

**EMPIRICAL RESEARCH QUALITATIVE** OPEN ACCESS

# Exploring the Challenges of Context in Accessing Mental Health Support in Rural New Zealand: A Case Study Approach

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## ABSTRACT

**Objective:** This paper explores the complexities that impact access to mental health services in rural New Zealand. Historical, cultural, social and political factors will be examined against the philosophical positioning of Foucault and Fairclough.

**Study Design:** This research is a single-embedded case study design exploring participants' discourses in the context of a rural, bounded geographical area of New Zealand.

**Results:** The results show that mental health support that addresses people's actual needs rather than the needs that governments map against ever-changing policy is required and that an awareness of context within case study research is important.

**Discussion:** The process of case study design is described, including building upon a rationale for selecting the case, collecting data and conducting case analysis and interpretation. This study examines factors influencing the real-life rural context of accessing mental health support. This article demonstrates that case-study research can be valuable for navigating context complexity and developing nuanced understandings of complex phenomena.

**Conclusion:** The paper highlights how the multifaceted case study context is more than mapping discourses against a rural backdrop. It is necessary to consider the power dynamics that shape experiences and their impact on service creation and its consequent delivery.

**Implications for Research Policy and Practice:** Rather than services being created that are complex and not meeting people's needs, there is a need to listen to the people who have experienced mental health distress and provide services and support in locations other than clinical settings.

## 1 | Introduction

This paper uses critical discourse within a case study that examines the discourse of men who have experienced mental health challenges and have sought either professional help or

help from non-professional support people, such as assistance from family/friends. The study utilises a single embodied case study methodology and adopts (Stake 1995, 2000) understanding of a "case" as a study of the particularity and complexity of a single phenomenon. The context of this research is within a

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rural setting, with (Ferris-Day et al. 2024); Stewart, Jameson, and Curtin (2015) suggesting a detailed approach to understanding locality and its context. However, as Tomoaia-Cotisel et al. (2013) argued, a detailed account of the context is rarely examined, and contextual elements for interpreting and applying findings are often absent.

Understanding context is important because it allows researchers to gain a deeper understanding and develop insights that might not be apparent regarding a phenomenon without considering the broader context. For Foucault (1972), context is inseparable from power relations. Discourses reflect and reinforce power structures in society and are shaped by historical conditions and social structures of their time, which emerge and change depending on the context within which they are situated (Angermuller and Kollmorgen 2019). The phenomenon of a healthcare setting is complex and presents many challenges. This complexity arises from various factors, including the diversity of needs and the complicated organisational structures and processes involved in health care delivery. Stake (2005) suggests that researchers who use a case study approach must consider the case's historical background, physical setting and economic, political, legal and aesthetic perspectives. Kovandzic et al. (2012) propose that the context in which health care occurs shapes the experiences of health services, including policy design, governance, staff recruitment/retention, professional roles and culture. Strauss and Corbin (2014) also recommend addressing the complexity of macro–micro relationships in the phenomenon under study. Both Foucault and Fairclough stress the importance of examining the discourses (as action and text) in society because they contribute to the production and maintenance of social orders by legitimising specific power structures, norms and practices. Fairclough describes the analysis of discourse through levels of social order and orders of discourse. His three-dimensional approach connects text (micro-level), discursive practice (meso-level) and social practice (macro-level), allowing for the examination of how discourses in society reflect and reproduce broader social orders and power relations (Fairclough 2001). Table 1 addresses the micro, meso and macro elements of this study.

The macro-, meso- and micro-perspectives, as suggested by Cohn et al. (2013), are dynamic and continuously evolve. Multiple reviews and strategies have been created within New Zealand that have attempted to address the complexities people face. Yet, the problems continue; people seeking support often have unmet needs (Spiers et al. 2022). In the popular children's book series *Where's Wally?* Internationally, the characters are presented under various names, including Waldo, Walter, Willy, Hugo, Charlie and Holger. Readers are tasked with finding the elusive character of Wally, who is hidden among crowds of people, objects and complex backgrounds. He, too, is hidden in plain sight.

Wally was presented to the researcher while working as a mental health clinician many years ago by a service user who was receiving mental health support. The person voiced the opinion that the support being offered was not helpful and not what they needed—he could vanish and would be just one of the many who become invisible—just like Wally. Accordingly, this paper

**TABLE 1** | Micro-, meso- and macro-contexts used within the research.

Domain	Contextual factors	Description
Macro	Government and Health Service	National regulations, policies, strategies and frameworks relating to mental health and social/emotional well-being directives Health service enquiries
Meso	Health and associated services that impact the region in the study are set	Health service policies Models of care Economic data Management and inter-relationship of support services
Micro		Rural demographics Structural capabilities Service demographics

explores the contextual factors influencing how men in rural New Zealand receive mental health support.

## 2 | The Study

This paper presents the influences of accessing and supporting mental health services in one rural area of New Zealand by providing a contextual overview of the healthcare environment and then focusing on interviews with people accessing mental health services in that region. The research was awarded ethics approval (Massey University Ethics Application—SOA 21/16).

The study region has a population of approximately 35,000 and a total land area of 8423 km<sup>2</sup>; in addition to one sizeable municipal town, there are several small towns and villages. Accessing mental health support in rural contexts presents unique challenges, including limited access to mental health professionals and few accessible support services (Casant and Helbich 2022; Ferris-Day et al. 2021; Helbich et al. 2017). Studies often refer to people's hesitancy to seek help in rural communities due to the small population, potential for gossip, poor transport and being staunch (Carpenter-Song and Snell-Rood 2017; Ferris-Day et al. 2021; Graves et al. 2024; Morales, Barksdale, and Beckel-Mitchener 2020; Roberts et al. 2020).

