MENTAL HEALTH AND WELLBEING STRATEGIC FRAMEWORK 2026-2036

18 May 2026

Hauora Taiwhenua Rural Health Network is a national peak body representing rural health professionals and the health/wellbeing of rural communities in Aotearoa New Zealand. We represent a broad coalition of rural health professionals, communities, and organisations committed to improving health outcomes for people living in rural and remote Aotearoa.

Our members are often in the front line when an emergency occurs, often caring for those in the community that are most vulnerable.

We welcome the opportunity to make a submission on the Mental Health and Wellbeing Strategic Framework 2026-2036.

CONSULTATION QUESTIONS

1. From your experience, what most gets in the way of people or whānau getting the mental health or wellbeing support they need, including support for addiction, substance harm and gambling?

1.1. The barriers to accessing mental health and wellbeing support in rural communities are well documented and often interconnected. They can be broadly grouped into issues of access, service availability, system navigation, and social context.

1.2. **Physical access and cost barriers remain significant**

1.2.1. The time, cost, and availability of transport to reach specialist services - often located in urban centres - continues to limit access. For many people, particularly those on lower incomes, attending appointments can be financially prohibitive. In addition, connectivity issues and the cost of mobile data or internet access reduce the effectiveness of telehealth and online supports, which are often positioned as solutions to geographic isolation.

1.3. **Limited local service availability exacerbates delays and unmet need**

1.3.1. Emerging New Zealand evidence indicates that rural residents experience a clear mismatch between need and mental health and addiction service use. Despite higher suicide rates, rural populations are less likely to access mental health professionals and have lower rates of hospital presentation for non-fatal self-harm. This reflects both reduced access to services and unmet need within

rural communities.[1] Rural areas have fewer specialist mental health, addiction, and crisis response services. This leads to longer wait times and fewer appropriate care options. Crisis support is particularly limited, resulting in reliance on police, rural hospitals, or general practice urgent care services, which may not be resourced or designed to provide specialist crisis intervention.

1.4. **Workforce constraints and service gaps result in misaligned care**

1.4.1. When specialist services are not readily accessible, people are often treated by whichever service is available locally, rather than the service best matched to their needs. For example, a person presenting in a rural general practice with moderate depression and harmful alcohol use may be assessed and referred to specialist services but face long wait times and difficulty in getting to them to attend. In the interim, the GP may initiate antidepressant treatment and arrange support through a part-time Health Improvement Practitioner (HIP), who may not have expertise in addiction. While some support is provided, key issues (such as ongoing alcohol use) may remain unaddressed.

1.5. **Delays can lead to deterioration and further barriers**

1.5.1. By the time a visiting specialist clinician becomes available, often several months later, the person's circumstances may have worsened, for example, through loss of employment or financial stress. These changes can introduce new barriers, such as the inability to afford transport which often results in missed appointments and disengagement from care.

1.6. **System complexity and fragmentation make services difficult to navigate**

1.6.1. Service visibility is often low in rural areas. People may not know what services are available locally or how to access them, particularly when services are fragmented or regionally commissioned with inconsistent entry points and eligibility criteria.

1.7. **Social and cultural factors also play a role**

1.7.1. Privacy concerns - both real and perceived - are amplified in small communities, where people may fear stigma or lack of anonymity. This can discourage individuals and whānau from seeking help early, or at all.

1.7.2. Limited health literacy within some rural or culturally diverse populations can be a significant barrier to help-seeking. Individuals may struggle to recognise early signs of mental health or substance use issues, and even when these concerns are identified, uncertainty about where to access appropriate support can lead to delays in receiving care.

1.8. **Social determinants of health**

1.8.1. Before individuals can effectively engage with mental health or addiction and substance use support, they must first experience a sense of safety and stability, rather than remaining in a heightened "fight-or-flight" state. Various social determinants of health can undermine this foundation, including inadequate or insecure housing, limited employment opportunities, and barriers to education, among others.

