Introducing the *findings papers*

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 Topographic Science,
University of Glasgow, Glasgow G12 8QQ
&
Department of Geography,
University of Dundee, Dundee DD1 4HN

Findings Paper No.1, 2002

Introducing the *findings papers*

Logic of this paper

The majority of our principal findings from the project are brought together in a series of fifteen *findings papers*, each of which bar this one comprises a relatively self-contained amalgam of 'data' from the project – chiefly in the form of quotes, phrases and paraphrases from users of mental health services who we have interviewed in depth – together with our interpretations, arguments and conclusions based on this primary data. The purpose of this paper, the first in the series, is hence to introduce the other fourteen findings papers, and thereby to provide a quick guide to what they contain and how they 'fit together'. This series of finding papers runs alongside a series of more disparate working papers, which include conference presentations, drafts of papers for publication and sundry other items.

In this paper, we begin by laying out the basic purpose, approach and methodology of the project as a whole, including a re-statement of the initial research questions as these 'map' on to the different findings papers. We continue by listing the findings papers themselves, and concluding with summary bullet points of the main claims found in each of the following fourteen empirical findings papers.

Basics of the project

The research project that we have been conducting since January 2001, funded by the ESRC (Economic and Social Research Council), is concerned with what we term the 'social geographies of rural mental health'. Our initial prompt for undertaking this research was the relative paucity of attention paid – by academics at least – to mental health issues in a *rural* context, but it has also emerged from a fascination with the patterns of human existence in the Highlands of Scotland. As such, we have chosen to focus our research in the Highlands, chiefly in rural localities but also including work on Inverness, and our findings are therefore very much to do with the Highlands. While we think that our research will have applicability to rural settings elsewhere, and hence to contribute to the wider literature on rural mental health (see our working paper reviewing and critiquing this literature), our particular aim is to inform people about mental health issues in the Highlands. In so doing, we hope 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.

It is worth repeating here the six research questions posed in our initial ESRC research proposal, and in brackets after each question we indicate which of the findings papers most directly provide 'answers' to the question. In this way, we can satisfy ourselves that to a large extent we have been able to address the questions originally set, meaning, in short, that the project has basically achieved what it set out to achieve. These are the six research questions:

(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? Supplementary questions are whether such 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? Processes of social exclusion and inclusion in rural communities will be assessed, with the intention of amassing qualitative data on whether rural places are more or less accepting/rejecting of individuals with mental health problems. (See *findings papers #2, #3, #4, #5 and #7*: we have ended up saying rather more about the specifically Highlands dimension to answering this question, especially 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? The character of 'participation' for service users will be addressed, emphasising the phenomenon of local pressure groups … . (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

Our project is framed very much in terms of *user experiences*, aiming as far as possible to hear the 'words', to access the views, stories, hopes and fears, of people who are using mental health services of one sort or another in the Highland region. Throughout the findings papers we sometimes deploy the term 'user' to mean *user of mental health services*, although we realise that this as a term it has its drawbacks (not least because calling someone a 'user' can imply, for certain audiences perhaps, something very different from what we intend). It is also a term that may be used more frequently by the 'politicised' clients of mental health services in large urban areas such as Nottingham, where Hester has completed much of her earlier research work (eg. Parr, 1997), although it is not unknown in the Highlands thanks to the respected efforts of the Highland Users Group (HUG: see our findings paper on **User networks**). In fact, throughout our findings papers we tend to say 'interviewees' more often than we say 'users', although sometimes the latter term is particularly appropriate because we are explicitly discussing interviewee experiences associated with the use of mental health services (see our findings papers on **Formal services**,

Drop-ins and **User networks**). Occasionally, though, we simply say 'users' to avoid repetition of the term 'interviewees'.