Accessing mental health support is complex and, at times, problematic. Gluckman (2017) stated that New Zealand mental health services were fragmented and disconnected. Indeed, such a position is also echoed by the New Zealand Ministry of Health (2018, 2021), in which the mental health inquiry identified that services were not meeting a population's needs and that there were insufficient mental health resources to meet demand. However, a deficit-based approach does not address the richness that communities may possess. Accordingly,

a detailed approach is needed to understand locality and its context (McKenzie et al. 2018; Stewart, Jameson, and Curtin 2015).

### 3 | What Is Case Study Methodology?

Case study methodology investigates a particular phenomenon in a real-world setting. It has a much broader view than many healthcare professionals understand a case study to be, that is that of a person presenting with a clinical problem or symptoms (Alpi and Evans 2019). Instead, case study research allows for a holistic understanding of a phenomenon within real-life contexts (Ebneyamini and Sadeghi Moghadam 2018; Stake 1978). The case study methodology is suitable for capturing information on more explanatory “how,” “what” and “why” questions. Thus, case study methodology enables a researcher to examine the data within a specific context, such as a small geographical area or a minimal number of individuals as the study subjects. A key aspect of case study methodology is defining the case (Sibbald et al. 2021). The case under investigation in this research is about men seeking mental health support, addressing the phenomenon of the actual pathway men take to access mental health support. The case is bounded within a specific context of one rural New Zealand locality. It focuses on the inter-relationship of men seeking mental health support from three perspectives: men who have sought mental health support, mental health professionals who provide the support and, lastly, family and friends who offer valuable but not professionally structured support.

### 4 | Choosing the Case Methodology

Stake (1995) advocates that the first criterion in choosing a case study should be to maximise what can be learned. It is not intended that a case is studied to understand other cases. Case study research is an empirical inquiry into a phenomenon in its real-life context. Stake (1995) explains that a case study approach can be used to explore context and highlight the actual phenomenon of interest. (Stake 2005; Tomoiaia-Cotisel et al. 2013). Additionally, it is essential to identify the study's boundaries and parameters for what will and will not be included (Gangeness and Yurkovich 2006; Miles, Huberman, and Saldana 2020). When using case study methodology, several approaches can be taken (Harrison et al. 2017; Harrison and Mills 2016). Many methodologists refer to Yin, Stake and Merriam (Merriam 2016; Stake 1995; Yin 2018). They each have their epistemology; Merriam views the case as a single entity with no boundaries; Yin has a more empirical approach addressing the how and why of the phenomenon. From an epistemological position, Yin subscribes to a position of positivism, whereby a person's reality can be measured, whilst Stake views case study approaches as a bounded complex and functioning entity, integrated and operating within a constructivist paradigm. This research primarily uses the methodology proposed by Stake (1995), who refers to qualitative researchers who hold that “knowledge is constructed rather than discovered” (p.99). Using the case study approach, we wanted to know who was involved, the processes they used, the outcomes of their activities and the context within which these were situated. It is how the researcher gathers and interprets what is being collected, that there are many truths to the narratives gathered and acknowledging their positionality within the context of the case.

Within this research, the researcher engaged in reflexivity using the approach espoused by Finlay (2002). In using a case study approach, the researcher did not want to focus just on the individual narratives of each participant group, which would result in three separate case studies; the interest was more aligned with a holistic analysis, wanting to know who was involved, the processes they used and the outcomes of their activities, all within the context within which these were situated (Stake 1995). This research explored the experiences of men accessing mental health who live in rural New Zealand and the people supporting them. Boblin et al. (2013) addressed the phenomenon under investigation within its gestalt, that is as a whole, within the research, the three units of analysis within the case were consequently viewed holistically (Figure 1).

### 5 | Maintaining Methodological Rigour in Case Study Research

This single-embedded case study has multiple contexts. Contexts interlink and are influenced by many extraneous factors, such as government strategy to address healthcare access. Invariably, many contexts will not be uncovered within this study, and personal perspectives that were not explored or did not emerge within the data gathering. It is acknowledged that this may reduce the potential for unearthing additional complexities. However, it is essential to be upfront in case study research and make explicit the case boundaries at the outset.

The case study used a thorough and rigorous methodological approach presented in detail to ensure credibility, transferability, dependability and confirmability (Stake 2006). Table 2 presents the methods that were used. Johnson, Adkins, and Chauvin (2020) describe the role of rigour in qualitative research as “to ensure that the research design, methods and conclusions are explicit, public, replicable and free of bias” (145). In conducting the research, the researcher was explicit in declaring their positionality within the field of research with transparency effectively presented, involving a systematic, reflective critique that is systematic and occurred throughout the study (Ferris-Day et al. 2024; Glassick 2000).

#### 5.1 | Transferability of the Case Study Results

The case addressed within this research is centred on one rural geographical location. Transferability refers to how the study's

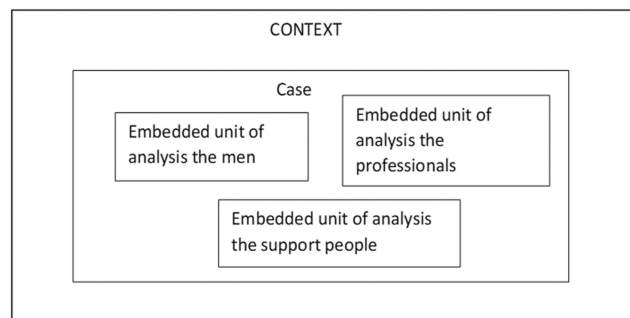


FIGURE 1 | Single case study.

