NZNO Mental Health Nurses Section
Newsletter
December 2021

Welcome to the re-launched MHNS Newsletter

There's always a bit of excitement around Issue 1 of a new periodical – and so it is, for us. Born of necessity after the demise of the Stop4th Nursing Information Provision Service (SNIPS), which provided our content up until July, the MHNS Newsletter will now showcase the *International Journal of Mental Health Nursing*. Each issue will feature a local article from the journal and the contents list. Full access to the journal is a benefit of MHNS membership. To obtain an article, please email library@nzno.org.nz with the citation of the full text article you would like. The MHNS Newsletter now be coming to you bimonthly, matching the *IJMHN* publication schedule.

Committee news

The MHNS Committee met over two days on 18-19 November. Due to the Covid Alert Level in Auckland, the meeting was a blend of Zoom and face to face participation.

Our full agenda included discussions with the MOH Deputy Director of Mental Health, Toni Dal Din, and MOH Principal Advisor Anne Brebner. Toni spoke to us briefly about reviewing guidelines for statutory officers, for the transport of special patients and for seclusion.

But the bulk of his kōrero was about the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The first phase of consultation on transforming our mental health law closes on 28 January, with further consultations to follow. Drafting of the new legislation is due to take place in 2023. The MHNS Committee will ensure that members' voices are heard in this process.

Anne Brebner spoke about the role of the Specialist Services Team and the other parts of the Ministry which it interfaces with. A major piece of work for her team is the forthcoming Mental Health and Addiction System and Services Framework. This will guide the first major reconfiguration of the sector since the Blueprint for Mental Health Services in 1998.

We also discussed the review of the NZNO Constitution. As one of the movers of the 2020 remit for a full and independent review, the MHNS Committee is represented on the Constitutional Review Advisory Group. The independent consultants who are assisting

with the review zoomed in for this agenda item.

The November meeting farewelled Philip Ferris-Day and James Mather, who are both stepping down to pursue new opportunities. We are appreciative of Phillip's long service and many contributions on the Committee over the last four and a half years, and we are very grateful that James and former Committee member Cecil Williams will continue their “on the ground” assistance in preparing for the 2022 Mental Health Nurses Forum. The Committee is now:

Helen Garrick (Chairperson)
Margaret Daniela (Minute Secretary)
Jennie Rae (Treasurer)
Brent Doncliff (Committee member/Facebook group administrator)
Grant Brookes (Committee member/Newsletter editor)

Committee vacancies – call for nominations

The departures of Philip Ferris-Day and James Mather mean that the MHNS Committee is now looking to co-opt two additional members. This is an opportunity to get a taste of Section leadership, for a shortened term up until the Biennial General Meeting in August 2022. We invite any new, emerging leaders to join us. Please click here for the nomination form. Nominations close 17th January 2022.

2022 Mental Health Nurses Forum – Registrations now open

As announced by email on 1 December, the rescheduled Mental Health Nurses Forum is back on for 2022. Presented in collaboration with Southern District Health Board, this MHNS Forum is an excellent professional development opportunity for any Mental Health Nurse.

Date: Friday, 18 March 2022
Venue: Hutton Theatre, Otago Museum, Dunedin
Theme: “Capacity and Duty of Care”

REGISTER HERE
Click here for the forum flyer.

All details can be found on the Mental Health Nurses Section webpage. We look forward to seeing you there.

NZNO Mental Health Nurses Section Committee

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Issue Information
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Mental health, climate change, and bushfires: What’s colonization got to do with it?
Kisani Upward RN, BN, MPhiL Candidate, Vicki Saunders BPsych, MPH, PhD, Myfanwy

Feature article

International Journal of Mental Health Nursing

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Review Article

An integrated review of the barriers and facilitators for accessing and engaging with mental health in a rural setting

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ABSTRACT: *The review investigated the barriers and facilitators associated with assessing and engaging with mental health in a rural setting. The aim is to describe and synthesize the literature that examines the experiences of adults who access or attempt to access mental health services in rural settings. A systematic search from 2010 to 2020 was conducted using CINAHL, PsycINFO, Web of Science Core Collection, PubMed, Psychology and Behavioural Sciences Collection, Google Scholar, and Scopus. PRISMA protocols located 32 relevant papers from the overall 573 first selected. Braun and Clarke (Qualitative Research in Psychology, 3:77–101, 2006) thematic analysis methodology was applied to the data resulting in two themes: first theme identified help-seeking with subthemes of stigma and locality of health services. The second theme was connectedness, inclusive of subthemes of support systems and personal identity. The review identified gender-related perspectives concerning accessing mental health support, exposing the need for more research to examine the diverse social connections and support networks in rural communities. The findings suggest the need to further explore the impediments that reduce the likelihood of accessing mental health services in rural communities.*

KEY WORDS: *barriers, health beliefs, mental health, psychological distress/stress, rural health services, rural or remote.*

