



University
of Glasgow

Philo, C., Parr, H., and Burns, N. (2003) *Social Geographies of Rural Mental Health: Summary Report*. Project Report.

<http://theses.gla.ac.uk/96751/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Social Geographies of Rural Mental Health: Summary Report

Chris Philo, Hester Parr and Nicola Burns

*Social Geographies of Rural Mental Health
(ESRC Funded Research Project, Award No·R000 23 8453)*

*Department of Geography and Geomatics,
University of Glasgow, Glasgow G12 8QQ*

&

*Department of Geography,
University of Dundee, Dundee DD1 4HN*

March 2003

Can be cited, but not to be quoted from without permission

Social Geographies of Rural Mental Health: Executive summary

Introduction

This executive summary presents the major findings of an Economic and Social Research Council funded research project (Grant award R000238453) '*Social geographies of rural mental health: experiencing inclusion and exclusion*'. The summary is divided into three main sections. First is a brief description of the research project, its aims and methods (p3). The second section details the main findings to have emerged from the study (p4-6). The third section presents recommendations emerging from the project (p7).

Background information and approach

- The research from which this report is drawn is a qualitative study investigating how and if people with mental health problems in rural communities experience processes of social inclusion and exclusion, and to show how these processes and experiences vary between different rural places.
- The project is funded by the Economic and Social Research Council (ESRC) and began in 2001 and is scheduled to finish by June 2003.
- The research is primarily qualitative in nature, using in-depth semi-structured taped interviews (with full permission), participant observation and documentary analysis.
- Four areas of the Highlands were the focus of the study: Inverness and surrounding district (designated mixed urban-rural by the Scottish Office); Easter Ross (designated rural settlements dominate); Skye and Lochalsh (designated remote rural) and North West Sutherland (designated remote rural).
- The research focused primarily upon the experiences of individuals with mental health problems (referred to as 'users' throughout the report) in rural areas, with 107 in-depth semi-structured interviews conducted with users throughout the Highlands. In addition, 43 service providers and 17 informal carers were also interviewed for the study.
- A bespoke postal questionnaire was sent to 229 GPs in the Highlands with the aim of understanding the role of GPs in the provision of mental health care in the Highlands and their views on care practice, delivery and management of such services. The survey elicited a 22 per cent response rate.

Findings

This section provides the main findings of the research. It should be noted that these are general findings drawn from analysis of data from all four areas. The section is divided into three main sections, representing the findings from analysis of users of mental health services, service providers and informal carers.

User experiences and views

- Many users of mental health services feel both included in and excluded from their local communities.
- There is a stigma surrounding mental health problems due to the limited understanding of mental health problems within many local communities.
- The status of individual users within the community (such as whether they are 'local' or 'incomer') can effect community responses to illness.
- There is a perceived 'culture of silence' around mental health issues in rural and remote communities, whereby many people cannot and will not discuss emotional issues.
- Many users attempt to hide their health problems due to a fear of negative community attitudes and the stigma associated with mental health problems. Social and physical isolation can result and available services may not be accessed.
- The lack of anonymity in rural Highland communities presents a number of difficulties for those with mental health problems, not least in terms of accessing services.
- There is a lack of 'safe places' in remote and rural Highland localities where users feel supported, valued and able to talk freely about their experiences.
- Changes in the demographic profile and attendant social characteristics of the Highlands are challenging norms around mental health issues.
- The relative acceptability of alcohol misuse in rural communities means that alcohol is frequently used as a cover for mental health problems.
- The physical landscape of the Highlands is thought by users to have both a positive and negative effect on mental health.
- There is a perception amongst service users that people with mental health problems are attracted to rural areas, seeking a peaceful, supportive, less stressful environment.
- There is a perceived 'East-West' divide in the Highlands which is manifested in social, economic and cultural differences, all of which impinge upon mental health issues.
- There is an uneven geography of service provision and lack of specialist mental health services in the rural and remote Highlands. The west Highlands has poorer service provision in comparison to the east, with secondary care services located primarily in Inverness.
- A key problem in access to and delivery of mental health services is the distances that users and some service providers (notably CPNs) are expected to travel in rural and remote areas.
- A much valued aspect of mental health care delivery in the rural and remote Highlands is the CPN service, where these providers often represent the only form of support available to users of services and outlet for 'mental health talk'.
- Residents of remote areas are disproportionately reliant on GPs as the providers of mental health care due to the lack of secondary services available.
- The lack of 'places of safety' during acute phases of illness in rural and remote areas is of great concern to users.
- Drop-ins play a key role in combating social and physical isolation experienced by those with mental health problems.

- Many users feel part of a ‘mental health community’. Emerging from service sites of collective care, ‘mental health communities’ are crucial in fostering informal social and support networks between users of mental health services and thus in combating social isolation experienced by users.
- The Highland Users Group (HUG) plays a significant role in raising the political consciousness and activity of users throughout the Highland region.

Service provider views

- There is a perception amongst some service providers that there is significant inequity in terms of access to mental health service for people in remote and rural areas as compared to urban dwellers.
- There is a perception amongst some West Coast service providers that resources and personnel are more readily deployed in Inverness and the East Coast, and that this further inequity should be addressed.
- There is a perceived need for more outreach clinics in rural and remote areas. However, there is still a need for centralised mental health service in Inverness, but with good centre-periphery networks, systems and relations.
- Issues of rural poverty and deprivation are identified as exacerbating mental health issues in rural areas
- CPNs are under pressure to provide crisis and after hours services from GPs, users and carers.
- Service providers perceive there to be a shortage of CPNs and psychiatrists in rural and remote areas. It is argued that current staffing levels and resources do not acknowledge the physical environment in which these providers operate and that staffing and resources should be increased to take into account the vast areas where service providers deliver mental health care.
- The lack of support services enabling users to recover and move on from their experiences is a significant issue recognised by all service providers. The efforts of TAG and drop-in centres are acknowledged in combating social and physical isolation. However, resources are limited in these projects.
- Service providers believe that stigma exists throughout the Highlands but that attitudes are changing for the better. However, it is recognised that users are often unwilling to access services.
- Some communities are perceived to be tolerant of those with mental health difficulties. Locals with mental health problems are more likely than incomers to be tolerated, although repeated illness or odd behaviour may lead to exclusion from the community support networks.
- There is a perception that people with mental health problems migrate to the Highlands seeking peace, solitude and the rural idyll. The time of a range of service providers is taken up with tourists with mental health problems and those who migrate to commit suicide.
- GPs perceive themselves as the frontline primary mental health care service in rural and remote communities throughout the Highlands.
- GPs in remote and rural areas provide crisis services for people in acute phases of illness and do not feel that they have adequate back-up from centralised services when ambulance transportation and an adequate place of safety is required.