**TABLE 2** | Actions to enhance rigour.

Quality criteria	Actions to enhance rigour
Credibility	<ul style="list-style-type: none"> <li>• Use of reflective commentary</li> <li>• A detailed description of the phenomenon under scrutiny</li> <li>• Triangulation of data</li> </ul>
Transferability	<ul style="list-style-type: none"> <li>• A detailed description of the phenomenon in question to allow comparisons to be made</li> </ul>
Dependability	<ul style="list-style-type: none"> <li>• In-depth methodological description to allow the study to be repeated</li> </ul>
Confirmability	<ul style="list-style-type: none"> <li>• Triangulation to reduce the effect of investigator bias</li> <li>• Upfront acknowledgement of researcher's biases</li> <li>• In-depth methodological description to allow the integrity of research results</li> </ul>

findings apply outside its particular context to have meaning or application for another group or context (Byrne 2001; Streubert-Speziale 2007). There is no intent to assume the results from this study may be representative of another region; the researcher was mindful of the criticism that case studies relate only to small numbers of participants or cases and the subsequent challenges when transferring findings to other localities. The research findings may well be attributable to different locations, and learning may occur that benefits other localities. However, the bounded nature of the study focuses on the issues representable to the study location, with no intent to represent the findings to other regions.

## 5.2 | Confirmability

Multiple data sources were used to gather information, with participant interviews being the primary data source. The researcher also accessed and examined relevant key documents, including policies, reports and publications. According to Stake (1995), triangulation of the data necessitates the collection of various data sources, which are collected and analysed to obtain multiple perspectives and points of view to provide a holistic understanding of the phenomenon being researched. Comparing the different data sets helped check other data sources' consistency.

## 5.3 | Criticisms of Case Study Research

Critics have argued for and against the value of case studies. Sometimes dismissing the value of case studies, claiming they lack rigour in collecting, constructing and analysing empirical materials (Takahashi, Wünsch, and Araujo 2020). However, Yin (2014) and Stake (1995) suggest that generalisation is not a primary aim of the case study method; the intent is not to study a case to understand others. The objective is to understand the case being examined, emphasising its uniqueness. As human behaviour is time and context-bound, such an

inquiry can only produce a working hypothesis that relates to a given and specific context.

## 6 | Data Sources

All participants were 18 years of age and above and were not currently experiencing mental health distress or receiving professional mental health support. Refer to Table 3 for inclusion/exclusion criteria. The study aimed to examine emergent discourses associated with the positioning of the participants who had volunteered their time to be interviewed. In the case study, three groups of people were interviewed: men who had experienced mental health challenges and had accessed or tried to access support, professional clinicians (such as general practitioners, nurses and psychologists) and, lastly, lay people who provided support, such as partners or friends. Participants' Demographic data were collected, including age, ethnicity, profession, gender and income source. This study did not examine gender-related discourses if a person self-attributed a gender that was what was accepted.

New Zealand operates from a bicultural perspective, with English and Te Reo (Māori Language) being the first languages. All participants were told they could present their narratives in Te Reo with a translator; however, no participants wanted additional support.

Participants were recruited through local and regional newspapers, Facebook, community flyers and snowballing, whereby one participant suggested that another person be involved. The prime focus of the study was to look at the experiences men had when reaching out for mental health support. Support is provided in many ways, and consequently, rather than just focusing on the men's experience, the researcher also chose to interview the people who provided support and consequently examine emergent discourses that arose.

Participant narrative was obtained via recorded interviews; they were transcribed and uploaded to Nvivo (2022), which is a data analysis software program used to examine the data and aid in constructing themes. Themes were examined using Foucault and Fairclough's social orders, which addressed discursive practice associated with the context and phenomenon of the study.

## 7 | The Context of the Case

Despite the context of a study being central and an aspect of the research that must be addressed, Rogers et al. (2021) assert that researchers often fail to use a consistent approach to analyse and present the context so that little sense of the health and social context is made. As Gaber et al. (2022) discussed, effectiveness, implementation and context are interconnected, resulting in a requirement to consider the overall relationship between the healthcare and study contexts in which they sit.

The research was conducted in one rural geographically bounded region in the North Island of New Zealand, the Wairarapa. The population demographics of the region show that 79% of people

**TABLE 3** | Participant inclusion and exclusion criteria.

	<b>Inclusion</b>	<b>Exclusion</b>
Men	Those who have experienced mental health problems/ challenges and have sought support but who are currently not receiving formal mental health support Over the age of 18 at the time of the interview Live within the study region English/Māori speaking only	Children Men are currently being treated for mental health disorders/ problems/challenges. Do not reside in the study area
Lay supporters	Men or women over the age of 18 who support men experiencing mental health distress and are not in a professional mental health role Provide support within the study region English/ Māori speaking	Children
Professional	Professional clinicians, including support worker roles, who provide services to men who are presenting with mental health distress mental health nurses nurses medical staff psychologists social workers mental health peer support workers	Children

in the area identify as European, 18% as Māori, with Pasifika and Asian accounting for 4% and 3%, respectively. The region where the case study was conducted is viewed as rural, yet there is no internationally established definition of rurality. Research, such as that by Whitehead et al. (2022), found over 30 definitions of rurality in New Zealand. Rurality, generally, in New Zealand describes the location and characteristics of the rural landscape of the people who live and work there, as well as the interactions between people and their environment (Stats 2021). Despite no universal understanding of what is meant by rural, New Zealand has a rural health strategy (Ministry of Health 2023) that declares the need to address the health inequities within the rural sector. Within the boundaries of the case study, Yong et al. (2017) found that the Wairarapa region where the study was conducted ranked significantly deprived on the Index of Multiple Deprivation (IMD). The IMD ranks deprivation against seven criteria: employment, income, crime, housing, health, education and service access (supermarkets, health providers, education facilities, etc).