1.8.2. Overall, these factors combine to create a situation where delays, limited service availability, workforce constraints, and practical barriers such as cost, distance, and stigma prevent people from accessing the right care at the right time from the right person. Even where initial engagement occurs, these barriers can lead to fragmented care and worsening outcomes over time.

2. From your experience, what most helps people or whānau stay mentally well or get the support they need for their mental health and wellbeing, including gambling and substance related harm?

2.1. Many of the same factors that act as barriers in rural communities can also, when working well, become the strongest enablers of mental wellbeing and access to care.

2.2. **Trusted local relationships are critical**

2.2.1. While concerns about privacy can be a barrier, established relationships with local providers - such as rural GPs, nurses, kaupapa Māori service kaimahi, and well-connected and well-trained Health Improvement Practitioners - are often the most important entry point into care. These providers are trusted, accessible, and play a key role in early identification, ongoing support, and continuity of care.

2.3. **Strong community networks provide essential support**

2.3.1. Although some individuals may feel reluctant to disclose concerns within their local community, informal support networks - particularly in rural areas - can play a vital role. Whānau, neighbours, schools, sports clubs, local service providers such as postal workers, farming support organisations, and faith-based groups frequently provide early intervention and help sustain wellbeing. These networks often serve as the first line of response within rural communities.

2.4. **Flexible, outreach-based models improve access**

2.4.1. Services that shift away from traditional clinic-based models are particularly effective. This includes urban specialist services regularly visiting rural communities, as well as local providers delivering care in community settings such as marae, schools, or through home visits. These approaches reduce access barriers and better meet people where they are.

2.5. **Capability of local services must be strengthened**

2.5.1. For rural models to be effective, locally available providers need strong access to ongoing training and professional development - particularly in areas such as trauma-informed care, identifying underlying addiction issues, and responding to complex presentations. Equally important is ready access to specialist advice and support, so local providers can confidently manage care while waiting for, or in conjunction with, specialist services.

2.6. **Culturally appropriate and locally relevant services are important**

2.6.1. Approaches that reflect the identity and context of rural communities are more effective. This includes kaupapa Māori services, as well as rural-specific initiatives such as Rural Support Trust, Farmstrong, and Surfing for Farmers, which resonate with local values and lived experience.

2.7. **Telehealth can improve access when implemented well**

2.7.1. Telehealth and digital supports can help overcome geographical barriers, offering greater privacy or anonymity and access to a broader range of services. However, their effectiveness depends on individuals having reliable internet connectivity, suitable devices, and the digital literacy to use them. It is also important that these options remain a matter of patient choice, rather than the only avenue for accessing care.

2.8. **Support for local determinants of health**

2.8.1. Strong cross-sector collaboration to address factors that contribute to mental health and addiction challenges is essential. This includes ensuring access to warm, safe housing with clean running water, as well as culturally appropriate education and meaningful employment opportunities.

3. What parts of the strategy feel the most right or important to you? Why?

3.1. Several aspects of the strategy align well with the needs of rural communities and provide a strong foundation for improvement.

3.2. The emphasis on prevention and early intervention is particularly important.

3.2.1. In rural settings, waiting for specialist services is often not viable. Strengthening early support, wellbeing promotion, and community-based responses is critical to addressing needs before they escalate.

3.3. **The commitment to reducing unwarranted geographic variation is essential**

3.3.1. Persistent differences in access and outcomes between rural and urban communities remain a key issue. A clear focus on addressing geographic inequities is fundamental to improving fairness and consistency of care.

3.4. **The focus on community-based supports and continuity across the continuum of care effects rural realities**

3.4.1. Rural people often access support through local networks and primary care services. A more connected system that supports continuity of care aligns with how services are actually experienced in rural communities.

3.5. **Recognition of workforce wellbeing, diversity, and new roles is also critical**

3.5.1. Strengthening and diversifying the workforce, including developing roles suited to rural contexts, is vital given ongoing challenges with recruitment, retention, and service sustainability in rural areas.