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Authorship Statement: Philip Ferris-Day is the major contributor (80%) for the conception and design of the article, and the acquisition, analysis, and interpretation of the data contained in the article. Professor Rhonda Wilson is the major contributor (5%) for the conception and design of the article, and the acquisition, analysis, and interpretation of the data contained in the article. Dr Claire Minton is the major contributor (5%) for the conception and design of the article, and the acquisition, analysis, and interpretation of the data contained in the article. Associate Professor Karen Hoare is the major contributor (5%) for the conception and design of the article, and the acquisition, analysis, and interpretation of the data contained in the article. Dr Andrea Donaldson is the major contributor (5%) for the conception and design of the article, and the acquisition, analysis, and interpretation of the data contained in the article. Associate Professor Karen Hoare revised the article critically for intellectual content with some editing and gave final approval for the version to be submitted for publishing.

Declaration of Conflict of Interest: Prof. Rhonda Lynne Wilson is an Editorial Board Member of IJMHN. The other authors have no conflict of interest to declare.

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INTRODUCTION

Rationale

It has been argued that there can be no health without mental health, citing that 14% of the global burden of disease is attributed to various mental health disorders, including depression, alcohol, substance use disorders, and psychoses (Prince *et al*. 2007). Prince *et al*. (2007) further propose that mental health awareness needs to be integrated into all aspects of health system planning and its consequent delivery, and what we have needs to be significantly strengthened. The World Health Organisation (2014) also elaborated on this, suggesting that mental health is significantly affected by the social determinants of health that included economic, housing, education, and where a person lives.

Rural locations also have unique challenges and include the need to improve the understanding of factors that hinder accessing mental health services in rural areas. Elliott-Schmidt and Strong (1997) found that rural men were quite stoic in their response to mental health issues and consequently tended not to use mental health services. Consequently, the need to have specific policy development that addresses the social determinants of health and foster community connectedness is viewed as being of significant importance (Wilson & Cordier 2013). Parr and Philo (2003) found that people would not seek help from a rural community because of the potential for gossip about private matters. Hooper *et al*. (2020) and Evans *et al*. (2011) note that by improving the ability to socialize and interact locally, there is a benefit of enhanced social wellbeing and psychological health.

McKenzie *et al*. (2018) proposed that men's health has been under-examined resulting in knowing very little about men's social support networks or how men go about seeking or mobilizing social support. McKenzie suggests that such issues are prevalent across Western society with men having dysfunctional coping strategies, including not reaching out for help, and being staunch. Such standing resonates with the position of Smith *et al*. (2018), who also suggest that men's mental health has been under-researched, with little understanding as to what the actual impediments are and how these impact men. Accordingly, the need to consider such impediments is a focus of the study.

Objective

This review aims to identify relevant literature related to accessing mental health support in rural communities and answer the specific question *What are the experiences of adults who access or attempt to access mental health services in rural settings?*

METHODS

A qualitative approach was used to complete an integrative review using Knafl and Whittemore (2017) design, which is selected for this study. This method facilitates a systematic process for searching and selecting relevant literature, extracting data and evaluation, data synthesis, and presentation. The strength of this method within the review is that it enables the collective inclusion of experimental and non-experimental research, supporting a more complete understanding of a phenomenon of concern. Multiple databases were used to ensure a comprehensive search (Conn *et al*. 2003; Torraco 2016; Whittemore & Knafl 2005). The databases used for the literature search were CINAHL, PsycINFO, Web of Science Core Collection, PubMed, Psychology and Behavioural Sciences Collection, Google Scholar, and Scopus. See Table 1 for the MeSH words used to guide the search strategy review was designed using the PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analyses) guidelines (Moher *et al*. 2009).

Eligibility criteria

As shown in Table 2, the inclusion and exclusion criteria guided discussions and judgements regarding each

TABLE 1 *Key search words including MeSH terms used in the literature search strategy*

men OR	men OR
male*	male* OR
OR	man AND
man	rural OR
AND	remote AND
Women	mental OR
rural OR	psychiatric OR
remote AND	psycholog* And
mental or	attitude* OR
psychiatric OR	belief* OR
psycholog* AND	perception* OR
"lived experienc*"	perceiv* AND
"life expereince	barrier* AND
	help-seeking

TABLE 2 *Literature inclusion and exclusion criteria*

Inclusion	Exclusion
Published between 2010 and 2020	Published before 2010
Written in the English language	Written in languages other than English
Primary research	Opinion pieces, editorial reviews, guidelines, literature reviews
Papers had to include rural and/or remote	Papers that focussed on young people under the age of 18 years
Research that focussed on people over the age of 18 years	
Papers focussing on men, men or women, and mental health	

article's potential relevance. In the first round of analysis, any articles that could be considered as having met inclusion criteria were added to the article database. For inclusion, the articles had to include rural or remote focusing on men, men OR women mental health, barriers, and help-seeking. All relevant and available peer-reviewed publications were identified. Studies were limited to primary research published in the English language, which were peer-reviewed within the date range from 2010 to December 2020. Regarding the date range, only contemporaneous research was sought (within the last ten years) as anything older, other than seminal works, are usually considered out of date. All book publications and grey literature, including opinion pieces, editorials, newspaper articles, and any unpublished works, were removed. This is not intended to detract from the value of these publications, but to maintain a targeted focus for this study. It is acknowledged that the restricted scope of this review is a limitation; however, an integrative review does not presuppose to be exhaustive on any given topic or topics, but rather exhaustive within its predetermined and declared boundaries (Torraco 2016). All studies published before 2010, alongside structured literature and scoping reviews, including editorial reviews, opinion pieces, and publications in languages other than English, were excluded. This research specifically focused on the experiences that relate to adults over 18; young people under 18 were not included.

