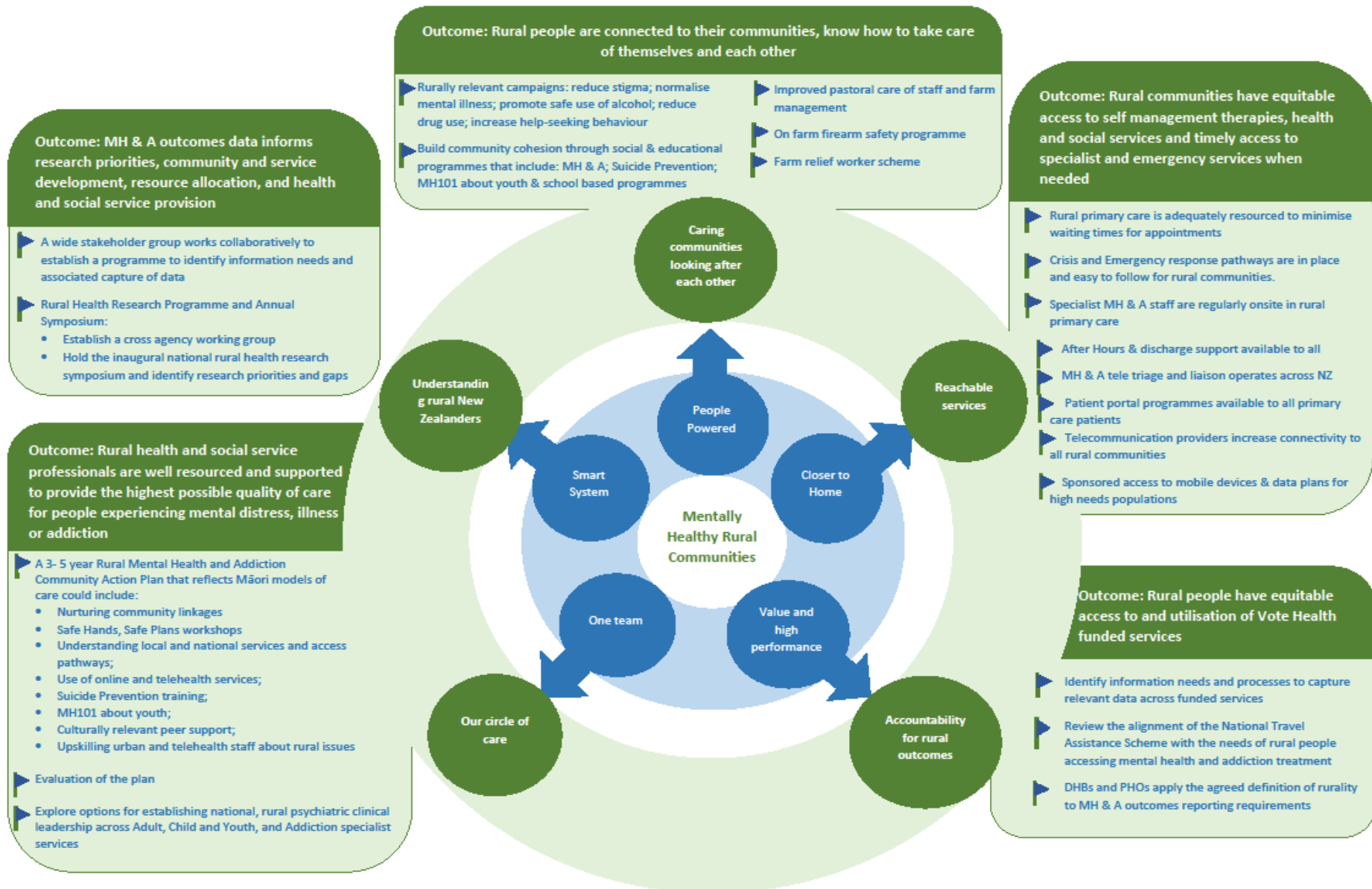
We acknowledge that the consultation and sector engagement in the development of the Framework has only been as extensive as time and budget allowed. However, we are confident that the Framework reflects the views of those we have worked with and has their endorsement.