3.5.2. Together, these elements provide a strong direction, particularly if they are implemented in ways that are responsive to rural contexts and needs.

4. What changes would make the strategy work better for people and whānau? Why?

4.1. To be effective for rural communities, the strategy needs to move beyond general statements of equity and explicitly make rural access, investment, and outcomes visible, measurable, and actionable.

4.2. **Explicitly recognise rural communities as a priority population**

4.2.1. Rural communities must be specifically identified throughout the strategy, rather than assumed to be captured within general equity language. This will strengthen accountability and establish the need for rurally specific actions in implementation plans.

4.2.2. Recent analysis using the Geographic Classification for Health demonstrates that rural suicide rates -particularly for men - are significantly higher than urban rates, with rural male suicide rates nearly 50% higher than their urban counterparts. .[1] Inequities are particularly

pronounced for Māori, with substantially higher suicide rates across both rural and urban settings, and amplified disparities for younger Māori in rural areas.

4.3. **Improve visibility and accountability for rural outcomes**

4.3.1. The strategy must require consistent application of the Geographic Classification for Health so that all data, monitoring, and reporting is disaggregated by location but most importantly, rurality, alongside ethnicity, age, and gender specific data. This includes all measures in the monitoring framework and Appendix One. Without this, rural inequities will remain hidden within regional or national averages.

4.4. **Align funding and workforce data with rural need**

4.4.1. Applying the GCH across all levels of service commissioning and service development will enable transparency on the extent to which mental health and addiction ring fenced funding is invested across rural and urban areas, and/or, directed toward rural communities. This will enable reporting the impact of investment into workforce development to show the number, and description of new professionals trained and working in rural areas. It will give information about the alignment between and evidenced based population need - rural, and remote Māori communities.

4.5. **Strengthen rural-specific service models**

4.5.1. The strategy must recognise the importance of service models that are known to be effective in rural settings, including regular and reliable outreach services, multi-skilled and multidisciplinary teams within rural general practice and Hauora Māori services, regular visiting specialists, and shared roles across services in line with contemporary rural generalist thinking.

4.6. **Ensure digital investment supports equitable access**

4.6.1. Telehealth and digital solutions should include investment in connectivity, affordable devices and data, and training for both providers and service users. Digital approaches should complement, not replace, in-person care options and should remain patient choice for use.

4.7. **Adapt service commissioning to rural realities**

4.7.1. Clearer direction is needed on how commissioning models will support small rural providers, who face challenges in sustainably meeting urban-centric service specifications and performance requirements. Rurally specific service specifications, developed in partnership with rural stakeholders, are required to reflect the higher costs of delivering services in rural communities, and the

realities of kaimahi working across multiple roles, travelling significant distances to see patients, and consequently, comparatively low-volume, contexts.

4.8. **Strengthen rural workforce development pathways**

4.8.1. This includes targeted incentives, training, and "grow your own" approaches that support people from rural communities into the workforce, provide accessible ongoing education and training, and rurally sensible and appropriate supervision.

4.9. **Transform trauma-informed support**

4.9.1. Rural communities are likely to experience higher rates of trauma exposure, which can significantly contribute to the development of mental health challenges. Ongoing, unaddressed distress can increase the risk of more serious outcomes, including suicide. Despite this, access to timely, trauma-informed care remains limited in many rural areas, highlighting the need to strengthen and expand appropriate support services.

4.10. **Embed rural voices in all levels of decision-making**

4.10.1. Meaningful rural input is required in policy development, service planning, commissioning, and implementation to ensure solutions are grounded in rural realities.

5. This strategy will come with a plan that sets out what needs to happen to bring it to life. The first plan will have a three-year focus. What are the most important steps we should take in the next three years to make the biggest difference to people's mental health and wellbeing, including reducing substance and gambling related harm. Please tell us why.