## 8 | The Complexities of Context

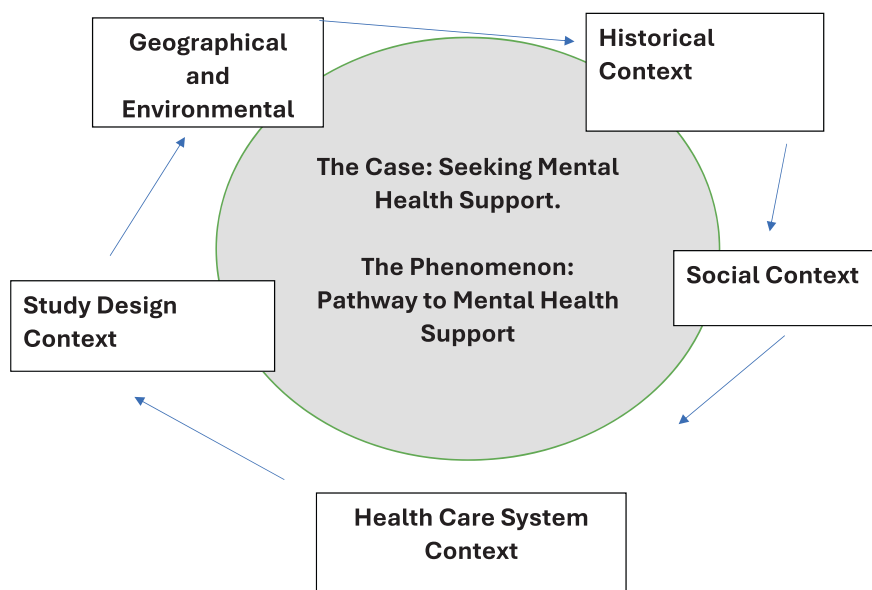
The rurality of the study sits within a complex schema with an interplay between contexts associated with where people live, education, culture and historical perspectives as to how and why the overall environment and behaviour are the way they are. Social factors such as cultural beliefs, socioeconomic status and family dynamics impact how individuals perceive and seek healthcare. Furthermore, the organisational context within healthcare settings, including health service policies, staffing levels and workflow processes, directly affects the delivery of care and the experiences of nurses and other healthcare professionals. Figure 2 (the quintain) was adapted from the work of Stake (2006) and addresses the interrelationship of contextual elements that impact a

person's access to or referral to mental health services and support systems. This study examined and considered each aspect of the quintain within the overall analysis.

It is navigating the complexities of the healthcare systems, such as geographical barriers and limited resources, that present obstacles to rural healthcare access. Such positioning is presented by Bourgois et al. (2017), who discusses the challenges in navigating the support pathways and argues for the need to address the structural vulnerabilities of service delivery. Structural vulnerability refers to how the socio-political aspects of health care are rooted in systemic inequalities, injustices and service power dynamics (Bourgois et al. 2017; Chung 2021).

New Zealand has acknowledged the challenges and inequities in mental health and has had several reviews (Ministry of Health 2018, 2021, 2022a) from which strategies to move from a reactive approach to one purportedly community-based and accessible. Williams, Haarhoff, and Vertongen (2017) comment that rather than the traditional paradigm of focusing on mental disorders, the focus is shifting to one underpinned by an early intervention model, which necessitates recognising local factors related to access to care based on geographic contexts. These interrelated perspectives need to be considered when addressing the context of case study research. Context is multifaceted; not acknowledging other factors is naïve and will not portray an accurate picture of the socioeconomic systems within the region being studied (Cockburn et al. 2020; McLaughlin et al. 2024).

Portraying individuals as personally accountable for their health needs involves transferring the burden of accountability for societal challenges from institutional responsibility, such as poverty and joblessness, to those of the individual through the concept of “self-care.” Thus, the person becomes the problem



**FIGURE 2** | The Quintain: the context (adapted from Stake 2006).

rather than the clinical condition of the health system (Judge and Ceci 2022). Such an approach is a characteristic of neoliberalism. It is the belief that individuals are ethically and economically responsible, can evaluate the advantages and disadvantages of a specific action and, therefore, have choice and free will in making self-determined decisions. Choice, however, is undermined when services and support are limited or non-existent (Ferris-Day et al. 2024).

## 9 | The Positioning of Foucault and Fairclough Within This Study

The theoretical position of this research is one couched within a post-structural framework and includes works of Foucault and Fairclough, primarily through a critical discourse lens.

Several cornerstones of Foucauldian theory, alongside Fairclough's social order, were used to examine the interplay between power, discourse and language and their intersection in various social institutions (Fairclough 2015; Foucault 1982, 1987). In the context of mental health research, Foucault (1961) examines how broader social and political forces influence psychiatric knowledge and practices. Similarly, Fairclough (2015) encourages the analysis of language to uncover underlying power dynamics and ideologies, including how knowledge is produced and disseminated. Furthermore, it is crucial to scrutinise the language and discourse surrounding mental health to identify how certain narratives and perspectives are privileged while others are marginalised (Phillips 2023).

Foucault (1977, 1978) introduced the concept of biopower to describe the mechanisms through which institutions regulate and control populations through health, medicine and biological processes. The concept of biopower prompts the question of who holds the power to define what is considered healthy or normal, with Foucault discussing how power operates through surveillance and normalisation or institutional practices. Examining

governmental practices in healthcare necessitates questioning how government policies and regulations shape health-related discourses and practices. Berry (2021) contends that despite state institutions often having an expansive interventionist footprint, they invariably do less with more. Expanding in terms of institutional presence and fiscal risk but not achieving in terms of increasing its capacity to shape the economy and overall humanistic systems.