We acknowledge that both Ministries will need to undertake further due diligence with their stakeholders as part of their consultation processes. We will willingly assist with this as required.

“Ultimately, the rural-urban divide in mental health reflects the wider one in health care and addressing it will need to rely on strengthening rural health systems in general, and making sure that mental health is integrated into that shift”¹

¹ Mental Health and Integration – Provision for supporting people with mental illness: a comparison of 15 Asia Pacific Countries – Economist Intelligence Unit briefing paper

FRAMEWORK TO IMPROVE MENTAL HEALTH AND ADDICTION OUTCOMES IN RURAL NEW ZEALAND



Framework – Caring Communities

NZ Health Strategy – People Powered

Enhancing the mental health and addiction health literacy across rural communities; normalising mental health and addiction issues; being able to ask 'how are you feeling' and knowing how to refer on where necessary; increasing peer support for individuals, family and carers.

Rural people told us there is a 'rural culture' that flows through the way they work, play, live and care for themselves and each other. While each rural community is unique, and not necessarily cohesive, there are common features that unite them and contribute to the rural culture that all New Zealanders are proud of. This can lead to rural New Zealanders feeling that they are different from urban people and not well understood by them. This culture influences the way rural people seek help, what their needs are and how their needs can be met.

Rural people usually know their neighbours. They are community minded, and often have strong networks that support the local school, run community events, and help-out in times of challenging weather events such as flooding or drought. But when times get tough, they can more easily become isolated and hide depression and alcohol or other substance abuse. They are stoic; quick to offer help but often slow to ask for it.

They are proud of their 'No 8 wire' approach to life that gets them through so many day to day situations without expecting others to step in and come to their aid. There is a growing awareness that this isn't always enough to get on top of mental distress, illness or addictions and the impact that this has on the person who is unwell, their families and those who are caring for them.

Rurally focussed programmes that reduce the stigma of mental illness or addiction and increase the ability to recognise signs of this in themselves and each other are being well received. They encourage people to be confident in asking 'how are you feeling?'; knowing when and of whom to ask for help; being prepared to act on this; having confidence that when someone needs help, it will be there; trusting that interactions will be confidential, even if the person providing the help is the neighbour down the road, or their child's best friend's mother; feeling confident that the community will still include them and their family in social activities. These are things that matter to rural New Zealanders.

Research on farm related suicide shows that 40% of farm related suicides involved firearms. Ensuring rural people understand the risks associated with people who are experiencing mental distress having access to firearms indicates that a programme to improve on-farm firearm safety is essential.

Rural people told us that some ways in which we can reduce the impact of mental illness in their lives are: earlier intervention, a greater willingness to be helped or to give help and supporting them to be the caring communities they believe is grounded in their DNA.

In our online survey, we asked rural people - what might have made a difference?

"I should have asked for help sooner"

"I didn't know if what I was feeling was depression – or not"

"I had to wait too long for an appointment and so things went from bad to terrible"

"Encourage farm owners to create positive on-farm workspaces"

"Ongoing stress and compassion fatigue led me to contemplating suicide, it was unrelated to my rural location"

Rural people are connected to their communities, know how to take care of themselves and each other.

What's currently available?

- Sir John Kirwan, Dr Dave Baldwin, Doug Avery, Farmstrong, Dr Tom Mulholland, and GoodYarn workshops all contributing to a better understanding of self-care, depression, mental illness and addictions.
- safeTALK workshops and Mike King's sessions about how to talk about suicide
- Public campaigns run on TV, Social Media, newspapers and magazines across NZ that seek to normalise mental illness, reduce stigma, promote safer use of alcohol and increase help seeking behaviour.

What do we need to do next?