- Given the problems accessing secondary support services, GPs in rural and remote areas are likely to attempt to address mental health problems before referring on to secondary support services, often located in Inverness.
- GPs in rural and remote areas often perceive themselves to be working in a context of social, physical and professional isolation.
- Service providers are aware that they may be the only outlet of mental health talk with their clients.
- All service providers argue that there is a need for significantly more counselling and psychological mental health services in rural and remote areas. The provision of these services would free-up the time of GPs and CPNs and complement the work of psychiatrists.
- Alcohol mis-use is recognised as a continuing and significant problem throughout the Highlands. The complex relationship between alcohol and mental health is acknowledged by service providers as presenting problems in diagnosis and the accessing of appropriate services.
- There are issues for service providers with regard to living and working in remote and rural locations. Problems of confidentiality within rural and remote areas and professional isolation are often raised.
- The recruitment and retention of staff, particularly psychiatrists, is felt to be a pressing issue by most providers across a range of services.
- Service providers value and recognise the importance of HUG in representing the needs of mental health service users.
- The mental health framework policy is thought of as well-intentioned rhetoric, but a policy that has had little or no impact on the majority of the work and resources of service providers.

Informal carer views

- The Highlands is under-serviced in terms of its mental health care, particularly in the more rural and remote areas of the region.
- The term 'carer' is problematic for many Highlanders. This raises an important point for organisations aiming to identify this group and improve carers' situations.
- Carers identify the lack of out of hours and weekend support by any service providers as a significant issue.
- Carers' feel that their needs and situation are often 'invisible' to service providers and the wider community.
- Carers feel that there is little understanding or discussion of mental health problems in rural and remote communities. Carers can feel socially isolated, unable to discuss their experiences with friends or family.
- The status of users in the community is felt to be relevant in how the community responds to an individual's mental health problems. Those who are known and liked within the community are tolerated to a greater degree than those who are relatively unknown to the community.
- The lack of respite care in the Highlands is identified as an issue for carers, who feel that such a service would be beneficial not only to themselves but to those they care for.
- Many carers in rural and remote areas highlight the importance of GPs' having up-to-date knowledge and sensitive understandings of mental health issues, given

that they are the gatekeeper to specialist services and are often the main provider of mental health care in such areas.

- A lack of continuity in care in relation to psychiatrists is a key problem.
- A number of carers identify the need for the development of child and adolescent services in the region.
- Distance to secondary care services and to the psychiatric hospital New Craigs, raise practical and financial difficulties for carers.
- Support services such as day centres, drop-ins and TAG units are highly valued by carers. Such services are deemed crucial in combating the social and physical isolation experienced by users.
- Carer support groups are deemed essential by many as they provide advice, emotional and practical support often lacking in relations with service providers, family and the wider community.

Recommendations

Mental health awareness campaign

There is a need for a sustained and *localised* mental health awareness raising campaign throughout the Highlands in an effort to challenge and change attitudes toward mental health issues. Locally based, multi-agency initiatives, identifying and engaging with key members of the community, community groups and schools, could be developed in tandem with national efforts such as the current Scottish Executive 'See Me' stigma campaign. Certain key groups such as young men could be targeted.

The development of more collective service provision through statutory or voluntary organisations throughout rural and remote communities

This would not only improve service provision in these areas but would engender the development of 'mental health communities', fostering user support networks and thus combating the social and physical isolation experienced by users in their local communities. Furthermore, the presence of a local community facility would perhaps hasten the development of more positive attitudes towards mental health issues.

Improved transport links throughout the Highlands

The cost and variability of transport alongside the distances to be travelled are a major obstacle to inclusion in communities and effective treatment of those with mental health problems. Improved transport options in general, and more specifically for those with mental health problems, would go some way to combating social and physical isolation experienced by individuals and offsetting some of the problems of receiving treatment from secondary services located in Inverness

Increased numbers of service providers who can provide 'talking therapies'

A clear issue emerging from the research is that those with mental health problems have limited opportunities to discuss their problems with *anyone*, with CPNs mainly taking on this task. More CPNs, counsellors and psychologists positions are required both within rural and remote localities and centralised in Inverness.

Locally based care services in rural and remote areas

Outreach clinics based within GP practices in local areas involving psychologists, counsellors and psychiatrists would improve the delivery of care in rural and remote areas. Such a move would alleviate transport difficulties facing individuals. The

movement of a proportion of secondary support services to local clinics would also facilitate more communication between primary and secondary caregivers, tackling the professional isolation felt by rural CPNs and GPs.

The factor of distance should be taken into account when planning and allocating human and financial resources

Per capita measures are not sensitive to the unique geography of the Highlands and the large distances which service providers and users are required to travel. Factoring in distance through the use of, for example, notional lists, resulting in more staff (notably CPNs) would go some way to offsetting the problems faced by primary health care services in rural and remote areas.

Consideration should be given to the reallocation of resources to primary care services

Given the importance of the primary care services in the delivery of mental health care and the value placed on such services, resources should be channelled into local services such as GPs, CPNs and support workers.

The provision of places of safety in rural and remote areas must be re-evaluated

While it is acknowledged that the costs of establishing places of safety throughout the Highlands may far outweigh the use of such facilities in a financial sense, consideration must be given to the legality and safety issues raised by the current lack of provision.

Statutory services and User partnerships

Building on a successful and productive relationship with Highland Users Group, statutory providers should encourage further development of effective user-provider partnerships in rural and remote localities.

Further information

To find out more about the project or to read the *Findings Papers*, go to the project website:

<http://www.geog.gla.ac.uk/Projects/website/main.htm>

Should you have any queries about the project, or would like to discuss the project further, please contact:

Professor Chris Philo
Department of Geography and Topographic Science
University of Glasgow
Glasgow
G12 8QQ
Email: cphilo@geog.gla.ac.uk

Dr Hester Parr
Department of Geography
University of Dundee
Dundee
DD1 4HN
Email: h.parr@dundee.ac.uk

*Social Geographies of Rural Mental Health:
Full Summary Report*

Social geographies of rural mental health: Summary Report

Introduction

The purpose of this summary document is to offer an accessible route into the research project '*Social geographies of rural mental health: experiencing inclusion and exclusion*' for policy makers, practitioners and users of mental health services. The project can be described as a qualitative study investigating how people with mental health problems in rural communities experience processes of social inclusion and exclusion, and to show how these processes and experiences vary between different rural places. The research was conducted in the Highlands, focusing mainly in rural localities, but also in Inverness. The majority of the principal findings from the project are brought together in a series of *findings papers*, each of which relate to a specific theme to have emerged from analysis and interpretation of the data, generated primarily from interviews with users of mental health services (the main focus of the study). These findings papers can be accessed via the web and details are given below. The views and experiences of service providers and informal carers were also sought throughout the research and analysis and interpretation of these data are brought together and summarised here.