In *The Birth of Biopolitics*, Foucault (2008) argues that neoliberal forms of governance encompass both direct state intervention and the creation of indirect methods for guiding and regulating individuals without assuming responsibility for them. Lloyd (2021) also comments on power and whose interests the government serve. The politicians own or that of the people. The neoliberal ideology promotes a government that creates structures, institutions and laws that direct and control what the state wants rather than the people's needs. The freedom to choose and be responsible is a central tenet of such neoliberal governments, but as argued by Wilson (2017). The freedom the person has is constrained by the government, which decides what freedom of choice means. If few options are available, the choice becomes a moot point; grateful for what you get (Barnett, Ogden, and Daniells 2008).

On this note, a revisit of *Where's Wally* is somewhat apt, with Wally appearing lost in the maze of complexity. Holmes et al. (2017) argue that health systems invariably attempt to alter the context of service delivery rather than working with the people to "nurture emergent solutions" (555). Listening to and involving the person experiencing distress was central to the *He Ara Oranga* report (Ministry of Health 2018). Incorporating people's experience of health services has been shown to have value (Maher et al. 2017; Sagen et al. 2023). Such involvement requires effective communication, support of stakeholders, planning and visibility of outcomes. Unfortunately, within the boundary of this study, the visibility of outcomes and increased access to support remains problematic.

## 10 | Findings

The study's contextual complexities address the case phenomenon – the pathway to mental health support. Many challenges were encountered, with participants voicing frustration with mental health services. All acknowledged that being rural meant fewer services were available to access or refer people to. Yet, from a macro perspective, acknowledging rural challenges is at the forefront of the New Zealand government's Rural Health Strategy (Ministry of Health 2023), championing the need for equity of access. Other government reports have made similar statements (Ministry of Health 2018, 2021).

Nevertheless, accessing support continues to be problematic. The word cloud (Figure 3) was generated from participants' words. It is significant, as the emerging themes were associated with just needing help, and in many instances, the help wanted was difficult to access. In this section, participant interview extracts will be used and aligned with the Figure two headings of the quintain.

### 10.1 | Geographical and Environmental Factors

Research continues addressing environmental and geographical influences on well-being (Rentfrow 2018). Equally, Cortina and Hardin (2023) argue that people living in rural communities generally experience poorer mental health outcomes compared to people living in urban. However, many variables influence well-being; accordingly, environmental factors may shape social

norms, people's sense of belonging and their community identity, but in turn, they are influenced and often directed by local and national government directives. Several participants in the research discussed the need to be connected to the land and speak to people who understand rurality and the challenges people living in non-urban environments face. Participants often cited a non-governmental service that provided immediate practical and emotional support. Participants discussed the need to have options to manage their land and livestock if they could not work. It was important for many participants to be seen in the context of where they lived rather than having to go to a clinic, taking significant time out of their day to travel and be seen.

And they're in touch with rural people, they understand the challenges. Rural support services see people in their own setting, whereas when you go public, you go into the hospital  
(Participant A, Support Person)

You know these people are attached to the land; could there be a place where they could go, take their farm dog, you know, to have a sense of purpose  
(Participant B, Support person)

### 10.2 | Study Design Factors

This study utilised a case study design (Stake 2005) and acknowledged having a methodological lens that addresses power dynamics (Foucault 2000; Foucault and Gordon 1980). Alongside this was examining the inter-relationships across micro-, meso- and macro-perspectives that address localised voices and regional and then government directives (Fairclough 1993, 2010, 2015). An additional factor within the overall design is the positionality of the researcher, who currently lives and has worked as a mental health nurse in the region where the study is held. Acknowledgement of the researcher and their potential to bias and overlay influence on the research process is critical and needs to be an open aspect of the research process. Finlay's (2002) reflexive approach was used to ensure the researcher's position within the study was explicit and upfront throughout the study. An aspect of this is noted in a participant script whereby the research's intent was voiced to a person in distress, resulting in them voicing their challenges.

You know, I came to work for a farmer today, he rang me on Monday night and said that something had happened. And he needed extra help for the morning. I said that'll work perfectly because I'm going to see (the researcher) at 11 o'clock. When I arrived there this morning, I was working with him in the yards, and he said, so who's this guy you're seeing? I said it's something to do with the university and mental health. He said Is it to do with the work you do? And I said, yeah, probably. Next thing, you know, he's telling me a whole lot of stuff about his life  
(Participant C: Support person with lived experience)