- More of these and other programmes that target rural youth not in school, itinerant migrant workers, promote safe use of alcohol and help-seeking behaviour, teaching urban health and social support staff about the needs of rural NZers.
- Through locally based initiatives, identify and develop local leadership; communicate service options and referral pathways; help people navigate their way into the appropriate service.
- Encourage and incentivise rural agri-business and community organisations to support community cohesion through targeted social and educational activities.
- Improve pastoral care of staff and farm management through education programmes.
- Establish a farm locum service to enable time off or sick leave for staff and management; and develop and deliver a programme about on-farm firearm safety.

What would these things achieve?

- Earlier identification of mental distress, depression, alcohol or other substance abuse.
- An increase in help seeking behaviours and willingness to engage with appropriate services.
- Less impact on the person, their family and whānau, and carers.
- Farm staff will have improved ability to take breaks from prolonged stress, reduced staff turnover, and take time off for sick leave.
- Reduction in the number of suicides using firearms.

"When an ambulance or police car goes up your drive – everyone knows and wants to know why" Kaikohe workshop participant

Rural New Zealanders told us that they accept that geographic isolation is a reality of the life and work they have chosen. What they don't accept is the unnecessary impacts that this has on the level and range of essential services that are available to them when they are in need.

To be facing a serious mental health crisis, alone, miles from help is frightening - life threatening at times. Rural people told us that in these situations they are not sure who, if anyone will respond to their call for help. Often it is the local GP, policeman, priest or St John's Ambulance who is called out late at night, often on their own, to sit through the night with the distressed person and maybe their family, waiting for daybreak when more help can be sought.

Overstretched rural primary care services, many with locum doctors from overseas who may have limited knowledge of the NZ health system and the reality of rural life, are typically the first port of call. With often overfull waiting rooms, time pressures linked to 15-minute consultations and minimal support and advice from specialist services, rural health professionals care for people whose levels of acuity of mental illness regularly seems to exceed that of patients in urban primary care centres.

For those who fit the criteria for treatment by secondary mental health and addiction services, there are extra challenges that get in the way of attending treatment sessions, particularly when more than one service is involved. Improved coordination between services seems a simple yet elusive solution. Additional barriers to treatment result from extra time and costs involved due to distance and often small rural businesses having limited capacity to allow staff time off to attend appointments or take sick leave.

Those who are admitted to secondary mental health and addiction services for treatment say that discharge planning is often lacking with few support service options available to them. Limited choice of providers in rural areas can be a further barrier to seeking help. Concerns about a lack of confidentiality, being embarrassed to be seen in a local pharmacy collecting a prescription for a mental illness and challenges with interpersonal relationships between individuals and health or social service providers are further issues faced in smaller communities.

The challenges of recruiting and sustaining our rural health and social support workforce are well documented. The DHB mental health and addiction specialist workforce face similar problems with support through outreach clinics inevitably reduced in times of staff shortages.

Building rural primary care skills, confidence and capacity to support patients is fundamental to addressing these issues and ultimately improving mental health and addiction outcomes in rural NZ.

"I found it difficult going to the doctor and pharmacy because I was so upset and didn't want any locals to see me in this state. It didn't ask /or don't know if you can request house visits or deliveries of meds which could have helped with my embarrassment". Regional workshop participant

Rural communities have equitable access to self- management therapies, health and social services and timely access to specialist and emergency services when needed.

What's currently available?

- Rural primary care: some have good access to mental health and addictions specialists often in regular clinics. Some offer patients online access to their own medical records.
- Trials of Skype based primary care consultation occurring in some areas.
- Access for acutely unwell people to specialist MH & A services but often with considerable waiting times.
- Online and telehealth services available but not widely known or used, and not packaged with locally based face to face services.

What do we need to do next?

- Ensure consistent crisis or emergency response services are available across rural NZ – including after hours.
- Provide immediate support to people in crisis waiting to be seen by a specialist service.
- Empower individuals through support to use self-management tools and resources – online, telehealth, books or community based activities.
- Support rural primary care services to confidently provide clinical care and support.
- Continue to advocate for improvements to rural connectivity and mobile services.
- Advocate for national telecommunications providers to sponsor mobile devices and data plans for targeted groups.

What would these things achieve?