Quality appraisal

All the studies were initially evaluated by two researchers (author 1 and author 4), Critical Appraisal Skills Programme (2018). The final articles were identified and confirmed through careful application of the inclusion and exclusion criteria, and the quality evaluated through the quality appraisal process as outlined by Hawker *et al*. (2002). The checklist by Hawker *et al*. (2002) includes nine criteria that address the quality of each study. The criteria address abstract and title; introduction and aims; method and data; sampling; data analysis; ethics and bias; results; transferability, implications, and usefulness. A rating of each study with scores ranging from 1 (poor) to 4 (good) was made, with higher scores indicating better quality. A total score of 36 being possible. The quality appraisal identified a range of weaknesses in specific areas, such as transferability of the research findings, but with the studies overall, reviewed to be of a quality standard. These quality scores are included in the literature table (Table 3).

Whittemore and Knafl (2005) note that quality appraisal of literature does not have a defined standard. However, Greenhalgh (1997) argues that a systematic review, with an explicit statement of objectives, materials, and methods, results in a transparent process. In that respect, it provides a quality standardized approach that is focussed and systematic (Greenhalgh *et al*. 2020). The reviews included all quantitative, qualitative studies and mixed method. They were peer-reviewed and published in English. Two authors (author 1 and author 4) screened titles and abstracts to determine whether each article met the inclusion criteria. Studies were not limited to any country; retained articles were included if the abstract addressed one or more search terms. A further nine additional articles were added through inspecting and analysing descendent citations of screened articles. In total, 32 articles were included. See Figure 1 for the PRISMA diagram of the screening process.

Each study that met the integrative study criteria was read; studies were discarded if their focus was centred on general health issues rather than mental health. Fifteen studies were quantitative, twelve qualitative, and five mixed methods. Three studies used Braun and Clarke (2006) thematic analysis to identify specific themes. Byrne *et al*. (2017), Hagler *et al*. (2019), and Haynes *et al*. (2017) described using grounded theory. McKenzie *et al*. (2018) employed a gender relations theory in conjunction with narrative storytelling. However, most of the studies were quite general, stating that the analysis was thematic, engaging in a constructivist paradigm.

TABLE 3 *Studies included in the literature review*

	Main issue/ research question	Article type/ research design	Sample number	Data Analysis	Key findings	Recommendations	Quality rating (Hawker *et al.* 2002)
1. Babbage *et al.* (2020) NZ	Attitudes of rural communities to online health and wellness services, and determine what barriers exist	Focus groups (qualitative) Social constructivist paradigm	*n* = 114	Thematic	Participants were generally positive about the role of technology in health care to improve access and autonomy	Support for the policy directions pursuing technology-supported approaches in health	34/36
2. Cheesmond *et al.* (2020) Australia	Value of peer support workers in facilitating mental health help-seeking in a rural setting	Online survey (quantitative) Online survey	*n* = 765	Statistical	Employing peer support workers may increase help-seeking behaviour	Further exploration of the actual role peer support workers may have in increasing help-seeking	34/36
3. De Deuge *et al.* (2020) Australia	How does a rural community resilience affect the impact of a mental health promotion programme?	Surveys, Semi-structured and focus groups (qualitative +quantitative)	*n* = 485 to 4347	Statistical Thematic analysis	Community connection plus resources helpful in implementing mental health promotion programmes	Research to understand the longer-term outcomes of rural mental health programmes	30/36
4. Kennedy *et al.* (2020) Australia	Effectiveness of an intervention, designed to reduce stigma among farming men with a lived experience	Digital intervention adult learning model (qualitative +quantitative)	*n* = 169	Analysis conducted using SPSS version 23 (IBM Corp. 2015). Thematic analysis	Attitudinal and behaviour change indicative of reduced stigma associated with mental health and suicide	Opportunities for targeted stigma reduction and suicide prevention	39/36
5. Roberts *et al.* (2020) India	Is travel distance associated with treatment-seeking in rural India	Questionnaire/survey (quantitative)	*n* = 568	Statistical	Travel distance did not affect MH access	Travel distance to mental health services will not increase access decisions should not be made on this basis	33/36
6. Packness *et al.* (2020) Denmark	Are perceived barriers to accessing mental health care in rural setting associated with their socioeconomic position	Cross-sectional questionnaire survey (quantitative)	*n* = 372	Statistical	The cost associated with accessing MH services Poor health literacy	The deprived and depressed have additional needs, such as social supports	29/36
7. Hagler *et al.* (2019) USA	What is the role of informal help in rural communities?	Surveys and interviews (qualitative and quantitative)	*n* = 170	Statistical and thematic analysis	Informal help is going beyond that offered by professionals	Need to expand the accessibility of professional care in rural areas	29/36