This summary report begins by laying out the basic purpose, approach and methodology of the project as a whole, including a statement of the initial research questions. The main findings from each of the findings papers are presented as summary bullet points and these represent the analysis of users of mental health services views and experiences. The report then turns to the main findings to have emerged from analysis of service providers and informal carers. A series of recommendations emerging from the project around mental health issues in the Highlands are then offered by way of conclusion.

While the research will have applicability to rural settings elsewhere, and hence to contribute to the wider literature on rural mental health (see working paper #1 reviewing and critiquing this literature), the particular aim is to inform people about mental health issues in the Highlands. In so doing, it is hoped to arrive at findings that will be of interest and even utility to various organisations – statutory, voluntary and user-led – operating in the Highlands mental health sector.

Background

The research project, which began in January 2001 and concludes June 2003, funded by the Economic and Social Research Council (Grant award R000238453), is concerned with 'social geographies of rural mental health'. Six main research questions informed and shaped the research, these are:

- (1) **experiencing rurality and remoteness:** how do people with mental health problems feel about and cope with living in country towns, villages and crofting townships? Do localities engender different positive or negative health/illness experiences in a variety of ways? (See *findings papers* #2, #3 and #6.)

- (2) **experiencing local rural communities:** are these reckoned to be supportive and conducive to good mental health, or hostile, stigmatising and damaging to mental health? Are rural communities more or less accepting/rejecting of individuals with mental health problems? (See *findings papers #2, #3, #4, #5 and #7*: the specifically Highlands dimension to answering this question has been addressed specifically in *findings papers #4 and #7*.)
- (3) **experiencing mental health care provisions:** what is the significance of formal psychiatric service provision in the maintenance of everyday life in rural places, and what are the functions of informal voluntary schemes and advocacy networks? In what ways are users involved in planning services, how are they consulted? What is the nature and role of user-led organisations in the Highlands? (See *findings papers #13, #14 and #15*.)
- (4) **experiencing natural environments and landscapes:** given the particular physical geography of the Scottish Highlands, and the wide acknowledgement of its influence on all aspects of daily life for residents in the region, particularly in remoter areas, how do these surroundings affect people with mental health problems? In particular, are aspects of the natural environment considered therapeutic, and do certain aspects of health and place become positively linked for some individuals in certain rural locations? (See *findings papers #10 and #11*.)
- (5) **what social differences can be detected in this realm of experiences?** Are there significant difference in mental health experiences between men and women, young and old, richer and poorer, or ‘locals’ (long-term locals) and ‘incomers’ (recent arrivals who have moved into the Highlands)? (See *findings paper #8, particularly as cross-referenced with findings paper #4*.)
- (6) **what spatial differences can be detected in this realm of experience?** Are there significant differences in mental health experiences between different parts of the Scottish Highlands, and in particular are there meaningful differences in this respect between more and less remote rural places? (See *findings paper #9, particularly as cross-referenced with findings paper #5*.)

Approach

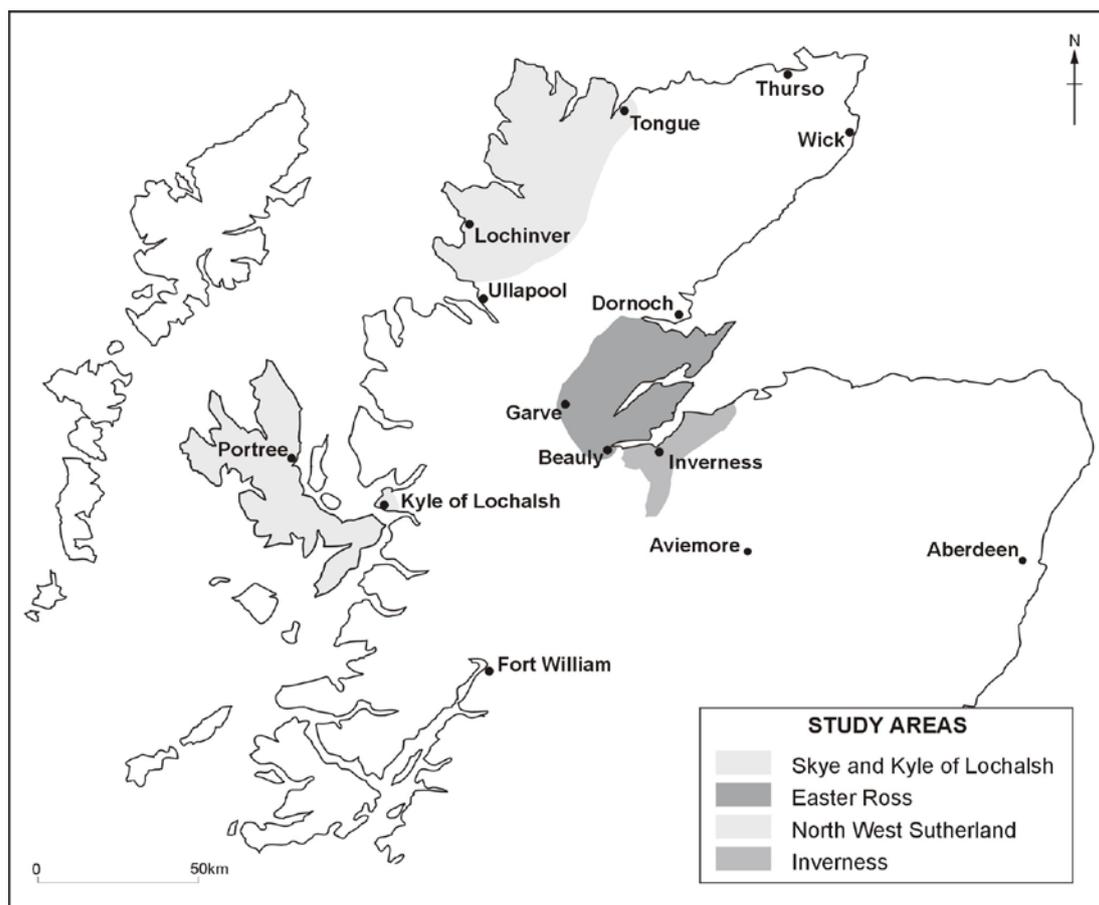
The project was primarily a *qualitative* one, depending on an in-depth semi-structured interviews, supplemented by elements of ethnographic observation (mostly in Highland drop-ins) and an analysis of relevant documentary evidence (e.g. policy documents). The project is framed very much in terms of *user experiences*, aiming as far as possible to hear the ‘words’, to access the views, of people who are using mental health services of one sort or another in the Highland region. Throughout this document and the findings papers the term ‘user’ means *user of mental health services*.