- Rural people will know what services are available and how to access them. They will make use of online, telehealth and face to face tools that enable self-management of their conditions.
- Patients will be able to access primary care and community MH&A services locally when they need to and before crisis situations arise.
- Waiting times for specialist MH&A services will be reduced and support will be available for people while they wait to be seen.
- Rural people will have reliable internet and mobile phone connectivity.
- Rural people who have high needs will have mobile devices and data plans that allow them to access online and telehealth services.

Rural New Zealanders told us they have a growing sense of being 'left behind'. They are quite sure that across their communities there are increased levels of mental distress, depression, people drinking dangerous levels of alcohol at home, greater use of drugs (particularly 'P') and more people at risk of suicide. Difficulties in navigating their way through unfamiliar services can make it harder to get the help that is needed. They are perplexed to find that there is so little information available about their health and social outcomes to support or disprove what they think they know.

DHBs and PHOs do not report on funding or performance indicators based on the geographic location of the populations for which they are responsible. Reporting and monitoring frameworks should be adjusted to adopt this approach and thus improve accountability and understanding of the needs of rural people.

The disparity in health outcomes between Māori and non-Māori people has been reported by DHBs and PHOs for many years. If this data was further analysed on an urban/rural population basis, it is likely to reveal significantly higher levels of disparity in outcomes for rural Māori whānau than whānau living in urban NZ. Very remote communities in the Far North and East Coast of the North Island experience high levels of unemployment, high levels of drug and alcohol abuse, greater difficulties in getting to appointments and overall access to services. In the Far North, we were told that a greater focus on developing peer support based on Māori models of wellbeing is an opportunity to improve outcomes for rural tangata whaiora.

Funding and contracting models often result in services being delivered in an urban centric way. This often leaves rural communities with outreach services that are difficult to sustain and, in the case of some specialist services, not available at all. With the mental health and addiction staff of both DHB and Non-Government Organisation (NGO) providers spread thinly across rural NZ, the need to work closely together is highlighted. Yet in some rural communities we were told that staff find contracting arrangements and targets get in the way of working collaboratively. 'Work-arounds' are common, exhausting those who go the extra mile to care for people in their communities.

Schemes such as the National Travel Assistance Scheme (NTA), with budgets managed by each DHB, can assist in the costs of accessing treatment away from home. Once again, anecdotally we heard that these are poorly aligned to the needs of rural people who need financial assistance to access secondary and specialist treatment some distance from home.

Through better information, and greater understanding and accountability, rural New Zealanders can aspire to mental health and addiction outcomes that are equitable with all New Zealanders.

What made recovery harder?

"The stress of running a multi-million-dollar business with so many staff and family dependant but no one else to rely on that would have the skills to keep it performing while help was being sought - and the pressure of needing to pay debt etc. had a terrible effect." Online survey respondent

Rural people have equitable access to and utilisation of Vote Health funded services.

What's currently available?

- Data: every person's contact with government funded health providers – DHB, PHO, pharmacy or NGO - is captured through our National Health Index Number (NHI).

What do we need to do next?

- Convene a wide stakeholder group to collaboratively identify information needs and processes to capture data across all funded agencies.
- Investigate options for reporting and analysis of rural population outcomes.
- Review alignment of the National Travel Assistance Scheme with the needs of rural people attending treatment for mental distress, ongoing illness, or addictions.

What would these things achieve?

- Equitable access to services that will contribute to equitable health outcomes.
- MH&A performance indicators and outcomes measures based on locality is routinely reported by DHBs, PHOs and NGOs.
- Performance against all National Health Targets is reported by locality.
- Contracting processes acknowledge the extra challenges of rural service provision, especially in relation to setting performance targets.
- Rural people utilise the NTA scheme for financial support to attend MH&A treatment sessions.

"The only pharmacist in the district took out a trespass notice against the tangata whaiora and she had nowhere else to get her medication.

For a week or more we drove 75km each way to take her medication to her every day while we looked for a more sustainable solution.

Finally, we got the rural hospital near where she lived to dispense the medication, and over 3 months we reduced her medication to a point where she no longer needed it." Addiction Service Staff member.