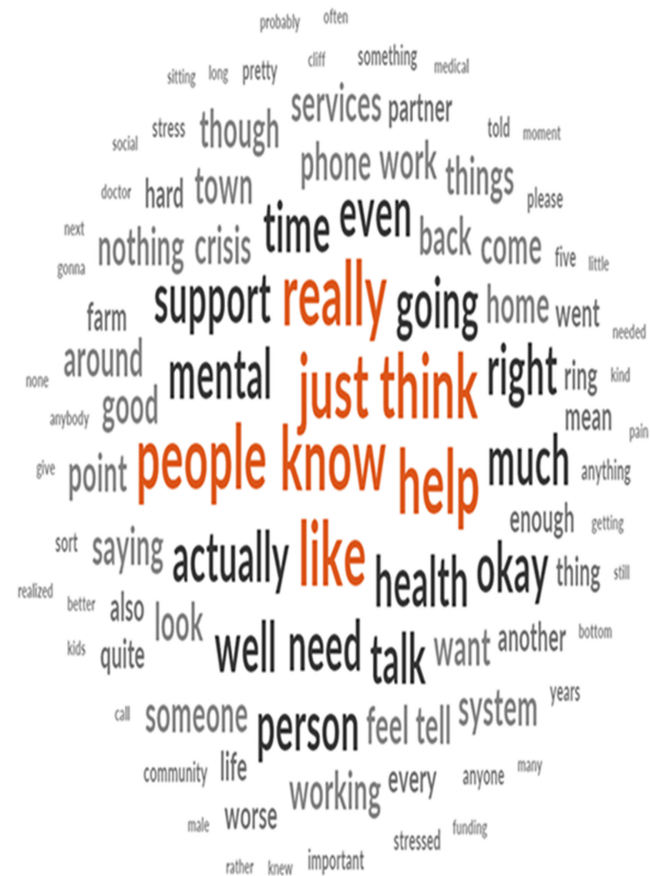


FIGURE 3 | NVivo word cloud.

Research demonstrates that the nature of interviewing people for a study can also have outcomes beyond data gathering (Bahner and Lindroth 2023; Perry and Bigelow 2020), such as therapeutic benefits from telling their stories.

### 10.2.1 | Healthcare Systems

The ability to access and or provide mental health support was a focus of many participants in this research. Several mentioned the lack of an integrated approach to receiving health care support, with many services operating within a silo, with services appearing to be fragmented and disjointed. However, such experiences belie those espoused by the government, which refer to an integrated service readily accessible to those who need it (Ministry of Health 2021). A common theme emerged associated with people attempting to access mental health being challenged to get the support they needed

For me, to access mental health support was hard. Like I said, it is the ambulance at the bottom of the cliff; unless you're in crisis, it's hard to get on their books  
(Participant D: Service user)

In a similar vein, a young man's support person asked for help but was effectively dismissed due to not being in sufficient crisis. Many participants inferred they were fobbed off and moved around like a pinball machine.

I said to him, look, his mental health is suffering, he is suffering. And they said we understand, but we're under so much stress that we cannot get him seen (a future date was given.... they were under so much stress, so much stress that they couldn't unless it were a crisis...things going on. And I said well, I think this is a crisis for us. And I said well, I worried about his life...I think I'll go in one day, and he'll be dead  
(Participant E: Support person)

Look, if we don't get something done about his mental health and his addiction issues, he's just going to spiral downhill... it's getting worse each day; his GP was quite arrogant, saying it's under the Official Secrets Act... if he wants help, he will come and get it, and I said, but he can't; he's ill. He (the GP) didn't understand a word I was saying  
(Participant F: Support person)

Several participants also felt like they were a burden to a service and were being dismissed due to what they referred to as potentially excessive costs.

"It all came down to funding, all came down to how much money my husband is going to cost them, how much services he's going to be sucking up, because there's other people that are way more. That's the

impression I got, there are people out there that are way worse off than you, and they are as if you're just sucking up too much funding. And you're just yeah. And they just don't seem to know what they were doing. Seems to be so many people and these roles like Brief Intervention practitioner, not actually helping anyone see."

(Participant G: Support person)

### 10.3 | Cultural Factors

Participants in the research did not specifically talk about their cultural values and beliefs being a roadblock to receiving support. However, what was discussed was the nature of small towns and communities, which tend to know what is happening in their communities. Additionally, some participants did not visit their general practitioners because they did not want to, only their files that they had mental health problems.

"So, I worry that if you go to your GP and you say, I've got mental health issues, I've got drinking issues, that suddenly that's on your file, and then that impacts on things like insurances ... So that's why I don't seek help"  
(participant H: Service User)

Many participants who had experienced mental health problems were reluctant to expose themselves to talking about their mental health challenges, especially with the real potential of accessing support where they know people who work there. The region in which the study was conducted was rural and had many farms. Several participants were farmers or were associated with farms; the challenge to seek mental health support was not just associated with the distance needed to travel to seek assistance but also related to the challenges of who takes care of the farm, animals and family if they must be off the land for several hours. Invariably, it was the wife who organised the logistics.

"I've been on a hell of a lot of farms over the years. And to me, the golden saviours of New Zealand farmers are the wives because they put up with some shit. Like they put up with some real shit from their husbands, and they're trying to hold the husband together. They're trying to deal with young kids most of the time. They've got staff on the farm, usually isolated. And that's why I've always tried to organise babysitters when I try to get a guy to go to the GP or make sure there are babysitters."

(Participant I: Support Person)

"They don't like being referred to certain agencies in the community because their aunt or uncle or grandmother, or you know some relative that works at the organisation, they don't want to go there because they don't want their family or whanau to know."

(Participant H: Mental health professional)

“Exploring why men struggle with emotions in this country and why we don’t ask for help. All these lightbulb moments around how men are raised and educated and conditioned to not sound like it’s not okay to not be okay, so don’t admit they’re not okay, because society doesn’t like that, or family and loved ones don’t like it when you admit that you’re not coping because we’re having to support so many others around us, we have to be strong and sort of repressed emotion and deny that we need help.”

(Participant J: Mental health Professional)

## 10.4 | Social Factors

Several participants in the research talked about the challenges of accessing meaningful and accessible support. Social determinants of health, such as poverty, unemployment, discrimination and social isolation, were discussed, especially in the context of accessing support. Finances were often seen as the inhibitor to access support; if they were to see a general practitioner, the cost of the consultation would be tempered by having to sacrifice other essentials, such as food.