Given our prioritising of *user experiences*, it should be clear that our project is primarily a *qualitative* one, depending on an in-depth semi-structured interview methodology, supplemented by elements of ethnographic observation (mostly in Highland drop-ins) and an analysis of relevant documentary evidence (policy documents and the like). Our project is therefore not a *quantitative* working with statistical indicators of mental ill-health incidence, care episodes and cure rates, although we certainly acknowledge the value of such research and are prepared to make use of some quantitative information where appropriate (to frame certain of our own findings). At the same time, we also acknowledge that our research is not couched in terms of medical-psychiatric diagnostic categories: we are not striving to reconstruct the spatial epidemiology of, say, schizophrenia or depression across the Highlands; and neither have we sought to control our 'sample' in such a way that findings about experiences can be cross-correlated with different diagnostic categories. Again, we recognise the potential value of such research, and in practice we do end up with informed impressions regarding the particular characteristics, causes and consequences of mental ill-health in the region (the seeming prevalence of depression, for instance). In addition, our project does not offer a systematic survey of services, their composition, uptake and usage, although we provide some information along these lines by way of context *and* we reckon that we can conclude quite a lot about user experiences 'on the ground' of such services.

To reiterate, then, ours is indeed a qualitative project, inspired by the anthropological and cultural end of social policy research, albeit maintaining a steady eye on the wider political economy of material circumstances and service availability that so deeply impact upon the mental health experiences of users. Thinking anthropologically, we are particularly interested in this thing called 'community', wondering about exactly what it entails in the remote, rural and Highland locations under study. We are thereby seeking to understand the dynamics that underlie the workings of communities here, notably in terms of *who* gets included and excluded, *how*, and with *what* implications. Our assumption is that people with mental health problems *will* stand apart from these communities in one way or another, through the noticeable differences in their own conduct and perhaps too because they more-or-less consciously elect to keep themselves to themselves, but also because of the attitudes, relations and practices that the host communities display towards these mentally 'different' individuals within their midst. We are particularly interested in the extent to which the communities involved *can* overcome fears and maybe prejudices to extend an inclusionary hand to such individuals, or whether the picture tends more often to be an exclusionary one. At the same time, we are centrally concerned with how these dynamics play out in the everyday spaces where people of the Highlands region routinely live, work and relax, from homes to streets to shops to hotel bars to sheep fanks.

What we should further emphasise is that our approach is explicitly *geographical*, 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 result is that we cannot explore

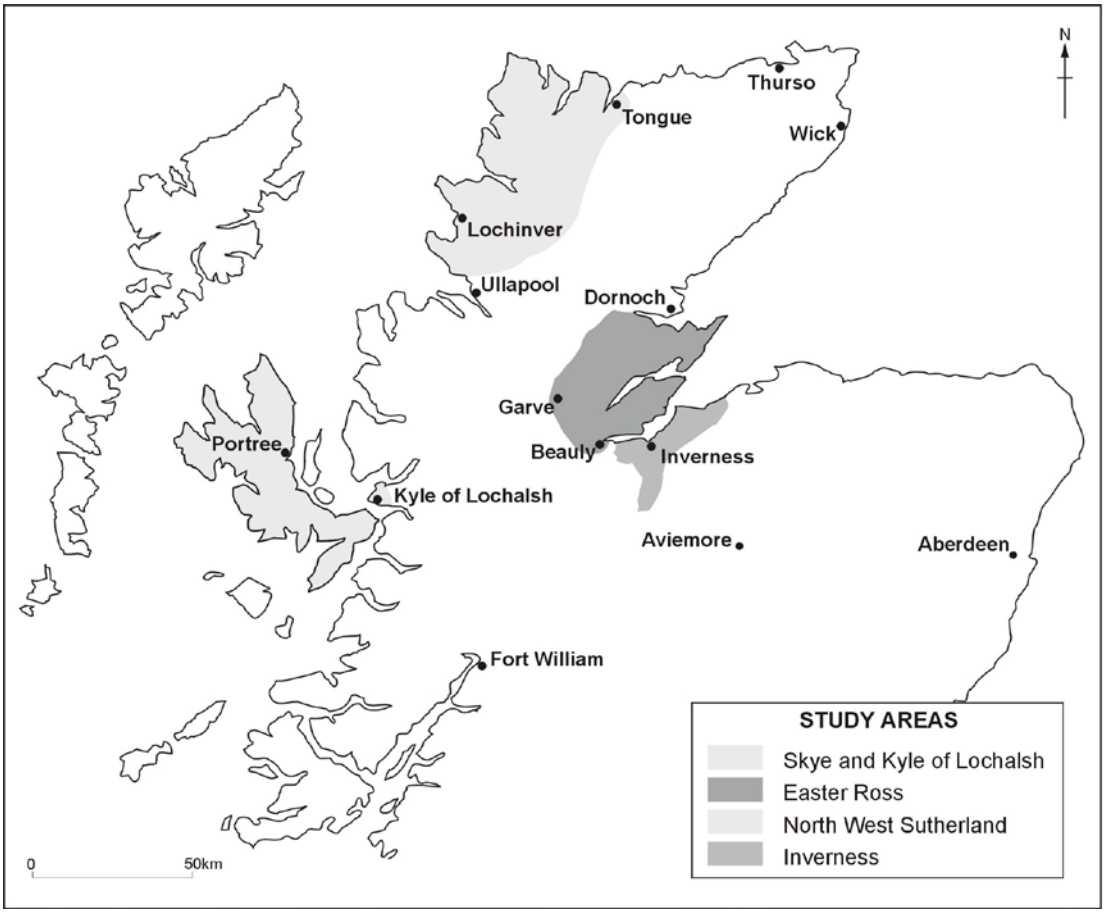
any subject-matter without wanting to know how *where* we are studying, the named localities (eg. the west coast of the Highlands) and the types of surroundings (eg. remote rural), make a *difference* to the subject-matter (eg. how people cope with the onset of mental health problems). More assertively, we believe that in many research projects, on mental health for instance, *in*sufficient attention is given to the question of *where* is involved (where are we talking about? where are the interviewees living? where is being serviced?). It would be possible to discuss at greater length the 'geographical critique' that shapes our ideas here, and we plan to develop such ideas at greater length in future working papers and publications. For present purposes, though, we will simply indicate that the notion of an indelible if complex bond between *geography* and *mental health* runs throughout our project; and we hope that we do indeed demonstrate the significance of this bond throughout the findings papers.