Framework – Circles of Care

NZ Health Strategy - One Team

Establishing and supporting primary care and multi-sector, community-based mental health and addiction teams to confidently care for people experiencing mental distress, illness or addiction. It's also about improving responses to crisis and serious mental distress.

Rural communities know that their relationships and networks can help them work together to care for those who are experiencing mental distress, illness or addiction. We noticed that the common thread woven through the stories we were told about 'when things go well it looks like this...' was in rural communities working together to create a circle of care around a troubled person or family/whānau. Every circle of care will be different as communities create solutions based on their relationships and the resources that are available to them.

Building and supporting these relationships through locally based leadership, professional development and education, peer support, easy access to specialist advice and appropriate resourcing is key to ensuring this way of working is the norm across rural NZ.

There is common agreement that crisis response in rural areas often falls to Police or St John's; that rural primary care is commonly the lead carer for those who are mentally unwell; that access to counselling services is limited by funding and a lack of skilled people who understand rural realities. We also heard that much falls to partners to maintain the daily rural business activities while their loved one is unwell. Milking the cows, feeding out, or getting through lambing while juggling children, managing staff, household chores, off farm work, on top of caring for their partner was described as relentless.

Building capability, capacity and service options in local 'circles of care' is critical to improving outcomes for rural people. An element of the rural community feeling of being left behind relates to a growing realisation that there are support and specialist service options available to urban people, that could and should be equitably available in rural communities.

For example: rural people told us the most important factor in their recovery from an episode of mental illness was the support of a friend or family member. However, the carers and family members told us that they themselves felt unsupported. The efficacy and contribution peer support makes to recovery from an episode of mental illness for the person, their family or whānau and carers is now internationally recognised but is a service option that is not consistently available to rural people.

Much is being achieved within existing resources but the increased demand on largely volunteer peer support services such as the Rural Support Trust raises questions of sustainability. Rural people told us that there are aspects of rural life not well understood by urban people, and that people who live, work and understand rural NZ are best placed to care for rural people. This view is consistent with the principles of formally trained and supervised peer support services. Resourcing, training and supporting rurally based peer support services would seem a logical approach.

A programme to train and introduce urban based health and social service professionals to rural folk, and the realities of their lifestyles is also likely to improve outcomes.

Neil Bateup from the Waikato Rural Support Trust shared this story: "One of the local bankers called to ask me to help a client he'd seen that afternoon. The farmer was facing huge financial stress and most likely, a mortgagee sale. I spent the afternoon with him, listening, and getting my head around what we could do to help. With his agreement, I made him an appointment to see his GP, we arranged counselling through the Rural Support Trust as it would be quick. We prepared for the next meeting with the banker, and I went with him to help him work out a good plan for the farm sale.

After a difficult few months, the farm was sold, and that went well. He was so grateful for the help he got from the RST that he has since volunteered to help others who need a break."

Rural health and social service professionals are well resourced and supported to provide the highest quality service for people experiencing mental distress, illness or addiction.

What's currently available varies from one rural community to the next but includes:

Rural General Practice, Pharmacists, some MH&A NGO services, DHB Specialist staff in varying roles and levels of activity, St John, Police, Clergy, Counsellors, school counsellors, Rural Support Trust, Māori Women's Welfare League, Telehealth services.

What do we need to do next?

Developing a 3-5 year Rural Mental Health and Addiction Community Action Plan (RMHACDP) that incorporates Māori models of care could include:

- Safe Hands, Safe Plans workshops.
- Understanding local & national services & access pathways.
- Use of online and telehealth.
- Suicide prevention.
- MH101 about youth.
- Peer support relevant to communities and rural whānau.
- Building relationships with urban and telehealth staff while upskilling them on rural issues.
- RMHACDP evaluation tools aligned to National Mental Health and Addictions Outcomes Framework.

Explore options for establishing national rural psychiatric clinical leadership across Adult, Child and Youth and Addiction specialist expertise.

What would these things achieve?

Rural MH & A communities will be:

- Engaged and upskilled to work as integrated localised circles of care.
- Trained and supported to work safely, confidently within their scope of practice.
- Improved and through shared responses place less reliance on a few people.