Reflecting the disciplinary background of all three researchers and a conviction that the deceptively simple qualities of ‘geography’ – meaning the spaces, places, environments and landscapes all around us – enter profoundly into all aspects of human social life, mental health issues included, the research approach is explicitly *geographical*. This results in wanting to know how *where* we are studying, the named localities (eg. the west coast of the Highlands) and the types of surroundings (eg. remote rural), make a *difference* to the subject-matter (eg. how people cope with the onset of mental health problems). In particular ‘community’ has been a central

interest in the project, with researchers seeking to understand the social dynamics that underlie the workings of communities, notably in terms of *who* gets included and excluded, *how*, and with *what* implications in the remote, rural and Highland locations under study.

Methodology

Four different Highland localities were selected in which to work, the aim being to detect both similarities and dissimilarities between the four in terms of mental health experiences. These localities sit on a continuum from urban-centred to extremely remote rural (see **map 1**):



Map 1: Study areas

- (1) **Inverness and district (east coast):** designated ‘mixed urban-rural’ in a Scottish Office report, and Inverness has recently been accorded ‘city’ status;
- (2) **Easter Ross (east coast):** designated ‘rural settlements dominate’, but does include largish centres such as Alness, Golspie and Tain;
- (3) **Skye and Lochalsh (west coast):** designated as ‘remote rural’, and Skye introduces an ‘island’ dimension;
- (4) **North West Sutherland (west coast, but including some north coast):** designated as ‘remote rural’, entailing a sizeable locality with very long distances between crofting townships.

In the findings paper on **Spatial differences** more detail is provided on both the basic socio-economic and the mental health service profiles of these four localities, as well

as teasing out user perceptions of ways in which these localities do indeed differ in terms of mental health and mental health care. However in outline, it can be stated that the range and density of mental health care provisions – statutory, voluntary and user-led – declines considerably from (1) (with in-patient facilities, out-patient clinics, psychiatrists, psychologists, a mental health team, CPNs, psychiatric social workers, drop-ins, and advocacy groups) through to (4) (with one or two CPNs, patchy psychiatric cover from elsewhere, and whatever the occasional GP can offer).

Within each of these four localities, interviews were conducted with 107 users, 17 carers for people with mental health problems and also with 45 service providers (including GPs, social workers, CPNs and voluntary workers). The spread of interviews across the four study areas was roughly even, but it was not possible to control the ‘sample’ in such a way as to ensure a fully ‘representative’ coverage of different diagnoses, genders, ages, ethnicities. The sample has generated numerous responses in the two key social groupings of ‘locals’ and ‘incomers’: the former being people who are long-term residents of the Highlands, often with family around and ancestral roots through several generations; and the latter being people who have moved into the Highlands from elsewhere more or less recently, and whose embeddedness within the ‘local’ community may therefore be quite limited.¹

Research participants were contacted through a variety of means, but mainly through the assistance of mental health teams, CPNs and drop-ins. Issues of confidentiality and anonymity were of prime importance throughout the project and efforts were made to ensure that participants were informed fully about these issues before and during participation in the research. In short, we have endeavoured to be as ethical as possible, to gain the full support and approval of all parties involved,² and to let people know that they can withdraw from the project – stopping interviews, asking for materials not to be used – at any stage. Interviews were semi-structured and were based around a collection of topics informed by the initial research questions. Furthermore, interviewees were encouraged to discuss issues of relevance to themselves. With permission from interviewees most sessions were tape-recorded and subsequently transcribed. Given the size and complexity of the archive a software computer package NVIVO was used to code and analyse interviews with users of mental health services.

The project also used a bespoke postal questionnaire to over 200 GPs in the Highlands - administered in December 2002 - with the aim of understanding the role of GPs in the provision of mental health care in the Highlands, eliciting a 22 per cent response rate.

Findings

In this section the main findings of the research, drawing on data from all four areas, are presented. This is divided into three main sections: users views and experiences;

¹ Interestingly, in some localities incomers may be regarded as people hailing from elsewhere in the Highlands, notably Inverness, although typically they are southern Scottish (sometimes known as ‘grey settlers’) or English (sometimes know, rather dubiously, as ‘white settlers’).

² For certain parts of our project, we needed to gain formal ethical clearance from the Highland Health Board Ethical Committee, and we would wish to thank all of those mental health professionals who assisted us in this process.

service provider views and informal carer views. Given the primary focus of the research on user experiences, the majority of the findings focus upon users experiences of mental health issues and are arranged around a series of findings papers. Findings from the analysis of service provider and informal carer interviews are available through various findings and working papers. The findings papers and working papers are available as a paper or electronic copy (contact Chris Philo for details or go to the project website:
<http://www.geog.gla.ac.uk/Projects/Website/Main.htm>)

User views

#2 Inclusionary social relations and practices

- Some users experience inclusionary attitudes, and claim a measure of local tolerance
- Some users hence feel included within the local community, with a reasonably strong sense of being part of this community
- Some users talk about being actively *re*-included after periods of in-patient treatment
- Specific caring acts can be identified, from being visited in hospital and helped with shopping to the more basic practices of being ‘looked out’ for and ‘checked up’ on
- A common perception is nonetheless that such acts are *not* always or even commonly underpinned by a deeper understanding or empathy (which is more than just tolerance)
- Some users feel spatially included, due to interactions in public places that can be friendly and supportive (but can also be awkward and even intrusive)
- Different users have different experiences, some more inclusionary than others, depending on their standing in the community and their levels of community involvement
- Inclusion may be restricted to within a quite specific ‘mental health community’ of people with similar experiences