I have to pay my rent for one week, so we can feed ourselves for two weeks. So, the next week, I pay my rent, or we don’t buy food

(participant K: Service user)

“I know people don’t work 24/7; community mental health work until 4.30. The general practitioners work until 6, but my ex-partner works 8 am-6 pm, six days a week. When can he access those services”

(Participant L: Support Person)

It all came down to funding, how much money my husband is going to cost them, how many services he’s going to suck up

(Participant M: Support person)

Yet, there were contrary positions from participants seeking help who found that the support they received in a rural location was greater than that within an urban centre.

I didn’t begin to recover until I moved to this rural region. The services I have received were superior to the services I received in the city

(participant N: Service user)

## 10.5 | Historical Factors

Considering the historical systems and processes is necessary as it grounds the development and delivery of services. Over the last thirty years, New Zealand has had several major mental health reviews (He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction 2018; Mason Inquiry Report 1986;

Minister of Health 1997, 2005; Ministry of Health 1994, 2001, 2002, 2005; Oakley Browne, Wells, and Scott 2006). The reviews have identified recurring problems, such as services not meeting a population’s needs and insufficient mental health resources to meet demand.

The Te Rau Hinengaro, New Zealand mental health survey (Oakley Browne, Wells, and Scott 2006) identified significant progress in the New Zealand mental health system. Developments included establishing the Mental Health Commission, which focused more on service user needs. Despite the positive gains made due to the Mason report (Ministry of Health 1996), Gluckman (2017) continued to be critical of mental health services, stating that mental health services were fragmented and disconnected from actual needs. Such a position also resonates in the latest national review, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018), proposing a focus beyond mental health, identifying community connectedness, addressing poverty, poor housing and easier access to services being critical to enhancing overall mental well-being. Yet, similar initiatives to address identified problems are not new; solutions are proposed, but service users’ experiences accessing or trying to access mental health support remain unchanged.

## 11 | Discussion

The case study highlights the importance of considering multiple factors impacting the context of accessing mental health services in one rural setting. A holistic approach to the context was used that considered historical, cultural and social factors to develop a practical understanding of the context in which the case phenomenon was addressed. When this study commenced, the New Zealand government voiced and championed that the time was right to create change to alter the trajectory of health from one fraught with fragmentation to one that provided services and had its citizens’ well-being as central (Ministry of Health 2018). The findings represent the challenges of implementing strategies and policies that, although pragmatic, struggle to address the issues identified.

### 11.1 | The Challenges of Seeding Change Through Policy

Policies and strategies are required to function from a social and political perspective, with the determinants of health, such as poverty and housing, being the cornerstone of mental health to address the overarching presenting problems (Barry et al. 2024). The He Ara Oranga report (Ministry of Health 2018) was vocal in viewing mental health in the overarching context of emotional well-being, yet there has been little traction. Fleming et al. (2024) articulate the challenges for improving youth mental health within New Zealand and present a framework to address inequities. Such frameworks are helpful, but you need the will of the government to ensure policy is implemented rather than remaining rhetoric. Schnitzspahn and Hegerl (2024) suggest the need to have a stronger community approach to address mental health problems, albeit in an Australian context. There are parallels experienced by

participants in this study whereby health-seeking is thwarted by challenges, with difficulty accessing services, sometimes associated with participants not being unwell enough to reach the threshold that met the criteria of the admitting service. Mental health and well-being are more than focusing on the symptoms; the contextual elements impact a person's well-being and are associated with the interplay of affecting factors, such as poverty. The New Zealand Salvation Army (Newshub 2024), who provide wide-ranging social support for New Zealanders in need, has had to significantly cut back its food bank due to government cuts of 25%; such positioning is also resonated by Hollingworth (2024) who voiced the likelihood of a significant reduction in food parcels to those most in need. Yet such positioning is not alone; multiple agencies and professional groups are also voicing dismay associated with the current government approach. Research identifies the existing problems and provides suggestions on how to address the identified problems. Newton et al. (2024), for example, argue that a multifaceted approach is needed to address the complexities of health and state that “reducing structural inequalities in the economy is necessary for improving the health and wellbeing of people, which itself receives less attention than other factors.” (202). Alongside this theme, Akhter et al. (2023) also suggest the need for community cohesion and collective control. Carey, Crammond, and Keast (2014), in reviewing how governments need to change to address social determinants, cite similar approaches, namely the need for inter-departmental collaboration. Articulating that governments lack the architectural nuances to achieve such an alignment. Carey suggests that more collaborative research needs to occur to address the roadblocks and to have a coordinated approach that looks at the outcomes of the interrelated social determinants. The research findings of this study align with such complexity and chaos, yet the policies and strategies have good intent; implementing their content appears problematic. Perhaps, as suggested by Bacchi (2016), rather than the problem presented in the policy, what else is going on and what is silenced in the health discourse? Systemic issues contribute to the problem. Gluckman et al. (2023) addressed such challenges and commented:

“In New Zealand, it could be argued that the shallow nature of our democratic institutions has left us particularly susceptible to short-term and too-often simplistic policymaking at the expense of consultative processes seeking broad consensus on complex issues that crosses partisan divides.” (9)

The short-term perspectives refer primarily to the cycling nature of New Zealand politics, which are short-term and do not allow the embedding of real change. Wanting to achieve a position of excellence is admirable, but it needs to address the underlying issues and be supported by systemic changes, as opposed to the metaphorical moving of the deck chairs on the Titanic ship and expecting an outcome other than sinking to occur. The rural health strategy (Ministry of Health 2023). For example, it has elements of other strategies, such as Kia Manawanui, yet the rural health strategy continues to make bold statements:

“Rural communities will have broader options for services that support their health, delivered by locally based entities. Primary and community care services, other community-based services.”