Methodology

Our methodology is hence designed to allow 'room' to this concern for both geography and user experiences. Drawing upon ideas about hierarchies of abstraction and spatial scale, we wish to be able to generalise about the influences of rurality and remoteness while also being more specific about the influences of, firstly, the Highlands region as a whole and, secondly, differing localities within the Highlands. We thus selected *four* different Highland localities 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, and they also permit us to pick up on possible 'east coast – west coast' distinctions (see **map 1**):

(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 that many residents feel to be 'urban' in character;
(3) **Skye and Lochalsh (west coast):** designated as 'remote rural', although Portree on Skye is felt by some to be 'urban', 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, and perhaps carrying the most pronounced connotations of remoteness.

Such thumbnail descriptions convey little of the flavour of these localities, however, so that the challenges of Inverness as a new 'city' and the drama of the Highlands mountain, glen and coastline remain hidden; yet, the rich details of these geographical settings *do* emerge repeatedly in the words of our interviewees. Such descriptions also tell us nothing about the differing mental health service profiles of the four localities, but in baldest outline, and as supported by our interviewees, we can state 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).



Map 1: Study areas

Especially valuable to us in our research have been three drop-in centres, funded by charitable organisations: Cairdeas Cottage, Inverness; Companas Cottage, Alness, and The Cabin, Portree. In our findings paper on **Spatial differences** we provide more detail 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.

Within each of these four localities, we have conducted interviews with users, over 100 in total, as well as with various carers for people with mental health problems and also with a selection of service providers (including GPs in North West Sutherland, given their 'special' role in this connection). 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 or other axes of human variability (see **appendix 1**). This being said, the size of the sample has allowed a decent spread along most relevant axes, certain implications of which in mental health terms we explore in our findings paper on **Social differences**. Most pertinently – and relating back to another original concern of the project – our 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]

We have gained contact with users through different routes: in part through names of people willing to speak to us passed on by mental health teams and CPNs, and in part through contacts made with users attending at drop-ins when Nicola Burns (the Research Assistant on this project) has been present. A small degree of 'snowballing' has occurred, wherein one user has suggested other users to whom we might speak. We have been very careful to explain to all interviewees, but particularly the users, that everything talked about in interviews is confidential, will be treated with respect and circumspection, and that any quotes, phrases or whatever drawn from interviews for publications, reports or presentations will be anonymised (as you will see presently). 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. The interviews themselves were semi-structured, lasting anywhere from half an hour to two hours or even longer, based around a loose collection of topics that we wished to address (see **appendix 2**). We were precisely not delivering a questionnaire, the point rather being to open up an interactive dialogue about facets of the *geography-mental health* relationship of immediate concern *to* the inteviewee him or herself. With permission from interviewees, most sessions were tape-recorded and subsequently transcribed, furnishing us with a massive and, we would argue, incredibly rich 'archive' of materials accurately preserved in the words of our interviewees and potentially available at a later date for consultation by other researchers. (The intention is to deposit transcripts, suitably anonymised, in the ESRC's 'Qualidata' archive.) Interviews were conducted by all members of the research team, and we ensured that all three of us obtained vital 'field' experience, although the majority were completed by Nicola; and all three of us have since worked intimately with the transcripts to produce the findings papers and other outputs from the project.