#3 Exclusionary social relations and practices

- Some users experience exclusionary attitudes, and claim a lot of local intolerance
- Some users hence feel excluded from the local community, and have a limited sense of belonging to this community
- Some users are in no doubt about the stigma that attaches to them locally due to limited local understandings of mental health problems
- Specific ‘uncaring’ acts can be identified that may be quite extreme, from reporting and petitions to physical and verbal abuse to jokes, ridicule and humour to virtual ostracism from local groups
- Other ‘uncaring’ acts can be identified that are more subtle, from simply being ignored to negative bodily reactions/gazing/pointing to all manner of avoidance strategies (including *non*-visiting in hospital)
- Some users feel rejected not only by neighbours but also by those friends and even family members upon whose support one would normally depend

- Many users feel spatially excluded, isolated in their own homes, barred from other people's private space, and avoided in public places
- User perceive this exclusion to be rooted in certain cultural traits associated with Highlands society
- Incomers are more at risk than locals of enduring exclusion, chiefly because they are already 'alien' to the local culture and not part of shared local memories. Locals can experience inclusion, which can then shift to exclusion over time.
- Many users end up feeling worthless, trying to hide their 'illness', to remain silent about their problems and in effect to self-exclude themselves
- Some users seek to challenge the exclusions, questioning intolerance and stigma, while the solution for others is the ultimate one of migrating elsewhere

#4 *Highlands, economy, culture and mental health problems*

- The physical landscapes of the Highlands have an influence on some peoples' mental health problems, possibly a therapeutic one for some
- The economic restructuring of the Highlands, linked to issues of poverty, unemployment and poor housing, negatively impacts upon mental health
- There are distinct aspects of Highlands culture, complex and changing as this is, that negatively impact upon mental health
- A culture of resilience persuades people that they should be able to cope with problems when feeling low, and never to complain
- Gaelic/Celtic culture, strict religious observance, a longer-term history of dispossession, a mixture of fierce pride, together with unspoken local 'rules' of conduct: all of these cultural dimensions have mental health implications
- A culture of silence prevents the expression of emotional difficulties – emotions are thereby repressed, especially for men – which means that people cannot readily voice their own difficulties or engage directly with those of others
- Practical 'caring' acts may be forthcoming from the wider community to those with mental health problems, but often without any deeper emotional connection
- There are limited regional 'vocabularies' for discussing emotional difficulties or, more specifically, mental health problems
- Due to the culture of silence, people with mental health problems often remain silent about their problems, which can exacerbate their difficulties.
- Silence around mental health problems can be viewed as an obstacle to developing new thinking that might lift the stigma of mental health problems

#5 *Remoteness, rurality and mental health problems*

- Isolation (physical, social and cultural) is a feature of Highland rural life
- Such remoteness and isolation negatively impact upon mental health, in particular fuelling the 'depression' that many users feel due to their 'distance' from the right sorts of help and contact
- Interviewees perceive rurality to be about 'green' landscapes, sparse populations, and close-knit communities, and they hold differing views on the mental health implications of these 'rural' dimensions
- Some interviewees harbour favourable impressions of a 'rural idyll' *contra* an 'urban hell', and suppose rural areas to be conducive to good mental health

- In this respect, assumptions are made about rural areas being less stressful (less of a ‘rat race’, more peaceful), a safer setting, friendly, forgiving and more supportive when it comes to mental health problems
- At the same time, assumptions are made about urban areas being more stressful (noisy, chaotic, too busy), an unsafe setting, unfriendly, unforgiving and unsupportive when it comes to mental health problems
- Some people with diagnosed or incipient mental health problems are attracted to the perceived ‘rural idyll’ of the Highlands
- Some interviewees harbour unfavourable impressions of a ‘rural hell’ *contra* an ‘urban idyll’, and suppose rural areas to be harmful to good mental health
- In this respect, assumptions are made about rural areas being ‘backward’ and ‘traps’ for people, characterised by the omnipresent gaze, gossip and judgements of local people, which is ultimately unhelpful when it comes to (certain) mental health problems
- At the same time, assumptions are made about urban areas being ‘enlightened’ and affording people the relief of anonymity, allowing them to escape notice, inquisition and censure, which can actually be quite helpful when it comes to (certain) mental health problems.
- Some interviewees hint at how much more painful it can be to endure exclusions in rural surroundings when, thanks to the lack of anonymity, rejection cannot but be personal and taken personally

#6 Experiencing mental health problems

- A lack of awareness and cultural attitudes may lead to Highlanders not recognising when they have mental health problems
- Some people cope with illness symptoms by consuming more alcohol instead of accessing services
- Cultural attitudes to mental ill health and fear of exclusionary practices lead some to conceal their illness from others by a variety of means (including alcohol use, migration and hiding service use)
- Experiencing acute phases of mental health problems can mean a disruption in daily routines that threaten to expose concealment strategies
- Key to successfully hiding mental health problems is the ability to ‘pass’ as ‘normal’ in everyday dealings with the community: people with mental health problems can be very adept at knowing and practising what constitutes ‘normality’
- Users can find socialising very difficult, especially if their social life is constituted by close-knit family and friendship networks: social withdrawal may occur
- For some, a key part of the illness experience is a barrier to coping with the demands of sustained friendships and social contacts
- Extreme illness experiences can lead some people to attempt suicide
- Community reactions to suicide vary, but it could be seen as a key moment for collective attitudinal change

#7 Visibility, gossip and intimate neighbourly knowledges

- The physical geography of Highland communities can make it easy for residents to observe each other
- An important part of social and cultural life in rural places is the practice of gossiping about other residents

- This gossip can be based on the observation of both an individual's daily routine and any disruptions to it
- The dense family and friendship networks that span the Highlands can mean that news of an individual's mental health problems carries across large distances at a rapid rate
- Accessing services in small places can be a very visible activity and hence carries a risk for the person with mental health problems who wishes to conceal their health status
- The consequences of gossip for those with mental health problems can be both positive and negative, and this may depend on the community status of the individuals in question
- Negative consequences of gossip about users can include exclusionary practices
- Positive outcomes of gossip about users can include inclusionary caring acts, but these can also be constructed as rather superficial
- In light of the perceived risks of gossip, some people attempt to conceal their mental health problems, particularly when occupying public space
- Community knowledge about an individual's mental health problems can lead to increased observation by friends, neighbours and family, making rural lives seem even more visible