Rural Psychiatric Clinical Leadership provides oversight and leadership to the Framework and is working directly with individual rural primary care and community MH& A networks.

Little is known about the health and wellbeing of rural New Zealanders - a population group that together would be the size of New Zealand's second largest city.

Rural people talked about the unintended consequences of national road safety policies that raised the driving age for young people and changed blood alcohol levels to reduce drinking driving. These recent and other such policies have over time, had an unintended but significant impact on the social structure of all ages of people living in rural New Zealand. We all know of country pubs that have closed or struggle to remain viable and community sports and events that are much less active or attended largely because of the new laws.

We also know that about 4-5% of the total population accesses DHB funded Mental Health and Addiction Services including those provided by Non-Government Organisations. Estimates of those who are cared for in Primary Care suggest a further 10 – 12% of people are being treated at any given time.

However, there is no agreed process to capture or analyse health data based on where people live and most particularly, whether they live in rural or urban places. While there is a widely-held view that rural people experience heightened levels of mental distress, depression or addiction in times of extreme climatic events, global market fluctuations or other factors, there is no reliable data or information available to support this view or inform policy or resource allocation.

Suicide rates have over the years been used as a blunt measure of the overall mental wellbeing of rural communities, but this is a long way from understanding the overall wellbeing of each rural community.

The Royal Australian and New Zealand College of Psychiatrists estimates mental illness knocks 5% off our Gross Domestic Product (GDP). Given the significant contribution that Primary Industries make to our GDP it would seem sensible to understand the relationship and impact of one measure against the other.

NZ health and agri-business organisations, university based and other research institutes, are undertaking investigative projects, research and evaluations of programmes and activities. A nationwide process to identify research priorities, encourage collaboration, and share knowledge over a long period could address this dearth of knowledge and enable effective decision making, leading to more targeted and effective resource allocation.

The 8000 strong Farming Mums Facebook Group gets posts every day from women living and working in rural NZ. They cover all aspects of rural life from "How do I get the 4-wheeler going?" to "How do I make Chocolate Brownie?".

Sadly, every day there are also countless posts about struggles with isolation, supporting a partner who has depression (treated or not), pressure from difficult employment issues, and farming businesses that are vulnerable to global market fluctuations. This social media page raises serious questions about what is known about the mental wellbeing of rural New Zealanders, or how they want to be supported.

Mental Health and Addiction data informs research priorities, community and service development, resource allocation, and health and social service provision.

What do we know already?

- Data are collected at every point of contact with health services, MSD, WINZ and Education. This can be linked to where people live.
- While the ability to share individual's health data is guided by the Privacy Act, there are solutions for sharing anonymised data linked to their place of residence.

What do we need to do next?

- Convene a research focussed group to work together to:
 - Establish a Rural Health Research Programme and annual symposium.
 - Identify and prioritise research gaps.
 - Identify funding streams that optimise resources and research productivity.

What would these things achieve?

- Research and evaluation programmes utilise data and information captured by Government departments to inform their work and improve our understanding of rural health issues, priorities and outcomes.

Rural people told us that there are things about living in rural NZ that help in recovering from an episode of mental illness:

"We live in beautiful open spaces; working with animals can be healing; working physically can be healing; we know people who have been unwell and recovered"

"We appreciate hearing presentations like John Kirwan, or the safeTALK workshops without having to drive for miles and give up half a day's work."

"In little rural communities, far from a big town (sometimes more than an hour's drive away), neighbours and friends are very important and are more of a support service than the officials from away."

"Being able to engage within the community as a volunteer and/or part of community groups."

IMPLEMENTATION FIRST STEPS

The Framework emerged from the collective wisdom and experience of a wide range of organisations and individuals who have a direct interest in the mental wellbeing of rural New Zealand. The energy and support for this initiative has been overwhelming, and reflects the widely-held view that the disparity in mental health and addiction outcomes between rural and urban New Zealanders is increasing.