(*Continued*)

TABLE 3 (Continued)

	Main issue/ research question	Article type/ research design	Sample number	Data Analysis	Key findings	Recommendations	Quality rating (Hawker *et al.* 2002)
8. Fennell *et al.* (2018) Australia	Barriers to help-seeking for physical and mental health issues in a rural setting	Computer-assisted telephone interview using a scenario (qualitative and quantitative)	*n* = 409	SPSS	Improving communication about rural suicide helps practitioners and policymakers develop appropriate and responses	Development of policy and strategies to increase the accessing to mental health services	29/36
9. McKenzie *et al.* (2018)	Every day lay perspectives of men and mental health	Life history and gender relations theory (qualitative)	*n* = 15	Gender analysis (Connell 1987, 2005)	Men's mental health outcomes are less likely to be informed by being male but by the social contexts	Mental health promotion strategies support men to challenge hegemonic masculinity	34/36
10. Byrne *et al.* (2017) Australia	Views of workers in rural mental health	Interview: Grounded theory (qualitative)	*n* = 13	Grounded theory analysis	Lack of transport/ lack of staff and services	Peer workers could address staff shortages	29/36
11. Haynes *et al.* (2017) USA	Understand mental health treatment barriers in a rural	Focus group (qualitative)	*n* = 50	Inductive analysis	Stigma main barrier Poor knowledge about mental health	Need to develop culturally relevant strategies for improving mental health in rural African American communities	28/36
12. Hull *et al.* (2017) Australia	Rural adults perceived barriers to accessing mental health service	Cross-sectional survey via computer-assisted telephone interview (quantitative)	*n* = 123	Statistical	Farmers reported more substantial barriers than non-farmers in need of Control and Self-reliance'	Policymakers to explore how best to develop pro-active health decision-making for the farming population	33/36
13. Maulik *et al.* (2017) India	Effectiveness of an anti-stigma campaign in rural India	Interviews (quantitative/ qualitative)	*n* = 2764	Statistical Thematic review	knowledge about mental health did not differ significantly following the intervention, attitudes and behaviours did	Future research needs to explore newer techniques of sharing information related to stigma and discrimination	29/36
14. Sanchez & Limamuttong (2017) Australia	What are the health-related benefits of community gardens in rural Australia	Semi-structured interviews (qualitative)	*n* = 10	Thematic review	Increased physical activity Friendships and support networks Sense of belonging and purpose	Gardens to promote overall health – influence policy	33/36

(*Continued*)

TABLE 3 (Continued)

	Main issue/ research question	Article type/ research design	Sample number	Data Analysis	Key findings	Recommendations	Quality rating (Hawker *et al.* 2002)
15. Alang (2015) USA	Characteristics and perceived causes of unmet need for mental health care associated with regional disparities	Data analysis from the national survey on drug use (quantitative)	*n* = 2,564	Statistical	Racial disparities in stigma and structural barriers in accessing mental health services	Provide health information on mental illness stigma among men, Blacks, Hispanics, and in rural areas	29/36
16. Brenes *et al.* (2015) USA	Barriers to seeking mental health treatment by rural older adults	Telephone triage + questionnaire (quantitative)	*n* = 478	Statistical	Multiple barriers to MH services, but older adults overcome barriers	Public campaigns to addresses stigma and mental health	25/36
17. Buys *et al.* (2015) Australia	Planning for an ageing demographic in a regional and rural Setting	Structured interviews (qualitative)	*n* = 12	Thematic analysis	Participating in voluntary groups provides connectivity	Enabling participation to social groups provides connectivity	28/36
18. Stewart *et al.* (2015) USA	stigma and attitudes towards speciality mental health care in a rural and urban setting	Survey (quantitative)	*n* = 129	Statistical	Need for development of MH stigma reduction programmes in rural areas	Target rural older adults in rural populations to increase appropriate service utilization.	29/36
19. Handley and Kay-Lambkin (2014) Australia	Evaluation of Internet-delivered mental health in a rural setting	Survey (quantitative)	*n* = 1246	Statistical	Internet-delivered MH services more likely to be used by males and younger people	Public health strategies to reduce stigma and perceptions of mental health services – develop IT health initiatives.	33/36
20. Roy *et al.* (2014) Canada	Lay understanding and practices of help-seeking in male farmers' mental health	Interviews (qualitative)	*n* = 21	Thematic review	Confidentiality and acceptability were barriers to help-seeking	Preferences for treatments and service settings should be integrated into future healthcare initiatives and interventions	29/36
21. Hammer (2013) USA	Help-Seeking: Examination of differences across rural and urban Community	**Quantitative** The Self-Stigma of Seeking Help Scale (SSOSH) (Vogel *et al.* 2006) was used to measure participants perceived self-stigma associated with seeking psychological help	*n* = 4,748	Statistical	Masculine norms are linked to self - stigma and is twice as strong for rural men that other population groups	Men's health promotion needs to address men self-stigma by providing information about mental health issues	29/36