#8 Social differences: locals, incomers, gender, age and ethnicity

- The Highlands as a region is cross-cut by many axes of social differences, and as such there are many different 'communities' which constitute the area
- A key axis of difference for Highland communities is that relating to 'incomers' and 'locals'
- 'Local' status is bound up with long-term family-place associations and other cultural traits such as Gaelic language skills. 'Local' communities are constituted by close knit social networks and reciprocal social relations
- 'Incomer' status is related to the lack of long family-place associations and recent (last 30-40 years) migration to the Highlands. There are 'grey' and 'white' incomers, the former referring to Scottish migrants and the latter to English migrants. Incomers are (initially, but for some, permanently) less well-connected to other rural residents (especially locals)
- Local communities can be tolerant of local people's symptoms of mental health difficulties, but inclusionary social relations may be reduced over time
- Local people are more beholden to cultural norms of emotional and behavioural restraint than incomers
- Incomers may experience rejection because of their mental health difficulties, but they are also less beholden to cultural expectations around emotional and behavioural restraint
- Incomers' attitudes to mental health issues may be challenging dominant understandings in the Highlands
- Gender is also an important axis of social difference, and Highland men find it particularly difficult to come to terms with mental health difficulties
- There is some evidence of attitudinal differences in different generations, with younger Highlanders being less concerned about the stigma of mental health issues
- Ethnic prejudice amongst Scottish Highlanders can influence attitudes towards English migrants with mental health problems

#9 Spatial differences: east and west, Inverness and the rest

- The Highlands as a region contains within it different localities supporting more-or-less different forms of economic activity, social relations and cultural life
- Interviewees identify an east-west ('east coast'-'west coast') divide with economic, social and cultural dimensions: a relatively well-to-do east and a relatively poor west; a relatively 'modern' east and a relatively 'traditional' west
- The west in particular is often pictured in terms of certain images (stereotypes even) of alcoholic dependence and religious strictness, with presumed mental health implications
- While some suppose the west to be friendly, tolerant and supportive of people with mental health problems, a more common view is that community surveillance, gossip networks and emotional distancing create an environment that is less supportive in this respect
- While some suppose the east to be stand-offish towards people with mental health problems, others speak of the east being less plagued by 'hang ups' and hence less inquisitive about and judgmental of such people
- West coasters perceive the east coast to contain more and a greater range of specialist mental health services
- Interviewees identify a second divide that collapses east-west distinctions on to those between Inverness (the 'capital city' of the Highlands) and the rest (virtually everywhere else in the Highlands): a 'modern', 'progressive' and urbanising city as opposed to a 'traditional', 'backwards-looking' rural hinterland
- While some suppose Inverness to be polluted, chaotic, individualistic, materialistic and hence damaging to mental health, an equally common view is that it affords basic tolerance, a much-needed anonymity and hence a better place to exist if mentally unwell
- There is some qualitative evidence of people with mental health problems, incipient or diagnosed, leaving remoter rural parts of the Highlands for Inverness
- Such migrants are attracted by the anonymity, but also by the density of specialist mental health services as linked to the fostering of active user networks

#10 Therapeutic landscapes

- Many interviewees discuss in some detail their feelings about the 'physical' environment of the Highlands.
- For some, the 'wild' landscapes, together with poor weather conditions of rain, wind, snow and ice, are reckoned to be detrimental to their mental health
- Such feelings are exacerbated during the winter time, when the nights are very long, and many react badly to the lack of natural daylight
- For others, the dramatic scenery of the Highlands is uplifting, and reckoned to be a positive influence on their mental health: for them, these are genuinely 'therapeutic landscapes'
- A number of our interviewees actively 'use' this scenery through hill-walking, rambling and sight-seeing, revealing an embodied interaction with therapeutic landscapes: for these people, such landscapes are a site for emotional release and recuperation
- A number 'consumed' this scenery through painting, poetry and other artistic representations, either as produced by themselves or by others

- A few interviewees nonetheless find themselves ‘oppressed’ by the beauty all around them: being unable to appreciate it, and sensing that they are inadequate for not being able to do so, such Highlands scenery can actually end up making them feel worse

#11 Safe and unsafe places

- For many interviewees, particularly if ‘in crisis’, their home places are felt to be the best or even the only ‘safe places’ to occupy
- For many interviewees, a process of ‘self-confinement’ in their homes can be identified: the home is used as a haven or bolt-hole allowing a distancing from the wider social world
- Fears abound of homes being violated, notably if people end up being ‘sectioned’ and forcibly removed from their homes
- Fears also abound of becoming trapped at home, due to being afraid to venture out: tensions arise between wanting the safety of the home and knowing that to ‘go out’ could eventually be beneficial for one’s mental health
- There is a micro-geography of places within their homes that are particularly significant to and used by certain people, again particularly if ‘in crisis’: beds and bedrooms are frequently mentioned
- For many interviewees, public places are more complex and challenging than home places, which is why the former may often be consciously avoided
- The value of walking on the streets is mentioned, even as itself a preparation for more difficult social encounters
- Certain cafés are undoubtedly valued for facilitating non-threatening social interactions, but many users are wary of public houses given either their own problems or worries about being rejected
- Religious sites, even quite informal ones with supposed spiritual significance, are valued as safe ones by some interviewees
- Specific places are also valued: but tensions arise between wanting to use such places to escape other people and embracing the presence there of other people and possible social interactions
- The lack of suitable public spaces for permitting safe social encounters may be a specific problem in more remote and rural Highland localities
- Drop-ins and TAG units (see findings papers) provide what might be termed a ‘third space’ between home places and public places, one valued for informality and an opportunity to be part of a non-threatening, understanding and supportive user or ‘mental health community’
- Activities and confidentiality are valued in such places, but the social side is probably most appreciated by interviewees
- Very embodied positive feelings about the safety and even inspiration of such places, in both their physical and social dimensions, are voiced by some interviewees

#12 Alcohol and mental health

- The relationship between alcohol and mental health problems in the Highlands is a complex one
- Alcohol is an important part of social and cultural life in rural communities
- Public houses are often the focus of community activities and socialising, particularly in remote rural areas, and they can be sites of inclusionary and

exclusionary relations and practices around those deemed ‘other’; as such they can be unsafe places for those with mental health problems