Findings

As indicated, the project has produced a huge archive of primary data, a first of its kind as a comprehensive qualitative record of reflections, opinions, anecdotes and anxieties from a substantial number of people with mental health problems in the Highlands. These are of course the people who are now supposed to be consulted as part of mental health policy-making, but in practice – and as so many of our respondents revealed – their voices still remain largely unheard and hence inaudible on the policy landscape. Certain individuals, notably ones who are 'recovering' and living in places well networked into the likes of the Highland Users Group (HUG), may be heard on occasion, but we have met scores of users who hardly ever talk about their condition to *anyone* (a staggering finding in its own right) let alone have their 'say' as part of consultation programmes. While hesitating to overplay the salience of our archive, we do sense that we have here a resource pregnant with implications not

[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.

just for academic researchers such as ourselves but also for mental health policy-makers in the Highlands (and maybe too elsewhere in Scotland and beyond).

Given the size and complexity of our archive, we have obviously needed to tackle it selectively in order to arrive at findings, interpretations and conclusions. Using the NVIVO software programme designed to deal with large text-based datasets, we have duly 'coded up' all of the user and carer interviews under a number of themes and sub-themes (arranged in a 'tree' structure of primary and secondary codes), these being suggested by both the original ambitions of the project and the specific concerns arising out of the interviews themselves (there being a iterative movement here between theory and evidence) (see **appendix 3**). We would not deny that there are subjective evaluations inherent in such a 'coding' exercise, but proceeding in this manner does enable a measure of rigour and consistency to be maintained when managing the data set without compromising the integrity or indeed 'losing' too much of its rich content. More pragmatically, the coding exercise has allowed us to extract quotes from users that reflect certain themes, and then to group together 'parcels' of quotes/themes for the purpose of deciding upon our core findings from the project. By working intensively with these quotes/themes, staying close to the empirical detail and nuances but starting to develop interpretations, arguments and conclusions built upon sentiments clearly shared by numbers of users,[3] we advance into the findings phase of the project.

As part of the writing up of the project we have already produced several *working papers*, reviewing relevant literature, dealing with specific elements of the project (such as 'caring' and 'emotional geographies') and more broadly summarising what the project is all about. (One or two of these have already been submitted for publication; others are conference presentations.) More importantly, though, we have now produced a series of *findings papers*, of which is the first, in which we write through large amounts of our data, principally the words of interviewees, working in precisely the manner described above: intensively probing the quotes as coded up into themes as the basis for interpretations, arguments and (preliminary) conclusions. Taken together, however, these findings papers do provide both an overview and numerous specifics of what the project has found out; and they will also provide the basis from which we will be extracting materials to include in future publications, presentations and reports (including reports 'back' to people in the study areas). Both the working papers and the finding papers are available as paper copy (contact Nicola Burns or Chris Philo for details) and electronically through the project website (at the moment go to *http://www.geog.gla.ac.uk/Projects/WebSite/main.htm*).

While each of the findings papers is meant to be fairly self-contained, overlap between them is unavoidable and in places deliberate, and some of the papers really do need to be read in tandem for an overall line of reasoning to emerge (notably, for instance, *findings papers #3, #6 and #7* or *findings papers #4 and #8* or *findings papers #13, #14 and #15*). Some of the papers may also appear to contain contradictory findings, notably the two on inclusionary and exclusionary social

[3] We would wish to underline this point, in that throughout the findings papers and other outputs from the project we try to ensure that any claims we make 'grow out' of what *a number* of interviewees, certainly more than one or two in each case (except where we are deliberately highlighting an individual exception), are saying to us in the interviews. In other words, we are looking for patterns, regularities and consistencies, and are endeavouring to 'let the data speak', to inform our interpretations, rather than us imposing *a priori* conceptions and expectations upon that data.