5.1. To deliver meaningful improvements for rural communities, the first three years should focus on embedding rural equity in decision-making, strengthening workforce capacity, and improving access to locally relevant services.

5.2. **Embed rural voices in decision-making**

5.2.1. Rural perspectives must be included at all levels of mental health and addiction policy development, service planning, commissioning, and implementation. To date, rural input has been limited, and this is reflected in a strategy that does not fully account for the disproportionate impact of access barriers on rural whānau. Incorporating rural voices will ensure solutions are grounded in lived experience and designed to work in rural contexts.

5.3. **Develop and publish rural-specific measures**

5.3.1. The strategy should include clearly defined rural access and outcome measures, with routine reporting against them. This is essential to track whether equity goals are being achieved and to ensure rural communities are not obscured within regional or national data.

5.4. **Intentionally grow a rural mental health workforce**

5.4.1. The rural mental health and addiction workforce must be deliberately designed and resourced, recognising that it will necessarily differ from urban models. Lower rates of service utilisation in rural areas, despite higher mortality, suggest that current service models are not reaching those most at risk. .[1] It should be built on strong rural primary care and hauora Māori services, supported by specialist input. This includes:

- Strengthening rural generalism across all relevant professions
- Expanding kaupapa Māori mental health and addiction roles
- Providing targeted training pathways for rural HIPs and support workers
- Ensuring access to specialist advice and supervision
- A focus on building workforce capability and understanding of the unique challenges faced by rural communities, including the application of trauma-informed approaches
- Supporting integrated service navigation and digital care options.

5.5. **Invest in community-based prevention and early intervention**

5.5.1. Early investment should focus on strengthening and flexibly scaling existing rural programmes and networks that are already working well, rather than creating new structures. Community-led and locally trusted initiatives are critical to sustaining wellbeing and reducing demand on specialist services.

5.5.2. Non-fatal intentional self-harm is a strong predictor of suicide and occurs at much higher rates than suicide itself. However, many of these events do not present to services, particularly in rural areas, highlighting the importance of early identification and intervention outside of specialist settings. .[1]

5.6. **Improve rural crisis response and support closer to home**

5.6.1. Rural populations are more likely to use highly lethal methods, including firearms, contributing to higher fatality rates. .[1] Crisis care needs to be more responsive to rural realities. This includes:

- Expanding local crisis and respite options to reduce reliance on emergency departments and police

- Ensuring discharge planning from urban EDs explicitly considers the person's rural context, including distance from services and limited after-hours support
- Enabling rurally specific criteria to accessing short-stay or respite care options to support discharge from ED or inpatient care.

5.6.2. Without these changes, rural whānau will continue to face significant barriers at their most vulnerable points, often returning from acute care environments to communities with limited support.

5.7. **Strengthen cross-sector engagement to address the social determinants of health and prevention of mental health problems**

5.7.1. Higher suicide risk is closely associated with socioeconomic deprivation and broader social determinants of health. .[1] Improving mental health and wellbeing outcomes in rural communities requires coordinated action across sectors to address the underlying drivers of need. Effective collaboration between health, housing, education, employment, social services, and community organisations is essential. This includes:

- Partnering across agencies to improve access to safe, warm housing and essential infrastructure
- Supporting pathways into culturally appropriate education, training and sustainable employment
- Aligning services to provide integrated, person-centred support that reflects rural realities
- Empowering iwi, and community-led organisations to design and deliver locally relevant solutions
- Strengthening local leadership and accountability for addressing social determinants of health

6. If you could choose just one thing for us to do to make the biggest difference in the next three years, what would it be?

6.1. **Build and retain a stable, locally embedded rural mental health workforce**

6.1.1. This workforce should be centred within rural general practice and iwi health or hauora Māori services, and be supported with the flexibility, resources, training, and specialist back-up needed to operate across the full continuum of care - from prevention and early intervention through to ongoing support.