- Excessive alcohol consumption, while not condoned by all in Highland communities, is widely accepted as being part of Highland life
- Excessive alcohol consumption acts as a ‘licence’ to behave in ways ordinarily deemed inappropriate
- Alcohol misuse by men on a regular basis is perceived to be acceptable, being part of an identified ‘male’ regional culture, allowing emotional release where other avenues to such release are often barred
- In contrast, women’s use and abuse of alcohol is frowned upon, with a belief that women should be able to ‘cope’ emotionally without resorting to alcohol
- The spaces where men and women consume alcohol differ, with women mainly drinking in the private space of the home, while men tend to drink in public spaces
- Alcohol misuse is perceived to be more acceptable than mental health problems in Highland communities, and the connection is not always made between the former and the latter (indeed, the connection is sometimes flatly denied)
- Many interviewees use alcohol as a ‘cover’ for mental health problems, highlighting the acceptability of alcohol use compared to the unacceptability of mental health problems in Highland communities
- Alcohol is used to self-medicate by some people with mental health problems, alleviating, albeit for a short time, the symptoms of mental distress
- The use of alcohol by those with mental health problems can lead to problems in the targeting of and access to appropriate health services

#13 Formal services

- Cultural influences and attitudes may mean that some people do not access services until they are ‘in crisis’
- There is a lack of information about how Highland GPs can help with mental health problems and about what other services are available
- Users are acutely aware of an uneven geography of service provision and the lack of specialist mental health services
- A key problem in the accessing of specialist services is the distances that users are expected to travel, making some unwilling or unable to use a service
- There are social and cultural risks associated with being ‘found out’ when using such services because of unenlightened attitudes towards mental illness in some parts of the Highlands
- User views on psychiatrists show that this service is difficult to access for those in remote areas – in some cases it has simply been unavailable – and that psychiatrists have little influence on everyday coping skills
- Users point to the CPN service as being the most crucial in rural and remote areas, largely due to that fact that this provider can be the only source of support and ‘mental health talk’; but they are also concerned about restrictions on this service and even actively worried about the health of over-stretched CPNs
- User views on GPs highlight how up-to-date knowledge and an empathetic attitude is essential for the receipt of a ‘good service’; but it is acknowledged that residents of remote areas are disproportionately reliant on GPs and lack access to more specialist care

- User views on TAG units emphasise how collective receipt of assistance in coping with mental health can result in the positive development of skills, confidence and informal support networks
- User views on the gaps in current provision highlight a range of concerns, including the need for improved access to care, aftercare and crisis care

#14 Drop-ins

- Drop-ins are generally ‘safe places’ for people with mental health problems within which they experience informal support from voluntary sector staff and other users
- Accessing drop-ins can be difficult for those in small rural places where attendance may be easily noted by others
- Drop-ins operate as important social spaces where new skills and interests are developed and new friendships are formed
- A key function of the drop-in is as a form of ‘domestic space’ that provides shelter and nutrition for people who may be unable or unwilling to cook for themselves
- Users can access different services through drop-ins, including counselling, assistance with benefits and other advice
- Contestation over the use of drop-in space can emerge around issues such as the relative ‘wellness’ of members, the dominance of drop-in staff, the presence of medical staff, and the internal organisation of space for different activities
- Community attitudes towards drop-ins can be an important barometer of wider attitudes to mental health
- The relationships between drop-ins and the wider communities in which they are located could be further developed in positive ways

#15 User networks

- While people with mental health problems may at times feel excluded from wider rural Highland communities, they may still feel bound into other types of communities, notably ones emergent from service sites
- ‘Mental health communities’ can include both users and service providers, as well as the relatives of people who access mental health services
- The presence of a ‘mental health community’ is related to the availability of services and the collective receipt of mental health care
- As such, Inverness is perceived to hold a large and dense ‘mental health community’, constituted by the concentration of different services in one place
- Informal social and support networks between users emerge from collective service provision, and can be seen as offering a key benefit to rural areas
- Formal user networks are focused on the Highland Users Group (HUG), enabling the development of a political consciousness amongst service users, particularly as related to matters of service provision
- The concentration of services in Inverness maybe militates against the development of a *regional* user group, as those working at the local scale outside of Inverness can possibly see little benefit arising from their efforts
- There are many people with mental health problems who are unaware of HUG’s activities, which may be related to the lack of collective service points in some remote areas

- Remote areas with no form of mental health service provision to bring users of services together create special challenges for providers and policy makers, and innovations in the facilitation of informal user networks are therefore needed here

Service provider views

- There is a perception amongst some service providers that there is significant inequity in terms of access to mental health service for people in remote and rural areas as compared to urban dwellers.
- There is a perception amongst some West Coast service providers that resources and personnel are more readily deployed in Inverness and the East Coast, and that this further inequity should be addressed.
- There is a perceived need for more outreach clinics in rural and remote areas. However, there is still a need for centralised mental health service in Inverness, but with good centre-periphery networks, systems and relations.
- Issues of rural poverty and deprivation are identified as exacerbating mental health issues in rural areas
- CPNs are under pressure to provide crisis and after hours services from GPs, users and carers.
- Service providers perceive there to be a shortage of CPNs and psychiatrists in rural and remote areas. It is argued that current staffing levels and resources do not acknowledge the physical environment in which these providers operate and that staffing and resources should be increased to take into account the vast areas where service providers deliver mental health care.
- The lack of support services enabling users to recover and move on from their experiences is a significant issue recognised by all service providers. The efforts of TAG and drop-in centres are acknowledged in combating social and physical isolation. However, resources are limited in these projects.
- Service providers believe that stigma exists throughout the Highlands but that attitudes are changing for the better. However, it is recognised that users are often unwilling to access services.
- Some communities are perceived to be tolerant of those with mental health difficulties. Locals with mental health problems are more likely than incomers to be tolerated, although repeated illness or odd behaviour may lead to exclusion from the community support networks.
- There is a perception that people with mental health problems migrate to the Highlands seeking peace, solitude and the rural idyll. The time of a range of service providers is taken up with tourists with mental health problems and those who migrate to commit suicide.
- GPs perceive themselves as the frontline primary mental health care service in rural and remote communities throughout the Highlands.
- GPs in remote and rural areas provide crisis services for people in acute phases of illness and do not feel that they have adequate back-up from centralised services when ambulance transportation and an adequate place of safety is required.
- Given the problems accessing secondary support services, GPs in rural and remote areas are likely to attempt to address mental health problems before referring on to secondary support services, often located in Inverness.
- GPs in rural and remote areas often perceive themselves to be working in a context of social, physical and professional isolation.