(*Continued*)

TABLE 3 (Continued)

	Main issue/ research question	Article type/ research design	Sample number	Data Analysis	Key findings	Recommendations	Quality rating (Hawker *et al.* 2002)
22. Kitchen *et al.* (2013) USA	Depression treatment preferences and anticipated service use in a rural community	Semi-structured interviews grounded theory (qualitative)	n = 16	Thematic review	Stigma and self-reliance reduce the likelihood of accessing mental health services	Preferences for treatments and service settings should be integrated into future healthcare initiatives and interventions for this cohort of rural young-old adults	29/36
23. Mcphedran& De Leo (2013)	Questioning the assumption that suicide by rural men is more likely to be accompanied by low help-seeking behaviour relative to urban men	Data analysis From the Queensland Suicide Register (QSR) (quantitative)	n = 3,303	Statistical	Lower levels of communication of intent do not characterize suicide among rural men in Queensland	Future policies to identify whom rural men are telling their suicidal thoughts to	28/36
24. Coen *et al.* (2013)	Depressed Men/ female partners strategies to positively reinforce men's gendered sense of self in Rural setting	Semi-structured interviews (qualitative)	n = 9	Thematic analysis	Men who experience depression draw significant benefit from men not going along with their gendered role	Masculinities can be mobilized and modified to support men with depression	33/36
25. Wilson *et al.* (2012) Australia	Factors that influence early help-seeking behaviours of young rural men and their families.	Interpretive phenomenological research design (qualitative)	n = 13	Thematic analysis	Help-seeking strategies. Reluctance to identify having an MH issue. Limited vocab' to describe issues	Review models of MH delivery Improve collaborative practice	34/36
26. Isaacs *et al.* (2012) Australia	Aboriginal stakeholders and mental health staff on improving Aboriginal men's access to mental health services	Interviews and Focus groups (qualitative)	n = 17	Thematic analysis	Need to modify service delivery to suit the needs of Aboriginal men. Having a more mobile service	more indigenous workers modify service delivery to suit the needs of Aboriginal men.	33/36
27. Deen *et al.* (2012) USA	Within a rural setting is the perception of needs the value of mental health-related to their use?	Interviews and focus group (quantitative)	n = 99	Statistical	A more positive appraisal of mental health service increased usage	Educating the public about the efficacy of mental health services can improve utilization	29/36

(*Continued*)

TABLE 3 (Continued)

	Main issue/ research question	Article type/ research design	Sample number	Data Analysis	Key findings	Recommendations	Quality rating (Hawker *et al.* 2002)
28. Kelly *et al.* (2011) Australia	Remoteness and environment would have a significant effect on the measures of mental health	Survey (quantitative)	n = 2,462	Statistical	Well-being relates to personal factors, life events, and aspects of social support, rather than the district or locality	Focus on enhancing community connectedness and personal support	33/36
29. Hardy *et al.* (2011) Canada	The role of rural residents concerning MH service utilization	Multi-stage stratified cluster design (survey) (quantitative)	n = 35,140	Statistical	Rural residence limits access to mental health services not supported	Rural living not related to using MH services; other demographic issues noted	33/36
30. Berry *et al.*, (2011) Australia	The role farmers' health plays as an element of adaptive capacity	Questionnaire data from a national survey (quantitative)	n = 3,993	Statistical	Climate/ economic vulnerability exacerbates existing farmer vulnerability	Support farmers in maintaining effective social support	31/36
32. Wilson (2010) Australia	Symptoms of psychological distress and intentions to seek help from friends, family, and professional mental health sources within regional and rural settings	Questionnaire (the general help-seeking questionnaire (quantitative)	n = 109	Statistical	Higher levels of psychological distress associated with intentions to not seek help from anyone	Early intervention programmes should incorporate education about young people's tendency to avoid support for low psychological levels	33/36

Data extraction and synthesis

The review's focus was narrative and reflected the descriptive nature of the studies identified in the search. Data and information were recorded and manually coded according to the categories identified. The coding of each article is based on a comparison of data from each of the retained articles with the emergent themes continually re-evaluated, enabling grouping of similar topics to emerge, resulting in the defining and naming of the final themes (Braun & Clarke 2006).

RESULTS

Thirty-two papers were considered to meet the inclusion criteria in this review; Figure 1 depicts the screening process stages to reach the selection in PRISMA format. Table 2 gives an overview of the included papers, inclusive of quality ratings. The studies reviewed were representative of several countries, with Australia being the most predominant (n = 15), New Zealand (n = 2), Canada (n = 3), Denmark (n = 1), India (n = 2), and America (n = 9). From the 32 articles examined, two main themes were found: help-seeking, with subcategories of stigma, and locality of health services. The second theme was connectedness and included subcategories of support systems and personal identity. Several papers addressed more than one category.