The implementation of the Framework is dependent on a cross sector, multi-agency approach to the enactment of agreed initiatives. Some of these initiatives may best be led by RHĀNZ alliance members who are leaders in the agri-business, telecommunications or industry training sector. Others are clearly linked to either the Ministry of Health through their engagement with District Health Boards or Primary Health Organisations. The Ministry for Primary Industries in collaboration with the Rural Support Trusts may also lead aspects of this Framework.

We recognise that a Framework Implementation Plan will be enhanced by engagement with DHBs' Rural Health Alliance groups to ensure initiatives are aligned and optimise resource utilisation.

The implementation of the Framework will require centralised governance, leadership and coordination which in turn will require appropriate funding and support. We propose the following structure to enable cross-sector support and collaboration, which builds on the momentum of the existing Framework Expert Advisory Group (EAG) members and their supporting organisations. Consideration should be given to either retaining the current EAG as a sector based advisory group, or inviting members to participate in governance and project groups as they are formed.

Therefore, we propose the following actions and structure to support the implementation of the Framework:

1. Establish a *Framework Alliance Leadership Group* (FALG) whose members include RHĀNZ, MOH, MPI, RST, MWWL and other capability based representatives. This Group would oversee the development of a *Framework Alliance Charter* to define its purpose, scope of activities, and key deliverables. Some members of the FALG would be drawn from the existing Expert Advisory Group.

From a rural addiction specialist:

"P is everywhere in rural communities and really easy to get. It's getting bigger because at the start it seems harmless and most people wouldn't recognise the signs of its use. We have an image of the typical P user- they're from the criminal world and so we don't realise they can be anyone we know.

With the long hours of seasonal work, the heavy workload and stresses on rural business owners and their workers, it's not surprising that so many rural people are resorting to a drug that at the start, gives you energy and a feeling of wellbeing.

Here's a couple of examples:

Firstly, there's Charlie, a gang member from a country town who's been manufacturing and selling P since it's early days in NZ. He's done a 7-year jail stint for it and might be what we think of as a 'typical' P user. But what we don't realise is the other health implications it's had on him. At 48 he's had a triple bypass because his heart couldn't cope with the strain his P use put on it.

Then there's the mum who nobody realises is a heavy P user. She started using to get a boost in her life but now her use of it is really dangerous. She uses P over the weekends and for the next 3 days, she doesn't eat or sleep and obsessively cleans her house. When it starts to wear off on Monday she's back at work at her job in the local day care centre. It takes her all week to get her eating and sleeping back to normal but her mood swings are so bad it causes huge upsets with her kids. Just as she is coming right, it's Friday and it starts all over again.

P can be very hard to pick up or recognise so she's got to a point she's seriously unwell, in a financial mess, her kids are in a state and her friends have only just started to wonder why she is losing so much weight. "

2. The FALG would work immediately to develop a *Framework Implementation Plan* that reflects the outcomes and priorities identified in the Framework. It would also consider options for socialisation and ongoing maintenance of the Framework.
3. Project specific groups are formed to provide expertise and resources for each project. Members of the project groups could in the first instance, be drawn from the existing Expert Advisory Group.