relations and practices (see *findings papers #2 and #3*). The first paper here charts various positive (inclusionary) experiences of certain users in relation to their 'local' communities, while the second charts much more negative (exclusionary) experiences of other users – and in some cases actually the *same* users – in relation their 'local' communities. We speculate in *findings papers #4, #6 and #7* on this seeming 'contradiction', proposing that inclusionary practices 'on the surface' may coincide with a distinctly if understandably wary and emotionally unaccommodating local culture 'underneath', as well as supposing that ostensible acts of caring (keeping an 'eye out' or 'checking up' on individuals) may also double as mechanisms within a local network of surveillance (visibility) and commentary (gossip) that can clearly be detrimental to some vulnerable individuals with mental health problems. This being said, we still think that there may be a valuable resource in the workings of local communities, in what we term (following the literature) their *Gemeinschaft* character, that could be mobilised to assist people with mental health problems in a more constructive manner than is perhaps the case at present.

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

Summaries of the *findings papers*

#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, thanks 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
- Users perceive this exclusion to be rooted in the restructuring of rural society and also to 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 other is the ultimate one of migrating elsewhere

#4 Highlands, economy, culture and mental health problems

- There are many ways in which the Highlands and mental health problems are associated
- 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
- Gaelic/Celtic culture, strict religious observance, a longer-term history of dispossession, a mixture of fierce pride and a wish to remain unhurried, together

with unspoken local 'rules' of conduct: all of these cultural dimensions have mental health implications

- A culture of resilience persuades people that they should be able to cope with problems when feeling low, and never to complain
- 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, but often without any deeper emotional connection
- There are limited regional 'vocabularies' for discussing emotional difficulties or, more specifically, mental health problems
- People with mental health problems, whether diagnosed or incipient, are often forced into a self-silencing, to their individual detriment and as an obstacle to developing new thinking that might lift the stigma of mental health problems

#5 Remoteness, rurality and mental health problems

- There are many ways in which remoteness, rurality and mental health problems are associated
- Physical and infrastructural remoteness, chiefly to do with overcoming long distances to access provisions and services, connect up with social and cultural isolation from kith, kin, neighbours and potential support networks of different kinds
- 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 successful concealment strategies is the negotiation of 'normal' social interactions in public space: 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's social world
- 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 migrant 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
- Using statistical indicators, this paper introduces the Highland region as a whole, before giving thumbnail socio-economic and mental health service profiles of the four study areas
- Chiefly through the words of interviewees, the following are explored: perceived variations across the Highlands in the characteristics and even 'causes' of mental health problems; perceived and experienced variations across the Highlands in how people with mental health problems are treated
- All of the above are also explored with reference to perceived and experienced differences in the mental health services on offer from one part of the Highlands to the next
- 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 phenomena such as the community gaze, 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 – we discuss the lobster port example – 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
- Public transport, so vital in remote and rural places, has implications in terms of whether or not people with mental health problems feel safe (in a psychological sense) when using the bus services (and even specific buses)
- 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, and it is difficult to determine the direction of causality
- Alcohol is an important part of the social and cultural landscape of the Highlands, playing an important role in the social and cultural life of 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 detail using 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
- Interviewees detail their use of alcohol to self-medicate, 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

Reference

Parr, H., 1997, 'Mental health, public space and the city: questions of individual and collective access', *Environment and Planning D: Society and Space*, Vol.15, pp.435-454

Appendix 1: Dimensions of the 'sample' of users of mental health services

Total number of interviewees = 107

Distribution by study area

Study Area	n
Inverness and district	28
Easter Ross	27
Skye and Lochalsh	26
North West Sutherland	26
Total	**107**

Distribution by origin and diagnosis

(based on personal 'histories' of residence and mental health problems given by interviewees)

	Incomers	Locals
Total(n)	69	38

	Depression	Manic depression	Schizo-phrenia	Other	Unknown
Total(n)	52	14	9	21	11

Distribution by gender and age

(the latter based on subjective judgement of interviewer, occasionally supported by information from interviewee)

	Gender		Age		
	Male	**Female**	**Young <30**	**Middle-aged**	**Old 65+**
Total(n)	51	56	19	84	4

Appendix 2: Selected sample questions from interview schedule for users of mental health services

This appendix contains a selection of questions used during interviews with users of mental health services. It should be borne in mind that these were simply used as a guide to the interviewer, with interviewees being encouraged to discuss issues important to them, leading to an interactive dialogue between interviewer and interviewee.