Help-seeking

Help-seeking behaviour for a health problem was defined as problem-focused, planned behaviour involving interpersonal interaction with a selected healthcare professional (Cornally & McCarthy 2011). Problems associated with help-seeking were categorized into two specific areas: stigma and location of services.

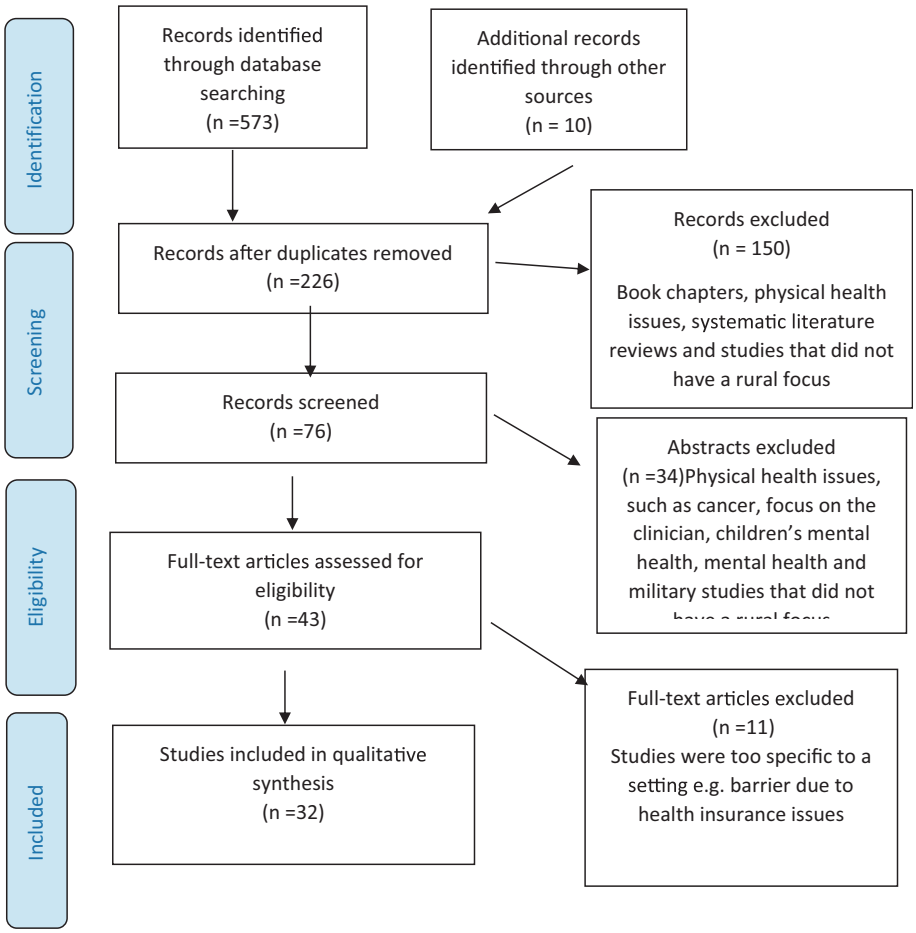

FIG. 1 PRISMA Flow chart search and inclusion criteria.

Stigma

Stigma contributed to people not seeking help concerning mental health problems. It included themes around personal shame (Isaacs *et al*. 2012) and the potential loss of social standing (Wilson *et al*. 2012). The studies identified a range of demographic detail, inclusive of rurality, occupation, and gender. Alang (2015) noted that women were more likely to decline mental health support because of cost, while men would forgo because of stigma. Like Alang (2015), Fennell and Hull (2018) aimed to identify gender barriers to seeking support. Whilst most of the studies had a mixed-gender approach, with no particular focus on men or women, some of the research identified gender-specific reasons associated with mental health service utilization. Fennell and Hull (2018), for example, found that men reported more barriers related to accessing mental health as opposed to physical health than women, including the desire for not wanting people to know about their problems. Recommendations to address poor mental health service uptake have public awareness and education campaigns (Brenes *et al*. 2015; Deen *et al*. 2012; Haynes *et al*. 2017; Maulik *et al*. 2017; McKenzie *et al*. 2018; Stewart *et al*. 2015; Wilson 2010).

Locality of services

Several studies refer to a rural residence and the access and likelihood of utilizing mental health services (Alang 2015; Babbage *et al*. 2020; Handley & Kay-Lambkin 2014; Hardy *et al*. 2011; Hull *et al*. 2017; Kelly *et al*. 2011; Kennedy *et al*. 2020; McPhedran & DeLeo 2013; Packness *et al*. 2019; Roberts *et al*. 2020; Roy *et al*. 2014). The location of where people live impacting mental health service uptake is addressed in several studies.