Ministry of Health 2023, (52).

Unfortunately, there continues to be no specific strategy for how this will occur. Rather than voicing admirable intent, have a plan with tangibles that address the intent, not just rhetoric advising that something will happen to address the problem identified. The need for social investment rather than re-writing and reorganising the same or similar policies or strategies is what is required. The right words are in place and have been voiced eloquently by the New Zealand Treasury that social investment is about improving the lives of New Zealanders by implementing social services that are evidence-based and appropriately funded. The challenge is to make that happen (Te Tai Ohanga: The Treasury 2024).

## 11.2 | The Need for Social Investment

Focusing on social investment is preferable to continuing policy and service restructuring. Reimagining policies to address the challenges of mental health and “well-being” will result in little change; the issues were effectively voiced in the He Ara Oranga report and the Kia Manawanui Pathway to Mental Well-Being. (Ministry of Health 2018, 2021). If “we” want to make a difference, connect people and tackle community well-being and belonging. New Zealand has a sound platform to address the problems identified, such as the New Zealand rural health strategy (Ministry of Health 2023), which has the right words and intent but has little emphasis on how the strategy will be addressed or unpacked.

In the He Ara Oranga report, the New Zealand government voiced the intent to make a once-in-a-lifetime pledge to get the mental health space working for the people of New Zealand (Ministry of Health 2018). However, Ramalho, Groot, and Adams (2022) assert that changes only occur when policies and services are designed and delivered. Despite the people's voices being noted, clinicians working within the New Zealand mental health service continue to express their concern about services under pressure, saying that they are disorganised and not for a purpose. Spence (2023) wrote in a national New Zealand newspaper.

“Years of poor planning, underfunding and understaffing produced a mental health system that is highly fragmented and confusing to navigate, with limited support for people in crisis, long waits for psychological therapies and overcrowded and poorly maintained inpatient facilities.”

(participant L: service user)

Similarly, the Royal Australian and New Zealand College of Psychiatrists also voiced that the New Zealand mental health services were not fit for purpose, under pressure and

under-resourced. (New Zealand Doctor 2023). This research examines the pathway to receiving mental health services in a rural setting, which participants viewed as problematic and, at times, described as chaotic.

I think it would be good if the medical centre had more capacity to deal with patients. When I first reached out and asked if I could talk to someone, they told me it would be a seven-week wait... which is not what you want to hear when you are thinking about suicide

(Participant M)

Budiyanto and Prananto (2019) comment on the need to understand the phenomenon being examined. The phenomenon in this research is the pathway to accessing mental health support. If clinicians find the mental health services fraught with challenges and difficult to manoeuvre, what is expected of Wally? Many of the participants in the study discussed difficulty accessing services; additionally, several participants discussed the fragmentation of the community to which they belonged. Gaber et al. (2022) posit the need to engage the community's stakeholders; similarly, Gluckman et al. (2023) discuss various options to address the complexities of social belonging, including promoting community activities to engage members, enhance social cohesion and examine what may be undermining it. Gluckman (2017) comments:

“We must eliminate disconnected, incoherent services and rather provide a net of resources within reach of all individuals. Crucially, we must ensure a predictable, preferably single, point of contact for services for each individual.” (14)

The voice of the people who receive or have received mental health support was central to recent New Zealand mental health reviews (Ministry of Health 2018, 2021, 2022a). People were asked their opinions on mental health and overall well-being factors. Wally was purportedly no longer hidden, the picture of confusion clearing; Wally was to be seen. Indeed, seen by mental health and social services, where and when needed were the underpinnings of New Zealand policy and directives (Ministry of Health 2022a, 2022b). The problem was that despite the government's intent to address the failings of mental health, little traction was forthcoming (Allison et al. 2019).

## 12 | Conclusion

Context in mental health research using concepts of Foucault and Fairclough underscores the importance of analysing power dynamics and language in shaping an understanding of mental health. By interrogating the historical, social and discursive dimensions of mental health and distress, researchers can better understand how power operates within the field and work towards more equitable and inclusive approaches to mental health research and practice. However, contextual understanding is often complex and multifaceted, requiring researchers to

navigate a range of factors and considerations to gain a complete picture. To navigate the complexity of contextual knowledge, researchers need to engage with community members and stakeholders and consider how broader social, economic and political factors shape the context in which they work. This understanding can lead to developing more effective interventions, policies and practices that address people's diverse needs. Research investigating the impact of context and recognising the interconnectedness of these factors and their effect on healthcare delivery is essential for developing interventions and policies that support them.

## 13 | Implications for Practice

This case study research is bounded within one geographical location and does not represent other geographical locations in New Zealand or overseas. Nonetheless, it has implications for future service provision. Like many countries, New Zealand has a repetitious approach to a problem, completing review after review and developing new strategies or policies. However, in New Zealand, there is a wealth of strategies that would have value if they were implemented. What matters is not the recurrent analysis of problems; New Zealand already has a sound strategy focusing on well-being. There will be little change unless “we” break the merry-go-round of discussion and act upon what has been identified and agreed upon. Make community well-being an outcome with specific measures attached that can bring well-being to the fore, not something to be dismissed in favour of political point scoring—we have balanced the books—the operation was successful, but unfortunately, the patient died.

### Ethics Statement

Full ethics approval has been granted through Massey University Ethics Committee: HEC: Southern A Application SOA 21/16.

### Consent

Per ethics approval, each participant consented to the research—no identifying information is present.

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

### Peer Review

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16577>.

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### Supporting Information

Additional supporting information can be found online in the Supporting Information section.