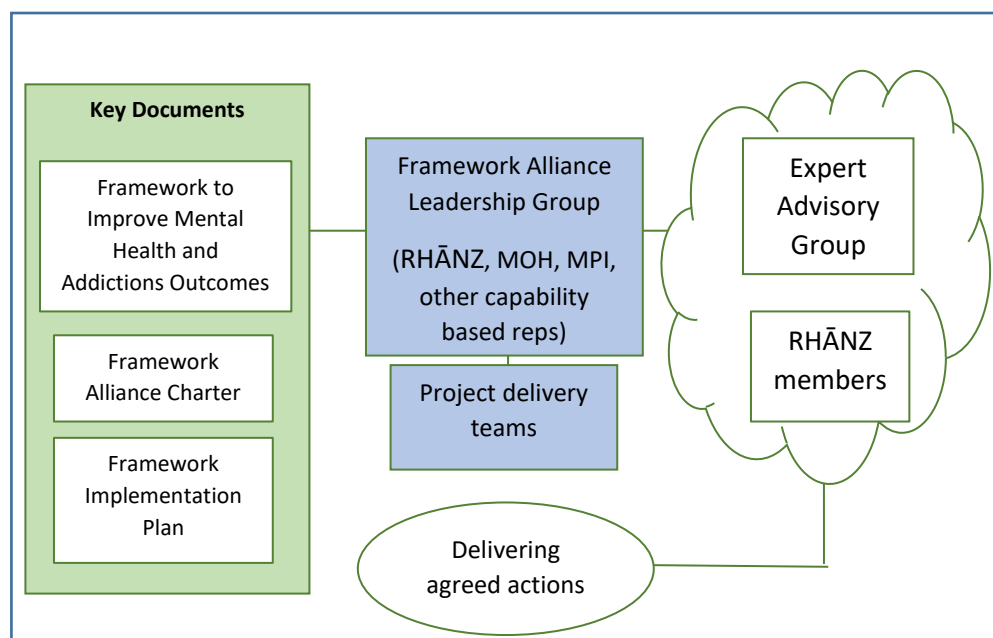


Figure 1 Proposed Implementation Approach

We are confident that the collective members of the Rural Health Alliance Aotearoa New Zealand, in partnership with the Ministry for Primary Industries and Ministry of Health, would be delighted to lead the coordination and implementation of the Framework.

FRAMEWORK ACTIVITIES PRIORITISED BY THE EXPERT ADVISORY GROUP

This Framework represents an ambitious programme of cross government, multi-agency initiatives, occurring in collaboration.

An Implementation Plan centralises and coordinates activity and ensures each lead agency's work plans will optimise the use of resources and timing for each piece of work. Some of this cannot be known until further preparatory work is done.

The Expert Advisory Group was asked to endorse the list of actions that are included in the Framework, and prioritise them on the basis of:

1. Those requiring immediate action.
2. Those that could take less priority.

The table that follows summarises the EAG's priorities.

FRAMEWORK ACTIVITIES PRIORITISED BY THE EXPERT ADVISORY GROUP	
Needing Immediate action – within 2 years	Actioned in the medium term 2 – 5 years
Caring communities looking after each other	
<ul style="list-style-type: none"> Rurally relevant campaigns: <ul style="list-style-type: none"> anti-stigma; promoting safe use of alcohol; reducing drug use; and increasing help seeking behaviour Community based mental health and addiction education / awareness / suicide prevention / including youth focussed On farm firearm safety programme 	<ul style="list-style-type: none"> Improved pastoral care of rural business staff and management Farm relief worker scheme
Reachable services	
<ul style="list-style-type: none"> Rural primary care is adequately resourced to minimise waiting times Crisis and Emergency response pathways in place and easy to use Patient portal to primary care services available to all After hours and discharge support available to all MH & A specialist staff regularly onsite in rural primary care 	<ul style="list-style-type: none"> MH & A Tele-triage and liaison services across NZ Reliable internet and mobile phone connectivity Sponsored access to mobile devices and data plans
Accountability for rural outcomes	
	<ul style="list-style-type: none"> DHB / PHO reporting of performance indicators includes analysis based on geographic location Review alignment of the National Travel Assistance Scheme
Our circle of care	
<ul style="list-style-type: none"> Establishment of national rural psychiatric clinical leadership across adult, child and youth, and addiction expertise A 3-5- year Rural Mental Health and Addiction Community Development Plan that reflects Māori models of care and includes: <ul style="list-style-type: none"> RMHI <i>Safe Hands, Safe Plans</i> workshops rolled out across rural NZ Use of online and telehealth services Suicide prevention training Peer support capacity and support (person / family whānau / carers) MH101 about Youth Understanding local and national services and access pathways 	
Understanding rural New Zealanders	
<ul style="list-style-type: none"> Nationally consistent definition of rurality as it pertains to health Centralisation of rural health and social service data Rural Health Research Programme and Annual Symposium 	

APPENDICES

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We also acknowledge the considerable advice, support and input to this work given so generously by:

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