Within the context of rurality, Cheesmond *et al*. (2020) and Kitchen *et al*. (2013) note that stigma associated with

mental health is significant. However, Cheesmond *et al.* (2020) found that rural residents felt more comfortable with a drop-in centre and accessing peer support workers and people they know. Similarly, Kitchen *et al.* (2013) ascertained that participants would access health providers they trusted. Conversely, Roy *et al.* (2014) found that men preferred to leave their rural locality and travel to urban centres, believing they would have anonymity. Stewart *et al.* (2015) note that there is a need to understand whether stigma has varying personal understanding levels, according to where a person lives. Wilson *et al.* (2012) note that once mental health issues become known within a community in rural locations, a person's social status can become compromised, resulting in challenges achieving the social standing that they had previously held.

Roy *et al.* (2014) also recognized help-seeking and accessing professional services to be more problematic in rural locations, primarily due to pride and lack of knowledge about services. Hull *et al.* (2017) also support such a position, referring to participants as stoic, not trusting health professionals and preferring to get help from their family and friends. However, Deen *et al.* (2012) and Roy *et al.* (2014) found that mental health knowledge improved and stigma decreased due to media campaigns. Nonetheless, Hull *et al.* (2017) comment that services and professionals need to adapt their practices to meet the need of those who access.

The challenge to access mental health information due to a geographical location is the focus of Kennedy *et al.* (2020) study. The study focused on addressing perceived stigma and included online opportunities to gain experience about stigma and share ideas and knowledge. Babbage *et al.* (2020) also examined attitudes towards using online health and well-being services. Babbage *et al.* (2020) found that younger men and women were more likely to use digital technology than older participants. However, in some rural location's, Internet access is poor and is a limiting factor in using online health activities as the expense to use satellite access is prohibitive. Handley and Kay-Lambkin (2014) also note that there is a general hesitation to use digital interventions among older residents within the rural and remote sector, believing that Web-based activities are not as helpful as that delivered in person.

Connectedness

Sixteen studies were examined under the theme of connectedness, identifying two main areas, support systems, eleven studies (Berry *et al.* 2011; Buys *et al.* 2015; Coen *et al.* 2013; de Deuge *et al.* 2020; Hagler *et al.* 2019; Hardy *et al.* 2011; Hull *et al.* 2017; Kelly *et al.* 2011; McKenzie *et al.* 2018; Sanchez & Liamputtong 2017; Wilson), and personal identity three studies (Coen *et al.* 2013; Hammer *et al.* 2013; McKenzie *et al.* 2018).

Support systems

The theme associated with support acknowledged the increasing availability of service provision via the inclusion of accessible programmes or acknowledging the diverse natural supports that people use. Hardy *et al.* (2011) recommend providing various professional mental health services to meet diverse rural populations' needs, with Byrne *et al.* (2017) proposing the need to employ more peer workers' to provide an alternative means of support. However, McPhedran and DeLeo (2013) note the need to find out who people are talking to in times of distress, suggesting that it is not just health workers that people speak to, but also people within a community, family, and friends.

Research by de Deuge *et al.* (2020) suggested that poor communication and poor community leadership were critical barriers to successful health promotion activities. Similarly, Sanchez and Liamputtong (2017) found communities that identified with a common purpose result in positive mental health outcomes. Sanchez and Liamputtong examined the health benefits of participating in community gardening. The results identified participants voicing an increase in psychosocial wellness and belonging and feelings of connectedness. Buys *et al.* (2015) and Berry *et al.* (2011) refer to the importance of belonging. Both identify the benefits of community involvement and the need to identify resources to address social contact; how this is to occur was not addressed. Both make statements associated with identifying resources to address an increase in social contact but make no recommendations on achieving this.

Kutek *et al.* (2011) study examined social support and a sense of community. The research focussed on adult men's informal networks. The findings show that social support and a sense of community were significant contributors to overall well-being, with social support being the major contributing factor. The research findings showed that community activities focussing on men's health needs have considerable value, and by default, promote social support. Kutek *et al.* (2011) study aligns with Sanchez and Liamputtong (2017) that involvement in social activities improves well-being. Haynes *et al.* (2017) also align with this position,

identifying that social support and a sense of belonging are significant factors contributing to the utilization of mental health support.

Personal identity

Although most studies in this literature review have a generic gender focus, some make specific attention to men (Coen *et al*. 2013; Hull *et al*. 2017; McKenzie *et al*. 2018; Roy *et al*. 2014). A common but not universal theme is that masculinity impacts accessing mental health support. Hull *et al*. (2017) commented that the stereotypes of stoicism and self-reliance were a predominant theme. However, McKenzie *et al*. (2018) suggest that the patterns of social connectedness among men are diverse and that there is a need to recognize male practices as fluid rather than fixed. Such a position is comparable to that of Roy *et al*. (2014) and Coen *et al*. (2013). They note that not all men go along with stereotypical male role expectations, especially in the context of men being more emotionally open around their partners than emotional expression amongst other men. Hammer *et al*. (2013) and McKenzie *et al*. (2018) suggest the need to have mental health promotion strategies beyond the 'traditional' staunch portrayal of men and celebrate the diversity of masculinities. Hammer *et al*. (2013) also recommend focusing on health promotion that addresses men's self-stigma by normalizing and providing information about mental health issues. The research of Roy *et al*. (2014) also supports this position, but alongside McKenzie *et al*. (2018), recognizes that rural masculine practices are fluid and diverse.