6.1.2. A workforce grounded in local communities, with strong relationships and access to specialist advice, is the single most important factor in improving timely access, continuity of care, and outcomes for rural people and whānau.

7. To make space for new or better ways of doing things, we might need to stop doing other things. What do you think we should stop doing, or do less of, so we can focus on what would work better? Please tell us why.

7.1. To enable more effective approaches for rural communities, the system needs to stop or reduce practices that reinforce inequity and limit local responsiveness.

7.2. **Reduce fragmented, short-term funding**

7.2.1. Short-term and piecemeal funding undermine continuity of care and workforce stability, particularly for small rural providers. Longer-term, flexible investment is needed to support sustainable services and retain skilled staff.

7.3. **Do less 'one size fits all' commissioning**

7.3.1. Standardised service specifications and performance measures disadvantage low-volume, high-need rural communities. Commissioning approaches need to better reflect rural scale, geography, and the importance of integrated, multi-role service delivery.

7.4. **Stop assuming digital equals accessible**

7.4.1. Digital services should not be treated as a universal solution. Without investment in connectivity, devices and data, and digital capability, telehealth can deepen inequities rather than reduce them. Digital options must complement, not replace, locally delivered care and be a patient choice to utilise.

7.5. **Reduce repeated consultation without implementation**

7.5.1. Rural communities tell us they are frequently consulted but see limited follow-through. They refer to the recurring scenario of pilots and engagement processes that lack sustained implementation support which result in provider and community fatigue and reduced trust in the health system. Greater focus is needed on scaling what already works and delivering tangible improvements.

8. We want to make sure that the things we do are making a difference for people. What should we be checking, measuring or keeping an eye on to know if the strategy is making a difference?

8.1. To understand whether the strategy is delivering equitable outcomes, it is essential that all key indicators are disaggregated by rurality using the Geographic Classification for Health (GCH), alongside other population measures.

8.2. **Access and timeliness of care**

- Wait times and access rates across the continuum (primary, specialist, crisis), reported by GCH categories
- Evidence that rural people can access services within comparable timeframes to urban populations.

8.3. **Workforce capacity and distribution**

- Workforce growth, vacancy rates, and training outcomes by GCH categories
- Number of practitioners working in rural communities, and continuity of staffing over time.

8.4. **Health outcomes and harm indicators**

- Rates of intentional self-harm and suicide by GCH categories
- Indicators of substance-related harm and unmet need in rural populations.

8.5. **Continuity and quality of care**

- Whether people can maintain ongoing relationships with known providers
- Smooth transitions between services and levels of care.

8.6. **Community wellbeing and lived experience**

- Feedback from whānau, schools, community organisations, and local providers
- Measures of perceived wellbeing, connection, and access to support within communities.

8.7. **Digital access and equity**

- Connectivity, device access, and uptake of digital mental health services in rural areas
- Whether digital options are improving access or creating new gaps.

9. We want to make sure that the things we do are making a difference for people. What should we be checking, measuring or keeping an eye on to know if the strategy is making a difference?

9.1. **Rural communities are not small urban communities**

9.1.1. They require intentionally designed models of care that reflect distance, workforce realities, and community context not adaptations of urban services at the margins.

9.1.2. **Equity must be operationalised, not assumed.** The strategy will only succeed if there is clear accountability for rural outcomes within the implementation plan, including visible measurement and reporting.

9.1.3. **Build on rural strengths.** Rural communities have strong foundations of resilience, connectedness, and community leadership. The strategy should actively invest in and support these strengths, rather than focusing solely on deficits.

9.1.4. **Move from consultation to co-design.** Ongoing engagement with rural communities must go beyond seeking input and instead enable genuine co-design and shared ownership of solutions, ensuring services are grounded in local realities.

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REFERENCES

1. Rural-urban differences in self harm in New Zealand. *Publication in preparation by University of Otago Geographic Classification for Health Team, Professor Garry Nixon*