- Service providers are aware that they may be the only outlet of mental health talk with their clients.
- All service providers argue that there is a need for significantly more counselling and psychological mental health services in rural and remote areas. The provision of these services would free-up the time of GPs and CPNs and complement the work of psychiatrists.
- Alcohol mis-use is recognised as a continuing and significant problem throughout the Highlands. The complex relationship between alcohol and mental health is acknowledged by service providers as presenting problems in diagnosis and the accessing of appropriate services.
- There are issues for service providers with regard to living and working in remote and rural locations. Problems of confidentiality within rural and remote areas and professional isolation are often raised.
- The recruitment and retention of staff, particularly psychiatrists, is felt to be a pressing issue by most providers across a range of services.
- Service providers value and recognise the importance of HUG in representing the needs of mental health service users.
- The mental health framework policy is thought of as well-intentioned rhetoric, but a policy that has had little or no impact on the majority of the work and resources of service providers.

Informal carer views

- The Highlands is under-serviced in terms of its mental health care, particularly in the more rural and remote areas of the region.
- The term ‘carer’ is problematic for many Highlanders. This raises an important point for organisations aiming to identify this group and improve carers’ situations.
- Carers identify the lack of out of hours and weekend support by any service providers as a significant issue.
- Carers’ feel that their needs and situation are often ‘invisible’ to service providers and the wider community.
- Carers feel that there is little understanding or discussion of mental health problems in rural and remote communities. Carers can feel socially isolated, unable to discuss their experiences with friends or family.
- The status of users in the community is felt to be relevant in how the community responds to an individual’s mental health problems. Those who are known and liked within the community are tolerated to a greater degree than those who are relatively unknown to the community.
- The lack of respite care in the Highlands is identified as an issue for carers, who feel that such a service would be beneficial not only to themselves but to those they care for.
- Many carers in rural and remote areas highlight the importance of GPs’ having up-to-date knowledge and sensitive understandings of mental health issues, given that they are the gatekeeper to specialist services and are often the main provider of mental health care in such areas.
- A lack of continuity in care in relation to psychiatrists is a key problem.

- A number of carers identify the need for the development of child and adolescent services in the region.
- Distance to secondary care services and to the psychiatric hospital New Craigs, raise practical and financial difficulties for carers.
- Support services such as day centres, drop-ins and TAG units are highly valued by carers. Such services are deemed crucial in combating the social and physical isolation experienced by users.
- Carer support groups are deemed essential by many as they provide advice, emotional and practical support often lacking in relations with service providers, family and the wider community.

Recommendations

These recommendations reflect an ‘on the ground’ perspective, being directly informed by the concerns and suggestions of those interviewed. The recommendations revolve primarily around service provision in rural and remote areas, particularly in the West Highlands and raising mental health awareness throughout Highland communities.

- **Mental health awareness campaign**

There is a need for a sustained and *localised* mental health awareness raising campaign throughout the Highlands in an effort to challenge and change attitudes toward mental health issues. Locally based, multi-agency initiatives, identifying and engaging with key members of the community, community groups and schools, could be developed in tandem with national efforts such as the current Scottish Executive ‘See Me’ stigma campaign. Certain key groups such as young men could be targeted.

- **The development of more collective service provision through statutory or voluntary organisations throughout rural and remote communities**

This would not only improve service provision in these areas but would engender the development of ‘mental health communities’, fostering user support networks and thus combating the social and physical isolation experienced by users in their local communities. Furthermore, the presence of a local community facility would perhaps hasten the development of more positive attitudes towards mental health issues.

- **Improved transport links throughout the Highlands**

The cost and variability of transport alongside the distances to be travelled are a major obstacle to inclusion in communities and effective treatment of those with mental health problems. Improved transport options in general, and more specifically for those with mental health problems, would go some way to combating social and physical isolation experienced by individuals and offsetting some of the problems of receiving treatment from secondary services located in Inverness

- **Increased numbers of service providers who can provide ‘talking therapies’**

A clear issue emerging from the research is that those with mental health problems have limited opportunities to discuss their problems with *anyone*, with CPNs mainly taking on this task. More CPNs, counsellors and psychologists positions are required both within rural and remote localities and centralised in Inverness.

- **Locally based care services in rural and remote areas**

Outreach clinics based within GP practices in local areas involving psychologists, counsellors and psychiatrists would improve the delivery of care in rural and remote areas. Such a move would alleviate transport difficulties facing individuals. The movement of a proportion of secondary support services to local clinics would also facilitate more communication between primary and secondary caregivers, tackling the professional isolation felt by rural CPNs and GPs.

- **The factor of distance should be taken into account when planning and allocating human and financial resources**

Per capita measures are not sensitive to the unique geography of the Highlands and the large distances which service providers and users are required to travel. Factoring in distance through the use of, for example, notional lists, resulting in more staff (notably CPNs) would go some way to offsetting the problems faced by primary health care services in rural and remote areas.

- **Consideration should be given to the reallocation of resources to primary care services**

Given the importance of the primary care services in the delivery of mental health care and the value placed on such services, resources should be channelled into local services such as GPs, CPNs and support workers.

- **The provision of places of safety in rural and remote areas must be re-evaluated**

While it is acknowledged that the costs of establishing places of safety throughout the Highlands may far outweigh the use of such facilities in a financial sense, consideration must be given to the legality and safety issues raised by the current lack of provision.

- **Statutory services and User partnerships**

Building on a successful and productive relationship with Highland Users Group, statutory providers should encourage further development of effective user-provider partnerships in rural and remote localities.

Further information

To find out more about the project or to read the *Findings Papers*, go to the project website:

<http://www/geog.gla.ac.uk/Projects/website/main.htm>

Listing of the *findings papers*

- #1 Introducing the *findings papers***
- #2 Inclusionary social relations and practices**
- #3 Exclusionary social relations and practices**
- #4 Highlands, economy, culture and mental health problems**
- #5 Remoteness, rurality and mental health problems**
- #6 Experiences of mental health problems**
- #7 Visibility, gossip and intimate neighbourly knowledges**
- #8 Social differences: locals, incomers, gender, age and ethnicity**
- #9 Spatial differences: east and west, Inverness and the rest**
- #10 Therapeutic landscapes**
- #11 Safe and unsafe places**
- #12 Alcohol and mental health**
- #13 Formal services**
- #14 Drop-ins**
- #15 User networks**

Should you have any queries about the project, or would like to discuss the project further, please contact:

Professor Chris Philo
Department of Geography and Topographic Science
University of Glasgow
Glasgow
G12 8QQ
Email: cphilo@geog.gla.ac.uk

Dr Hester Parr
Department of Geography
University of Dundee
Dundee
DD1 4HN
Email: h.parr@dundee.ac.uk