Context

How long have you lived in this house/area?
Have you always lived in this area?
How would you describe the place you live?
Do you ever feel isolated?

Social environment and community

Do you think there is a sense of community here?
Do you feel a part of the community?
Would you say the community is generally supportive of people with mental health problems?
Are there groups (formal/informal) which are welcoming to people with mental health problems?

Attitudes to mental health

Would you say there is local community knowledge of mental health problems? How do people refer to health problems like these?
Do you have any views on how mental health problems are understood in your area?
Do you think that there are particularly important people in local communities that influence whether mental health problems are discussed openly and supportively like the local GP, local priest or local publican for example?
Do you have any views on how mental health problems are understood in the Highlands? Do you think local attitudes you have described are similar to those throughout the Highlands?

Privacy and Support

Have there been occasions when you have tried to conceal your mental health difficulties? For example from friends, family neighbours. ?
Do you find concealing difficult to do?
Do you find yourself using the spaces of the community differently- when you are feeling unwell/ distressed?
Does your time in the home increase when you are not well?
Are there any 'safe spaces' where you are happy to go? Examples
Are there any places you like going to? (when feel well/unwell)
Are there any places you do not like going to/ you avoid? (when feel unwell/ well)
Are there places you would like to go but you can't because of transport/ remoteness?

Nature, Environment and Landscape

How do you feel about this place, the landscape around you?
Do you think the place/ the landscape where you stay affects your mental health?
In what ways?
Does this change according to the seasons/ time of year/ time of day?
Does this change depending on how you are feeling? For example when you feel well, happy is this different from when you are unhappy distressed?
Would you say there are aspects of the physical environment (like hills, wooded areas or particular landscapes) that are therapeutic for you - where and what are these?

Services

What formal services do you use/access?
How important are these services to you?
What do you think about the level and quality of the formal services in your area?

Appendix 3: Examples of codes used in NVIVO

In this appendix we have included a selection of the codes used for the analysis of the data-set. Codes were developed using a tree structure such as *'practices of community'* below, as well as 'free' codes being developed, e.g. *'concealment'*.

6 concealment
7 confidentiality
8 CPN
9 darkness
10 diagnosis label
11 east west
12 family
15 HUG
24 place
27 private space
28 psychiatrist
29 public space
30 religion
33 safe places
34 seasons
35 social worker
36 spiritual
37 suicide
39 TAG
40 TDH
41 time
42 transport and travel
43 unsafe places
45 user groups
46 weather

(7) /PRACTICES OF COMMUNITY
(7 1) /PRACTICES OF COMMUNITY/caring acts
(7 2) /PRACTICES OF COMMUNITY/incomers and locals
(7 3) /PRACTICES OF COMMUNITY/tolerance of difference
(7 4) /PRACTICES OF COMMUNITY/rejection of difference
(7 5) /PRACTICES OF COMMUNITY/visits

(10) /TALK
(10 1) /TALK/gossip
(10 2) /TALK/silence
(10 3) /TALK/sharing
(10 3 1) /TALK/sharing/family friends
(10 3 2) /TALK/sharing/other users
(10 4) /TALK/direct talk
(10 5) /TALK/formal
(10 5 1) /TALK/formal/positive talk
(10 5 2) /TALK/formal/negative talk
(10 9) /TALK/asking for help

15) /VISIBILITY
(15 1) /VISIBILITY/gaze
(15 2) /VISIBILITY/passing
(15 3) /VISIBILITY/using services
(15 4) /VISIBILITY/anonymity

(16) /EMOTIONS
(16 1) /EMOTIONS/expression of
(16 2) /EMOTIONS/sharing
(16 3) /EMOTIONS/hiding
(16 4) /EMOTIONS/distance

(17) /ISOLATION
(17 1) /ISOLATION/social
(17 2) /ISOLATION/physical
(17 3) /ISOLATION/cultural

(25) /SUPPORT NETWORKS
(25 1) /SUPPORT NETWORKS/existing
(25 2) /SUPPORT NETWORKS/ideal
(25 3) /SUPPORT NETWORKS/emotional
(25 4) /SUPPORT NETWORKS/practical support