DISCUSSION

The purpose of this integrated literature review was to explore barriers and facilitators for accessing and engaging with mental health in a rural setting. The literature review shows a range of common reasons people were not accessing mental health services, with stigma, privacy, and stoicism evident. The integrated review had a rural focus; however, a consensus on what is meant by rural was largely dependent on the study country. Hardy *et al*. (2011) describe being rural as a community with <1000 people. Alternatively, Cromartie and Bucholtz (2008) position rurality as a population of 5000 people or less, adding that an area's economic influence is also a factor in defining a place to be urban or rural.

Consideration and understanding of context need to occur. Comparing one countries rurality to another, such as rural or remote Australia, is not straightforward. Whereby access to mental health services in Australia can be thousands of kilometres away, in New Zealand, it could be <50 km. However, it may not be about distance but about personal and fiscal resources that are the limiting factors. The mental health service may be free, but the cost of travel being the roadblock to using them. Travel is one factor that could limit service utilization, but acknowledging where people are getting support, whether professional, community networks or personal resources, needs to be had. Accordingly, Roberts *et al*. (2020) see community connectedness as a critical factor in social integration and belonging. Cheesmond *et al*. (2020) comment that rural health providers need to understand how a community they are invested in works and how trust can be improved but makes no further comment on achieving this. Stewart *et al*. (2015) suggests that communities may go beyond geographical limitations. Despite living in a rural area, people may have little connection to the area they reside, working and using services in areas other than where they live, with Issues about a small town, everyone knowing everyone else's business being impediments to using services. In rural communities, social support networks are difficult to access or find, and there is a paucity of research discussing this point with men in particular (McKenzie *et al*. 2018). Mcknight (1995), nearly 30 years ago, argued that we disempower communities by finding solutions to problems rather than addressing the wealth and capital that communities already have, contending that professional service providers can reduce a community ability to manage their own needs.

Whilst most of the studies had a mixed-gender approach, with no particular focus on men or women, some of the research identified gender-specific reasons associated with mental health service utilization. Fennell and Hull (2018), for example, found that men reported more barriers related to accessing mental health as opposed to physical health than women, including the desire for not wanting people to know about their problems. Overall, Fennel and Hull found that both men and women reported more mental health-seeking barriers than physical health issues. Several studies within the integrated review focused explicitly on men and their reasons for reduced help-seeking for mental health problems (Kelly *et al*. 2011; McKenzie *et al*. 2018; Roy *et al*. 2014). McKenzie *et al*. (2018) suggest that men's social connections' gendered nature impacts how and where they connect or mobilize the support they need, with an interplay between masculinity and its context. Accordingly, Tannenbaum *et al*. (2016) recommend that studies consider

gender within the research design to understand gender-specific attitudinal barriers when considering the problem and the solution. An acknowledgement of a study's gendered nature needs to occur, with a clear understanding of sex, gender, and identity being explicit. Without such consideration, the extent to which the appropriation of gender has occurred may influence the findings, results, and consequent recommendations (Tannenbaum *et al*. 2016).

STRENGTHS AND LIMITATIONS OF THE REVIEW

According to Whittemore and Knafl (2005), a limitation to a search strategy is the inefficiency of computerized databases, yielding only 50% of eligible studies. This study chose not to include grey literature or research older than 10 years; however, the literature search was comprehensive, resulting in additional literature being sourced. There is a possibility that relevant articles are not included in this review. Articles may not have appeared in the review because they may have described phenomena using alternative words. Despite the limitation, a strength is that common themes were addressed across multiple studies and in various geographical locales. The themes were consistent and were evident beyond an individual study.

CONCLUSION

The review's findings suggest that having a more detailed approach to understand locality and its relationship to stigma, privacy, and barriers to access mental health support is critical. Measures to promote help-seeking for mental health should include gender-specific strategies to address mental illness stigma, improve mental health literacy in the community, and encourage community connectedness. However, gender within a study needs to be considered in explaining mental health service/support utilization. Research has identified differences in service uptake between men and women. Other research has found very little difference. Consequently, the literature review provides an opportunity to consider people's mental health needs, gender, and explore diverse social connections and support networks to improve overall health outcomes.

RELEVANCE FOR CLINICAL PRACTICE

The review indicates the need to explore further the impediments that reduce the likelihood of accessing mental health services in rural communities. The need to explore where people live in rural centres and access mental health support is crucial. There is an opportunity to examine how, where and with whom people access mental health support. Mental health rural services can improve overall outcomes by targeting mental health promotion activities; general health literacy activities may miss the target audience; the challenge is identifying what is needed, where and by whom.

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